THE MORECAMBE BAY INVESTIGATION

Wednesday, 16th July 2014

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

Before:

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

Ian Cumming

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DR KIRKUP: Hi, I'm Bill Kirkup. I'm chairing this panel. I'll ask my colleagues to introduce themselves.

DR WALTERS: Geraldine Walters, King's College Hospital.

PROF FORSYTH: Stewart Forsyth, a paediatrician and medical director from Dundee.

PROF MONTGOMERY: Jonathan Montgomery, PROF of health for UCL and chair of the Health Research Authority, and I've declared in that capacity we've met formally with Health Education England.

DR KIRKUP: You'll see that we're recording proceedings, and we'll make an agreed record at the end of this. We do also open these sessions to family members as observers. As it happens, there are none present this afternoon, but they do have the right to come and listen to the recording at a subsequent time.

MR CUMMING: That's fine.

DR KIRKUP: And you will also be aware that we have removed telephones and other recording devices

MR CUMMING: Yes.

DR KIRKUP: from ourselves as well, just to underline the importance that nothing goes outside of the room until we're in a position to report with everything properly considered in context. Do you have any questions of me about the process?

MR CUMMING: No, that's fine. Thank you.

DR KIRKUP: I will start off with one very general question and then hand you over to Geraldine, and that is: just describe briefly when you started at the Trust and what you did, and what happened subsequently.

MR CUMMING: Okay. Well, I started originally at the Royal Lancaster Infirmary in 1998, as Chief Executive of the Lancaster Acute Hospitals Trust. I'm happy to go into this if it's relevant to the enquiry, but then over the period of the next two to three years I proposed to the then Regional Health Authority, and then Regional Office by then, that I didn't believe that we had an appropriate configuration of organisations in that part of the world, for a variety of reasons – which, if you wish, I'm happy to return to. Would you like me to?

DR KIRKUP: No, that's fine.

MR CUMMING: No, okay. And the Regional Office accepted my proposals; they also spoke to the then Morecambe Bay Health Authority, who also supported those proposals, and effectively I was then asked to take on a lead role for a proposal to merge the three organisations, which was the Furness General Hospitals Trust, the Westmoreland General Hospitals Trust, and the Lancaster Acute Hospitals Trust. So, in 1997, back end of 1997, I came out into a project director role, to bring those three organisations together into a single organisation, which I was then subsequently appointed the Chief Executive of in March 1998, which then created Morecambe Bay Hospitals Trust, which later on became the University Hospitals Morecambe Bay, so effectively I'd been in the area from – and heavily involved with the organisation – from 1998, through until 2006, when I substantively left the Trust in terms of payroll, etc, at the end of September 2006, but in reality I left in July because I went on secondment to set up the PCT.

DR KIRKUP: Right, and that was the North Lancashire PCT?

MR CUMMING: Yes.

DR KIRKUP: Where you were until...?

MR CUMMING: Where I was until May 2009.

DR KIRKUP: And then?

MR CUMMING: Then I was Chief Exec of the West Midlands Strategic Health Authority. After that, when the SHAs clustered, I was asked by David Nicholson, because I'd been working quite closely with the Francis Inquiry, I was asked by David to become National Director of Quality, to look at lessons learned from Francis, and how we could spread those across the wider NHS whilst we were going through the transition from the old system to the new system. And then I was appointed Chief Exec of Health Education England in August 2012.

DR KIRKUP: Okay. Thank you.

DR WALTERS: Hi. How would you summarise the characteristics of the three hospitals you brought together? What sort of differences?

MR CUMMING: They were very different, and not least of which because the Barrow Hospital and the Kendal Hospital used to be part of the northern region of the NHS, whereas Lancaster was part of the north-western region of the NHS, and there was a very different culture in play in those three areas. I remember, actually, the first time I visited Furness General Hospital, which was when I was working for the Regional Health Authority, so probably back in about '93, '94. And the Chief Executive there at the time said to me that I was the first senior person he'd ever seen from the Regional Health Authority, because they were just so far away from anywhere that they were quite surprised that we were actually going out and meeting them and visiting them. And I'd come in from

Mersey region, when Mersey and NorthWest came together.

DR KIRKUP: You said that was the first person from the north west...?

MR CUMMING: Senior person, from the region, that had actually visited Furness General Hospital.

DR KIRKUP: Okay. Who was that person you spoke to?

MR CUMMING: Brian Cosgrove [?].

DR KIRKUP: Okay.

MR CUMMING: He was the Chief Executive, but that's early '90s I'm going back to now. That's some way in advance of this. So how would I characterise the hospitals? Well, Westmoreland General Hospital was a small hospital; didn't actually employ any consultants of its own. I think when we came together as a merger it actually had one consultant on its books, who was the Medical Director. The rest of the staff were all, or 95% of the rest of the staff, were actually Lancaster consultants, who did sessions there and the hospital paid us for those sessions. They undertook a lot of elective surgery, but all ASA Category 1 type activity, all safe patients. They didn't have an HDU, they didn't have any ICU facilities, and they provided an important service to the local population, and very much, very valued by the local population, who'd fought long and hard over many years to have a hospital in that location. But they recognised the niche they were in, which was predominantly non-elective surgery, but also some longer stay medical type facilities there.

Barrow was a hospital that I think over a number of years has struggled to recruit, and there are many reason for that which, again, I'm happy to go into should you wish, but they'd struggled to recruit, they had turned their back on

some training, which from my perspective, and this is partly relevant to my current role, but from my perspective as soon as a hospital turns its back on training you find it even harder to recruit, rather than easier, because if you don't have people coming through they don't experience some of the benefits of living there. And it was financially the most challenged of the three organisations when we came together. Lancaster was a place where, with one or two exceptions, there were never really any problems recruiting, because there were some very good schools in the area. It was a nice place to live, easy access to the Lake District, and it had a very good reputation for the quality of care that Id delivered. It had good links with Lancaster University, and therefore you knew that recruitment was really challenging if we couldn't recruit into Lancaster. So, that's, roughly speaking, how I would characterise the differences between the three.

DR WALTERS: So, I mean having just merged with another organisation, and trying to sort of flush out the quality issues really, really quickly; so, what was the quality and safety profile like across these three?

MR CUMMING: Well, again, different, and one of the things that we did immediately was actually start to look at what some of the quality challenges were we had in the various organisations, and what we could actually do about it. And I think we – and certainly from looking back at the records, I think in terms of the introduction of the concepts of clinical governance we were some way ahead of the pack, and there's a report from the Regional Health Authority sorry, Regional Office, whatever it was in those days – that sort of made that comment clear, that we were seen as leading that, and we did that because we

were taking over organisations that we didn't know. Now, Lancaster and Kendal was relatively straightforward, to be honest, for me, because I knew Lancaster and it was the same consultants that worked at Kendal, so I had a knowledge of the leadership of the clinical body. We didn't have concerns about nurse staffing levels at Kendal, or indeed AHP or other staff groups. Barrow was a bit of an unknown quantity to us.

One of the things that we did, and I'm perhaps straying from those early days now, but for example we were one of the first trusts to sign up with CHKS for their clinical benchmarking peer review system, to get a feel for what was going on in the organisations. We relied quite heavily on other external peer reviews, you know, be they Royal College visits or Deanery visits, to give us some external perspectives. If we were doing anything that in any way was unusual, difficult, our approach was to bring an expert in, so for example we had a big outbreak of Legionnaire's Disease in Barrow in 2002, and because we weren't sure we were doing it properly we brought in an expert from Manchester to come and advise us, and come and look and see if we were treating people properly. We ran a big cataracts initiative in Lancaster in 2003 and, again, because that was quite controversial we brought in an expert from London, and a public health expert, to advise us and make sure that we were doing things properly. So we relied quite heavily on external advice as well as internal, but one of the things that we did was create the concept of cross Bay teams, as we referred to them, in many areas. And the concept behind that - this goes back to the reason for the mergers, and the reasons for the mergers were to stop competition, inappropriate competition, between the organisations, and the

example I would give of that is MRI scanning. When there was a regional fund available for MRI scanners, Barrow bid, Kendal bid, Lancaster bid. None of them got it because it was a population of about 300,000, and they weren't going to put three MRI scanners in. As soon as we came together as a single organisation we put a bid in for an MRI scanner for the organisation and got it, so that was one of the reasons, to actually put a cohesive argument together. Another reason was to create bigger, more sustainable clinical teams, so urology, for example, one of the first things we did after the merger was to create a single cross-Bay urology team that wasn't based in one location. We brought the consultants from Barrow and the consultants from Lancaster together; we had a degree of sub-specialisation within them that we could deliver that we couldn't on a smaller basis, and they all worked around the Trust as a whole. So that peer review, that sharing of expertise was important, and I think the other thing that we did, you would guess from my current job, I'm passionate about training, and I firmly believe that having trainees in an organisation drives up quality, and also having trainees in an organisation are very important sets of eyes and ears in terms of what's actually going on; listening to trainees' views and feedback.

DR WALTERS: So what was at the top of your concerns list?

MR CUMMING: We had a range of things. I have to say maternity and paediatrics weren't. Paediatrics, we did have some issues at Barrow about staffing, about consultant staffing, but that was actually a little bit later on, so what did we do? Kendal was probably at the top of the list, so we moved from the obstetric unit at Kendal to a midwifery led unit, and that was driven by concerns about safety,

particularly doctor cover out of hours. We took non elective surgery out of Kendal, because we were concerned about surgical admissions with no consultant based on the premises out of hours. We stopped doing intrathecal chemotherapy across the Trust as a whole; we took the day case chemotherapy unit out of Westmoreland general. We created a single vascular unit for the Trust in Lancaster, because we were concerned about a small, isolated vascular unit in Barrow. We moved all the upper GI surgery to Barrow, because we had some concerns about the quality of upper GI being delivered on two sites. I mean, I could carry on, but we had a long list of very deliberate service moves, and I think probably the biggest, which was certainly by far the most controversial, was a proposal that came from the consultants within the Trust that they were concerned about the quality of acute medical care being delivered at Kendal, which led to quite a big piece of work that we undertook in the organisation which led to, just as I was leaving, a very big and very controversial public consultation exercise to stop taking acute medical admissions into that site, because we simply didn't have the consultant cover on that site to be able to provide safe care, and the idea that we were admitting patients with, I don't know, oesophageal varices, into Westmoreland General Hospital with no surgeons on site, no consultants on site, was a safety concern as far as we were concerned, which led to that significant service change.

DR WALTERS: And what was happening to the money all of this time?

MR CUMMING: We were always financially challenged, and I think one of the reasons for the merger was to try and do something about money, and we said as part of the merger – and it might not seem much now, but turn the clock

back a number of years – we took £1 million pounds out of management costs, and that was audited. I know people say mergers don't save money, but that was actually audited as genuinely coming out, to put into front line services. We were there or thereabouts in terms of break even through until about 2006, broadly speaking. And I know the accounts show we were about 1.1, 1.2 million, but that was cumulative, so it wasn't actually, we had about £1 million level of debt, which went from one year to the next year, so it wasn't the way we'd do it now, it wasn't an extra million in each year; it was the same debt that you had to roll over form one year to the next, and we had a degree of understanding with the SHA that as long as we broke even over a three year basis that they would provide some brokerage and some help to support with that. Our PCTs were financially challenged, and prior to that the Health Authority in South Cumbria was financially challenged. We were running services for a population, depending on what service it was, of somewhere between 250,000 300,000, and we had three hospitals. Whereas typically speaking, an average DGH would provide services, you'd have one A&E department, we had two and a half; you'd have one maternity unit, we had two and half, so we were always trying to stretch things out of the resource.

Where we really got hit was in about 2005, 2006, with the introduction of payments by results. I don't know if you remember, but we actually had the final tariff out very late on, and what we were anticipating as some adjustments for rurality weren't forthcoming in that final tariff, and that moved us to a position where in, and I think from memory it was about 2006, we were heading for a deficit of about £5 million. I remember distinctly a conversation with the

Chairman where we felt, and in fact it's recorded in the notes from the meeting, that we couldn't take out that level of resource from our organisation by traditional CIPs without having an impact on the quality 0f care delivered, which was basically meaning fewer people, so we decided that we weren't going to do it. We had a degree of coverage from the SHA, as long as we took a more structured view over the forthcoming months and years to actually try and get that resource out, but I left the organisation in mid 2006, late 2006, and I have to say one of the reasons for me moving on was first of all I had been there quite a long time, but I felt myself that I couldn't see a way of delivering that level of resource out of the organisation through traditional cost improvement programmes, and I also felt at the time that closing a service on one of the sites would have left us with a problem in the quality of care being provided to the population. We did a review of maternity services in 2005 06 considering all options. One of the options was closing FGH maternity unit, but that means you're then 52 miles away from the next obstetric facility, and our view and the expert view was that that was unsafe. We did – and again, I'm happy to supply this, because I have actually got this – we did an analysis of payments by results income to every service against expenditure, and maternity and paediatrics cost us £5 million more than the income for those services, so effectively we were cross-subsidising maternity and paediatrics by more than £5 million from, predominantly, elective orthopaedics, because that was quite a surplus generator for us.

DR KIRKUP: An interesting move to the PCT.

MR CUMMING: Sorry?

DR KIRKUP: An interesting move, in that case, to the PCT [crosstalk] any more money.

MR CUMMING: Yes. I mean, I moved to North Lancashire PCT.

DR KIRKUP: Sure.

MR CUMMING: Which the Royal Lancaster Infirmary was not our biggest provider. Our biggest provider was actually Blackpool

DR KIRKUP: Yes.

MR CUMMING: And we also had quite a lot of patients who accessed healthcare from Preston as well, but that was partly because I had never worked in public health. I wanted to get some more personal experience and exposure to public health, and I wanted to look at whether or not commissioning could actually make a difference to the quality of care that was being provided and look at it in a different way. And I think most of the financial problems were actually the Cumbria end of the patch, because that's where you've got the sparsity of population and that's where you've got the rurality issues. You've got a bit in north Lancashire, but nothing like the same extreme as they had in Cumbria.

DR KIRKUP: Sorry, Geraldine, for interrupting.

DR WALTERS: No, that's fine. I'm sure one of the others night want to pick up on the decision you were looking at to close FGH, but before that, you said there was nothing showing up on the radar about maternity. Were you getting any sort of positive assurances from anywhere?

MR CUMMING: Yes, I mean, I think there was certainly nothing systemic that I was aware of at the time that was showing up. We obviously had individual cases and individual SUIs, as you would d in any organisation, but there was nothing

systemic that we were aware of. We had two or three Royal College visits in the period I was in the Trust, and I'm talking 1998 to 2006 here, most of which were positive. Where there were criticisms or suggestions for improvement we took note of those and reported back a year later on what we'd done. We had Deanery visits, we had CHKS reports, and there was nothing coming back suggesting – and I've taken the benefit of looking back at what is now available, which unfortunately isn't everything, but what is now available – and there's nothing in there, even with the benefit of hindsight, that suggests that. At that timescale we used HSMRs, and we used HSMRs both for the Trust as a whole; I know when I left the organisation in 2006 the HSMR was 103; the SHA used to group organisations in terms of their HSMRs, and early on we were in the lowest group. We then just drifted briefly into the middle group, but we were way outside the band of concern. But we also looked at HSMR by individual area, and our HSMR in maternity, from memory, was quite significantly below the 100, and the same with paediatrics. We'd got nothing that I was aware of at the time or indeed I am aware of now that was a flashing light, that said 'we have got a problem.'

DR KIRKUP: it must have been a considerable surprise, what transpired. We'll take that as read, but do you have an explanation as to how those things could be reconciled now?

MR CUMMING: I think the honest answer is no, and I mean certainly by the time some of the serious concerns about the Trust were coming to light I was actually down in the West Midlands

DR KIRKUP: Sure.

MR CUMMING: Because I moved down to the West Midlands, as I said earlier, in 2009. And I will perhaps later come on to the period I was at the PCT, but certainly through to 2006 I thought we had a safe provision of service to the population, and where there was any doubt about it I think we undertook more service reviews and made more changes to the provision of service I'm not talking about maternity and paediatrics, I'm talking about across the board – than most organisations that we were aware of. Certainly, you know, in 20 I might get this date wrong, but it was '04 or '05 – we were singled out by CHKS as being one of the top 40 hospitals in the country for outcomes, for clinical outcomes, and that's across the board. But they also have a series of flags, so if you have poor performance in any one area you get pulled out of that. Barrow maternity unit won the Maternity Unit Miracle Award in 2004, Helme Chase maternity unit won a midwifery unit of the year award I think in 2003, so there was... I was genuinely really shocked and surprised to hear what was coming out in that latter period of years.

DR WALTERS: I'm finished, thank you.

DR KIRKUP: Okay, thank you. Stewart. Oh, sorry.

PROF MONTGOMERY: I mostly want to talk about the PCT and SHA – not your SHA but what you can tell us about the SHA up here but I just want you to pick up a couple of things you just talked about. One is the benchmarking processes; you described quite a lot of benchmarking processes. Not quite clear that carried on after your time. Would that be your impression?

MR CUMMING: I don't know. Certainly we were the first PCT in the country to commission CHKS to provide a benchmarking for commissioners, but I don't

know what happened in the Trust after I left.

PROF MONTGOMERY: We can have a look. Secondly, you talked about the college visits and a number of external assurances, and one of the things we're trying to get our heads around is where things sat in the governance processes in the organisation. I mean, would the Board have known about a college visit

MR CUMMING: Yes.

PROF MONTGOMERY: ...and its outcome?

MR CUMMING: So, the structure we had, and again apologies, this is a bit from memory, and I'm going back 10 years, but we had the Trust Board structure. Underneath that we had a governance group that I used to chair. It did change its name a couple of times, but basically all the way through it was the governance group. Underneath that we had a risk management advisory group, we had a clinical risk group; we had a non clinical risk group. We had one or two others as well. And we also had a specific, certainly from about, from memory, 2003 onwards, we appointed a lady called Jeanette Parkinson [?] as maternity risk manager for the Trust and it was part of our moving towards CMST Level 2, so we appointed here with the specific remit for maternity risk. She used to produce regular reports to the clinical risk group, and those would find themselves, and I've actually looked through the Trust Board minutes and you can actually see in the minutes we reported at CHKS at Board every month. We reported on it at the governance group, but two, three times a year we'd take a report to the Board. We also reported all serious untoward incidents to the Board, which at the time, I think, was unusual, and what we did was we took the detail in Part 2 and we took a summary in Part 1.

PROF MONTGOMERY: Thanks very much. It would be good to hear a little bit more about the 2006 review of maternity services and what the process was. Was that an internal review? Was it public?

MR CUMMING: It was... now I am dredging back. It was internal, but we did have some external advice and input to it as well, but I would have to go back and check in terms of who that actually was. Basically what we did was, as we were heading into 2006, we looked at those areas in which the Trust was actually significantly cross-subsidising financially, or in which for other reasons there were concerns about financial viability. And there were four areas – or, sorry, there were concerns about safety. And there were four areas that we looked at. This is where I'm going to struggle from memory to remember them. The maternity services across the Bay was one of them; the reasons I've already outlined in terms of £5 million cross subsidy and

PROF MONTGOMERY: So that wasn't a safety inclusion.

MR CUMMING: It wasn't a safety, it was finance. Well, finance and viability to a certain extent, and so if I give an example, I remember distinctly having a debate about the number of obstetricians that we would need, either on, well, on any of our sites, on either the Barrow or Lancaster site, to provide a safe service, and I think from memory it's about this time that the college guidelines were coming out about the number of consultant hours on the labour ward, and for us to deliver that we were looking at needing somewhere in the region of at least six consultant obstetricians, so first of all there's the issue about could we get that number of people, and actually there wasn't particularly a shortage, if I remember it rightly, at the time, of consultant obstetricians, that we seemed to

be over training. But I distinctly remember the debate about saying 'Well, if we have six obstetricians in Barrow, is there enough work for them to do? And not just obstetrics – is there enough gynae for them to do?' Answer: no, because this is about the time that a lot of the traditional operative gynae was being replaced with, you know, ablation, etc, etc. we were doing far fewer hysterectomies, it was becoming less interventional, and I remember having the debate with the obstetricians at the time about saying 'Well if we get these six obstetricians, how do we ensure that they maintain their surgical competence? Because we need them to be surgically competent, because otherwise who's going to do the emergency hysterectomy once a year at three o'clock in the morning when it needs doing, if we've got a series of people who aren't routinely operating? So we had the whole of that debate, so that did play into the review. But acute medicine was the big one that came out of that, and that ultimately was the one that was taken forward, but our review of maternity concluded that – and strength of public opinion did come into this, because these weren't done behind closed doors, these were done with a degree of public scrutiny – the idea of first all Helme Chase was much loved, and was a useful midwifery facility for people who wanted to choose to access a midwifery facility. And we didn't have any safety concerns. We had changed things; we'd stopped doing inductions at Helme Chase, that we used to there, for example. We'd stopped that on safety grounds. We'd some months earlier, although it's midwifery, we used to run one elective caesarean list a week there, in which the consultant would go up; we stopped doing that on safety grounds. So the numbers were coming down in Kendal, but we had no

safety concerns about it, but it was a bit of a Rolls Royce service.

Barrow, our issues were around borderline viability in terms of numbers for a proper obstetric unit. Roughly speaking, 65% of all the deliveries in the Trust were at Lancaster, so two thirds at Lancaster, one third Barrow, and it was an expensive unit to run, but our opinion, our very clearly stated opinion, was we didn't think we could expect people to travel more than 50 miles to the next nearest obstetric unit, and the reason I say more than 50 miles is it's 52 miles from Furness General to the Royal Lancaster, but actually our catchment population went further north than that, so it went halfway up towards Whitehaven, for example. It went quite some significant distance up into the south Lakes, so we had people that would potentially be travelling 60 or 70 miles to access an obstetric unit, and our opinion was that that was unsafe.

PROF MONTGOMERY: So, your successor taking over would have had a closed report that was sort of being worked the way through, or would it have been a live issue as you left?

MR CUMMING: Well, I left in sort of August, September, October time, August, September time, 2006. There was then a period in which Kevin McGee [?], who was my deputy, was acting Chief Executive, and I have to say he inherited the brunt of the acute services review and the closure of Kendal. He was in post as acting Chief Exec through until Tony Halsall [?] started , which I'm guessing was February, March, something like that, '07, and then Tony very much, I think, inherited a piece of work worked that on everything apart from acute medicine, which was still ongoing, had been closed down, and the Board had made a decision to not proceed.

PROF MONTGOMERY: And did that piece of work lead into a commissioning strategy for the maternity service from the PCTs?

MR CUMMING: Right, so if I move to PCT now, we, partly because I had been the Trust's Chief Executive, and partly because we were the minority commissioner of Morecambe Bay, we were not awarded Lead Commissioner status for Morecambe Bay Trust, which I have to say was a disappointment.

PROF MONTGOMERY: You've answered one of my questions.

MR CUMMING: Because I wanted to be Lead Commissioner, but I suppose, you know, the decision was made. About 40% of Morecambe Bay's activity was commissioned by North Lancs, about 60% from Cumbria, so the decision was made that Cumbria would be lead PCT, , which disappointed us for a few reasons, because first of all we weren't then given access to information for the whole of the organisation – they would only share information with Lancaster with us, whereas Cumbria had the benefit of having information for the whole Trust as Lead Commissioner. We were also unable to set quality standards in the contract, because the Lead Commissioner had the responsibility for setting quality standards with the provider. So we were actually in an unusual position in North Lancs PCT, that we weren't the Lead Commissioner for any major acute provider, because Blackpool was commissioned by Blackpool PCT, Preston was commissioned by Preston PCT, Lancashire Care mental Health Trust was commissioned by East Lancs PCT, and Morecambe Bay was commissioned by Cumbria ~~North Lancs~~, so we took on two roles. First of all we took on a particular role around looking at commissioning primary care, and at some of the early stages what could we do to improve the quality of primary

care being delivered, and I also personally was asked to take on the lead role for commissioning the independent sector in the north west.

PROF MONTGOMERY: That meant therefore that you were pretty much out of the maternity commissioning.

MR CUMMING: Yes, we commissioned for our own maternity units, so we commissioned for people who were born in Lancaster, but we had a tiny, again from memory, about 3% or 4% of patients who went to Kendal, and we probably had less than two babies a year who were delivered in Barrow, and they were probably, you know, people who were on holiday in the Lakes or something like that. So we commissioned from Lancaster, not from either of the other two sites.

PROF MONTGOMERY: That's helpful, thank you. And then moving to the way the CSHA operated, each of the SHAs had a different style.

MR CUMMING: Yes.

PROF MONTGOMERY: So can you talk a bit about their work? Was it mostly pushed out to the PCTs, or was there a high degree of coordination with the SHA? Did the SHA pull them all together?

MR CUMMING: I think it depends when, and of course we had different SHAs at different periods, so do you want me to stay within the timescale of an enquiry, or...

PROF MONTGOMERY: Within the enquiry.

MR CUMMING: Within the enquiry timescale, okay, so

PROF MONTGOMERY: If you could start with 2006 as you go to the PCT, and then take us through to the end of the enquiry timescale.

MR CUMMING: Okay. So, the SHA was proactive in some areas, so if you take advancing quality, for example, the SHA were very much the leader round the advancing quality initiative in the north west, and I actually sat on the SHA Board for advancing quality. They also set up one of the, in my biased opinion, best leadership academies in the country in the north west, I also sat on the board of that as PCT representative. And so I those areas they were very proactive around what we were doing. Around this timescale, again I'd have to check the date, but we went through world-class commissioning, and there was very tight ~~sight~~ scrutiny of what the PCT was doing with regard to quality in that world class commissioning period, and that was, although it was nationally driven that was very much led by

PROF MONTGOMERY: And was that shared within... I guess the question that I'm asking, because I've been asked this but haven't seen it, is whether maternity was flagged as an issue in the Cumbria PCT as a cross function.

MR CUMMING: Yes. Well, I can't answer for Cumbria PCT, I'm afraid. We didn't...

PROF MONTGOMERY: So you didn't have that to share.

MR CUMMING: We didn't have that data. Certainly within Lancaster, or, sorry, within North Lancashire, and this is where it gets slightly difficult, because one of the things we used to do is if you look at North Lancashire as a population, we actually have probably the majority of the population in North Lancashire accessing services from Blackpool, then Lancaster will be second, then Preston will be third, and one of the debates that I remember having with CHKS when we commissioned them to provide outcome data was giving me data for the population as a whole is meaningless, because you're averaging

averages, and you end up with, you know, you could have one that's the best, one unit's the best performer in the country, one's the worst, and actually it all ends up looking pretty average. So one of the debates we had with CHKS was not just showing what was happening in terms of outcomes to our population, but also differentiating that and breaking that down between providers, and I think it's fair to say that in the early stages they had a challenge doing that.

PROF MONTGOMERY: and in world class commissioning, was that closely scrutinised by the SHA?

MR CUMMING: Yes. That was a tough process.

PROF MONTGOMERY: Okay.

MR CUMMING: On a whole host of levels, both the work that went in in advance of it, but also the actual scrutiny itself that we went through. And if I look back now and compare it with other assurance processes I've been through since in different roles, we really did feel we'd been put through it in terms of that first round of world class commissioning. I'd moved on before the second round, so I don't know what happened in that.

PROF MONTGOMERY: So that gives me a bit of a sense of the SHA on the commissioning development side. How did it relate to the providers, because some SHAs say the FTs are not much to do with us, and others ignored the fact that there was an F in the title?

MR CUMMING: Yes. I think the – and this is where I discovered this myself when I moved to the West Midlands SHA, that the culture of each SHA, as I think I've alluded to, is very, very different. And the north west had far less of an us and them approach between FTs and non FTs than, certainly, the West Midlands

did, for example, when I moved down there. So, we used to have regular provider meetings which everybody went to, whether they were an FT or not. We had good discussion and debate in those meetings, and we had many FTs who were actively leading projects on behalf of the system, so I can probably only speak from personal experience from the West Mids and from the north west, but I think that it was much more cohesive in the north west than in the West Midlands.

PROF MONTGOMERY: And were they joint provider and commissioner meetings, or were they separate?

MR CUMMING: No, joint.

PROF MONTGOMERY: Okay. So, if I was asking about the profile of Tony Halsall and of UHMB at that stage while you were still in the system as a PCT Chief Exec, would he have had a high profile?

MR CUMMING: I don't know, is the honest... There was nothing that would say to me... I don't think he had a particularly high profile, but equally he went to meetings. I would see him at meetings with the SHA. I think we had a more difficult relationship than I would have liked between North Lancs PCT and the leadership of the Trust, and I never quite worked out whether that was because I'd been in that organisation and therefore it was a bit difficult, or quite what it was. I mean, I remember – and again, if you'd like this, I've got the paperwork – in 2008 we'd been doing some work on never events, and at that stage never events just didn't appear in the lexicon of what we were doing in the NHS, but myself and my medical director had been quite taken I've always had an interest in quality, it might be coming through myself and the medical director

had been quite taken with the work that had been going on in the States looking at never events in healthcare, and we decided, with the support of our board, that we wanted to introduce never events into the contract, and we had a battle because, as I said earlier, we weren't the Lead Commissioner, and therefore we weren't supposed to put quality in. But we produced a paper that said 'Okay, for year one let's look at these following as never events. If there is a never event in any of the population for which commission, we expect Director, Executive Director of the PCT, notification straight away; we expect full SUI disclosed to the PCT and we expect to not pay for that episode of care, being quite blunt. And I do remember that that paper was actually quite warmly received by Blackpool, who thought it was a really good way forward. Preston were pretty ambivalent about it; Morecambe Bay were very opposed to it. they didn't believe it was something a commissioner should be doing.

DR KIRKUP: Did you include intra partum still births as a never event?

MR CUMMING: They were... I can send ~~tell~~ you the paper, but there were two groupings. So, we put a never event, and we put a list of things that we wanted to add into never events from year two. That was in year two, so it's on the list, but it wasn't... the first year we went for literally four of the real, absolute, you know, wrong site surgery, things like that. Wrong site, wrong patient surgery, but that was in year two.

DR KIRKUP: Okay. Sorry.

MR CUMMING: Sorry, just to add, because I think it is relevant to that, the other debate that we had about the SHA was STEIS [?]. I don't know if anybody's mentioned STEIS to you – the Strategic Executive Information System, which

bypassed the PCT? So, if SUIs were reported by the Trust we knew nothing about it, and the only way we knew anything about it was if anybody in the SHA or the Trust told us about it. So I wrote to the SHA in about 2007, '08 and said 'If commissioners are responsible for the quality of care they're commissioning, this is unacceptable. We have to have access to these.' Mike Farrell [?] agreed with me, and wrote back to me agreeing, and actually just as I was leaving they'd put some sort of software patch in there to allow any SUIs reported by the trust to come back to the PCT, so the PCT was aware of them. And I think Cumbria had been piloting that for a year or so before that actually went live.

PROF MONTGOMERY: Then not long after you left that was devolved out of PCTs anyway, wasn't it?

MR CUMMING: It was then fully devolved out of PCTs, yes, so there was an interim patch and then it was given to PCTs, I think, in 2009, just after I'd left.

PROF MONTGOMERY: That's fine, okay. And what sort of common knowledge was there of challenges across the SHA? I'm particularly thinking that we know that there was a risk summit about universal ops [?] across Morecambe Bay in early 2009, where the SHA sort of took stock of what the issues were. Would that have been known to you?

MR CUMMING: I have no recollection of that. I know that Cumbria PCT, and again, this is from memory, had a financial challenge of somewhere in the region of £28 million around this time, and the majority of that as I understood it was associated with the north of Cumbria, but there was a big debate about how that got risk shared, and whether or not the £28 million should apply across

Cumbria as a whole. And I do know, and this was only from discussions with the trust, that there were plans afoot to spread that across Cumbria as a whole and to transfer some of that risk to the Trust rather than leave it with the PCT. And I know that was causing the Trust particular problems in trying to reduce those things that we were engaging with them on over quality and issues, I seem to remember anticoagulation being one that we were talking about at the time. They didn't have the time to be able to engage with us because they were associated with this, so other than that I don't remember a particular quality summit. Certainly I wasn't involved in it.

PROF MONTGOMERY: Thank you. I'm nearly at the end. Was this an SHA that sort of had a hotspots approach? You knew that Mike Farrell was focussed on a couple of things at a time.

MR CUMMING: Yes. Yes, I mean, certainly there were... I used to meet Mike on a one-to-one, as I did all the Chief Execs a couple of times a year. He would link in on what we were doing the rest of the time through other directors, so Joe Rafferty was the director of commissioning at the time. He had a very close link with Kevin McGee, who was my director of commissioning, in terms of what was going on on the patch, but certainly our impression was that there were those particularly challenging hospitals or providers, or commissioners, that the SHA was very actively engaged with, and I think, you know, Cumbria generally, in terms of some of the financial and other problems that they were in, Cumbria was very much on the SHA's radar, but I don't think we were enough, actually.

PROF MONTGOMERY: You'd breathe a sigh of relief when it's a short meeting. We're going to be learning, I think it's in the documents that this thing existed,

the Gold Command approach that the SHA took at one point.

MR CUMMING: Yes, that was some way after my time.

PROF MONTGOMERY: No, no, I'm not asking about this Gold Command. I'm trying to understand whether that's a particularly unusual thing for this SHA to do, or whether actually there was a series of hotspots where the SHA said 'Actually we've got to go in and get a grip of this.'

MR CUMMING: From memory, from my knowledge, and of course this happened after I left, but I hadn't been aware of that happening anywhere, although I know there were some issues of quality of care at Thameside [?], and they may have done something there, but certainly from my knowledge it was pretty unique.

PROF MONTGOMERY: It wasn't a normal way of working.

MR CUMMING: No, and certainly even in the West Midlands, you know, as we were managing the aftermath of Mid Staffs, we didn't go down that route even with that organisation, so I think it is a different way of approaching it.

PROF MONTGOMERY: Thank you. Thanks.

DR KIRKUP: Thank you. Stewart

PROF FORSYTH: Thank you. Just to go back to Morecambe and the challenge of services, when you were involved you were obviously giving some consideration to maternity services, and the financial gap there. Did you actually do a formal option appraisal of maternity services across the Trust?

MR CUMMING: We did, and effectively it was looking at everything from midwifery services through to obstetric services through to closure. I mean, effectively, we took each of the three sites and said 'Those are the three options: not have

one, have a midwifery provided service, or have an obstetric service,' and we mapped that on each of the three sites and looked at the various options. And I have to say, we kept coming back to this view that obstetric unit, obstetric unit plus midwifery unit, was the way forward. We did spend quite a lot of time on a debate about whether it could be midwifery unit/midwifery unit-obstetric unit, and actually put the obstetric unit into Kendal, because geographically that deals with a lot of the issues, but we didn't have a paediatric facility. So, we'd then have to have moved a paediatric facility into Kendal to make that a safe service; that would then probably make paediatrics non viable on the two sites, so ultimately that was before then [?].

PROF FORSYTH: So, there was no sort of solution to the underlying problem.

MR CUMMING: Well, the decision our board came to was that we had to continue to cross subsidise, because of the way that funding flowed for maternity services. We would continue to cross-subsidise, we would continue to do what we could to provide safe care, so we used birth rate plus, for example, and every year we mapped midwifery numbers against birth rate plus and made sure we were there or thereabouts in terms of the output. We relied on college visits, we relied on LSA visits to make sure that we were providing as safe a service as we could, and as I say that was £5.5 million over what we were funded for.

PROF FORSYTH: What about the paediatric services you touched upon there? Did you feel there were issues, particularly in Barrow, in relation to that?

MR CUMMING: Yes, I think we had... we struggled to recruit in paediatrics at Barrow, and in fact paediatrics nationally was more of a problem, especially to

recruit into at consultant level around that time, and we'd even had problems recruiting into Lancaster, and as I said earlier it was a real barometer for us if we couldn't recruit into Lancaster: we knew it was a national problem, because it was a very popular organisation to work in. and when we first came to work in – again, this is from memory, so apologies if this isn't 100% accurate – but from memory when we came together as an organisation we had four consultant paediatricians in Barrow. One of those then retired, and a second one then left the area and moved on, which took us down, for about a year I think, to two consultant paediatricians. And then just not long before I left we appointed a joint appointment with the community for a community and acute paediatrician, and then literally just around the time I was leaving we appointed two more paediatricians, taking it up to five in total, but one of those was a shared community/acute. And that was the number that we felt was right and appropriate. Perhaps going back to a question that had been asked early on, about, I think it was your question, Geraldine, about safety, when we were formed as a Trust we felt we hadn't got enough consultants, so if you look at the period between 1998 and 2002, we created an additional 48 consultant posts into the organisation, which is about 35%, 40%, increasing or numbers, because we felt we couldn't rely on junior doctors. So if I look at paediatrics again, in Barrow we were very reliant on a mixture of junior doctors and staff grades to provide much of the cover, and I remember increasing the staff grade complement by two. Can't tell you when it was, but it was some stage in this period, we put two extra staff grade doctors in, and what we were trying to do was to move towards a three tier cover. I can't– again, being honest, I can't

remember if we actually got there before I left or not, but that was certainly the intention, so we would have the SHOs, who were predominantly on the GP training programme, who would provide the first level of cover. And some of those were experienced, some of those weren't; some of those would be in their first paediatric job. We would then have the staff grades, who would provide the second level of cover for us, and then we'd have the consultants, four of the five did cover for the acute unit, so we were trying to move towards that three tier, away from what was a two tier, which was consultants and staff grade nurse/SHO combined, because we didn't feel it was safe to have very new SHOs covering paeds on their own. And I think, I think that we got there three, six months before I left.

PROF FORSYTH: Yes, and probably things have changed again with the junior doctors' hours and training and whatever, and I think more students are struggling.

MR CUMMING: As I was looking back through the minutes of the Trust Board I found a quote from myself which I think is quite interesting, that the Trust had the lowest number of junior doctors of any trust in the north west, and the north west had the lowest number of junior doctors of any region in the country, so we were really struggling, and you'll notice we lost stars in the star rating over a period of time, and the main reason for the loss of those stars, it wasn't around quality of care, if you look back to what that was about. Part of it was financial, but actually a big chunk of it was around doctor numbers, but it wasn't consultant numbers. It was junior doctor and middle grade doctor numbers. So what we did, we put the extra 48 in to try and offset the shortage that we

had in, and really moving towards a consultant delivered service, probably in advance of much of the rest of the country, because of our rurality and particular challenges, and moving away from relying on juniors for service.

PROF FORSYTH: And how were these 48 distributed across Lancaster and Morecambe?

MR CUMMING: Ooh, I'd have to go back and look at the documentation. They certainly weren't all Lancaster, because actually many of the problems that we identified where we needed additional posts were at the Barrow end of the patch. And what we started doing, from the day we merged, we started appointing people onto what we call cross Bay contracts. We inherited people in Lancaster who didn't want to go to Barrow; we inherited people in Barrow who didn't want to go to Lancaster, because it's a long way, but we made it a point of wherever we could we got people to do that, so I mentioned urology earlier on but there were other examples. But from the day we started we appointed people to cross-Bay contracts, so they had a base but they were contractually required to cover other sites as well.

PROF FORSYTH: Just to go back to the MRI analogy of three hospitals applying, and when you put in your original bid and you got an MRI scanner, where did it go?

MR CUMMING: The initial one went into Lancaster. We did debate putting it into Kendal, again because it was in the middle, but the Regional Health Authority – no, sorry, Regional Office, whatever it was in those days – they made it quite clear that actually we were likely to get two. So our initial bid went in for Lancaster, and that was on the basis that it was the largest population, and

then within six months we were putting a second one in Barrow.

PROF FORSYTH: Right. Were there other significant developments in Barrow during your time that you feel...?

MR CUMMING: Yes. I mean, at the time we came up with this concept that we called the single district general hospital operating on multiple sites, and that was the model that we were trying to work towards, and that was the model we were trying to sell to the population. We were basically saying 'You're not going to have everything on every site, but if you want to keep it in the area, we will do our utmost to keep those services that we can keep safely by operating on one site.' I can give you a long list: dermatology in patients all went to Lancaster. All upper GI surgery – and, sorry, we were a sub regional unit for that – all upper GI surgery, with the additional ICU beds to support it went to Barrow, and that also had a link in through to Preston for the MDTs, so we did the MDTs via video conference link to make sure we were part of the bigger unit. In fact, the surgeons there also did sessions at Preston to keep that linkage in place, because otherwise we would have lost it. We moved all vascular surgery to Lancaster. In urology, all the lithotripsy was done at Barrow for the whole of the bay; in gynae, all the uro gynaecological stuff was done at Barrow, for the whole of the Bay, and we had one Prabas Misra, who specialised in urological gynaecology, and that again was safety. Other services, so paediatric orthopaedics, for example, we had got somebody in the Trust who had spent quite a significant amount of time training in paediatric orthopaedics, so we made him the designated paediatric orthopaedic surgeon for the Trust as a whole. He operated on two sites, and we stopped everyone

else doing paediatric orthopaedics. So those were the sort of approaches we took, so not getting too hung up on geography, but basically saying we'll provide the best service we can. And we referred to – again, it's in the minutes – we referred to what we called 'jewel in the crown', because we felt that every hospital had to have something that it should be really proud of, part of staff esteem, part of prestige for the service, and Lancaster was vascular; Kendal was actually Helme Chase; Barrow was upper GI. You know, a service that really stood out as having really good clinical outcomes and really something that we could be proud of, and that was part of our approach as well. I still get all my patients.

PROF FORSYTH: Thank you.

DR KIRKUP: I just want to pick up one area, because I think it is important, and part of our remit, and that's this issue about three hospitals, one trust, that the cultures are very different

MR CUMMING: Yes.

DR KIRKUP: -in the different places. I suppose I have to start by saying I was fascinated to hear that you had attributed that to the south Lakeland, having previously been part of Northern Regional Health Authority. You won't know this, but in 1990 I actually negotiated the transfer of south Lakeland from Northern Region to North Western and Manchester or whatever it was called in those days. And the argument was 'We don't fit with Northern. We don't really link with the rest of Cumbria; we've different television stations, we have different shopping trips. There's a watershed at Kirkstone Pass.'

MR CUMMING: Yes.

DR KIRKUP: If that's true, where does Barrow link to it naturally? The junior doctor rotations were all from Manchester in those days too.

MR CUMMING: It's part of the North West. You know, particularly the Barrow area used to be known as Furness north of the sands.

DR KIRKUP: Lancashire over the water, I can remember.

MR CUMMING: Yes, so I do think it is very much part of the north west, and I think we were just seeing... certainly the way it was portrayed to me was just a bit of a hangover from, well, different cultures, different systems, different processes, and I supposed it is eight years on, actually, from when you were describing that, but...

DR KIRKUP: Sure.

MR CUMMING: But it just felt different. And it may be just because it was geographical isolation, but it just felt different.

DR KIRKUP: I think that's what I'm trying to get at, really, and I wonder to what extent this is because it doesn't really naturally fit anywhere.

MR CUMMING: That may well be true, and certainly it is at the end of a very long cul de sac in many ways.

DR KIRKUP: Yes.

MR CUMMING: And people going there have to travel quite some time to get there, people coming from there have to travel quite some time to get anywhere. Easier these days with video conferencing, but we didn't have that option in those days. Even people from Lancaster used to think it was a flipping long way to go to Barrow. I mean, it was an hour, but...

DR KIRKUP: Absolutely. Okay, so how effective do you think the cross-Bay

initiatives were? The one service on three sites dynamic.

MR CUMMING: In some cases very, in other cases not, and in some cases we actually decided to stop pushing it, because actually we had to run as distinct services. So, distinct services but with combined policies and procedures. When we came together, none of the three trusts really wanted to merge, if I'm being quite honest. Everybody saw the downside of it, and nobody saw what we thought was the upside, and I think particularly at Kendal – I'm a great believer that if you go through enforced change it's like this sudden bereavement, you go through the sadness, anger, resentment, acceptance, and I think we actually saw that in the staff at Kendal, because they had a really nice, friendly hospital, where they had, you know, small hospital, small number of beds, single site, Chief Executive knew everybody, they had their own Chief Exec, they had their own director of nursing, their own finance director, their own chief operating office, etc, so they had a full Trust Board of people for a hospital with less than 200 beds, and what we did was we moved to a single trust with one chief executive, one finance director, etc, one chairman, so the first thing that happened was we got allegations about visibility, and I have to admit I was on the verge of killing myself, the amount of miles I was driving trying to be visible on all sites and all the rest of it. But we still got this constant 'We never see the Chief Executive any more,' because there was one of us.

DR KIRKUP: Yes, I recognise that, because your correspondent who told you that nobody senior came out from the region in 1990 is dead wrong, I know how it feels. The people on the receiving end of it never see it; you, you're spending

all your time on the road going to these places.

MR CUMMING: Exactly. So that was a real challenge for us, I think, in terms of bringing the Trust together. Whenever I went to Barrow and had a debate around consultants or anybody at Barrow, I always got the 'Well, you're giving all the money to Lancaster.' Whenever I got to Lancaster, it was 'Well, you're giving all the money to Barrow.' And whenever I went to Kendal, I got the 'Well you're nicking all our money.' And actually that third one was probably true, because that hospital did generate a surplus, whereas Lancaster was, broadly speaking, break even, and Barrow was in financial deficit, so we actually balanced out some of the finances across the Bay but we ran a whole host of... what did we call them? CELT programmes: Creating Effective Leaders and Teams; and we'd take somewhere in the region of 30 people deliberately from different sites, and I'm talking of clinicians, here, not managers, and we put them together. And we ran one of these every month for three years, so we actually put people through this CELT programme that was all about, okay, what's the Trust all about? One of the things I used to do, and, again, if you'd like the presentation, I'm very happy to present that; I used to spend a day at each of these, and I did a presentation on clinical governance, quality and safety. We also had some experiential learning built into it, but we also did a session that was specifically about breaking down some of the barriers and some of the perceptions, and I remember a number of the feedback forms were 'Actually those people from Barrow aren't bad,' or 'Those people from Lancaster haven't got two heads and three legs,' partner whatever it may be. And that was valuable, but to be honest it didn't happen as quickly as I would

have liked it to have done, and quite how, one of the things, if I look back in terms of what would I have done differently, I think we should just have bitten the bullet and invested in even more of that. We did a lot, but I think we should have invested in even more of that, and I reckon we'd probably got through ~~50~~ 15% of the Trust staff over the first three or four years, but I think we should have speeded it up.

DR KIRKUP: Okay. Any...?

PROF MONTGOMERY: If I could ask a follow-on from that, we picked up from a number of bits of stuff that have come through to us about tensions between different professional groups.

MR CUMMING: Yes.

PROF MONTGOMERY: Can you say something about what you perceived about that?

MR CUMMING: There were tensions, and I think in some cases they had always existed and continue to exist, so I think midwives-obstetricians has always been a bit of a tension in the service. It's much better now than it used to be, and it varies. You know, some units the relationship is fantastic.

PROF MONTGOMERY: Are you talking generally here, or about Barrow?

MR CUMMING: I'm talking particularly about Barrow, I think, that... well, I'm talking about the Trust, I think, it's probably fair to say, so I think that we have some midwives that felt there was too much intervention going on, and perhaps normal deliveries should be allowed to proceed when perhaps there was intervention by consultants, be that, you know, non elective caesareans, or instruments, or whatever. That was a tension. I think there was an

obstetrician-paediatrician tension, and I remember one particular ~~par~~ case – again, I'm going to struggle with the date, but it's certainly within the terms of reference of the enquiry, I think it's probably 2006 – where we had a mum [redacted] and the obstetricians were really keen to manage this pregnancy, and the paediatricians were more apprehensive about managing this pregnancy, because the paediatricians were saying 'You've got one mum to look after [redacted] so I remember managing those sorts of tensions through, but we created probably in about 2003-04, I think, we used to have a women and children's directorate, and we actually split that in two, and we created a paediatric directorate separate from the women's directorate. And part of the reason for doing that was that our clinical director was an obstetrician, and the paediatricians didn't feel that their voice was being heard enough around my exec team table, because they didn't want their views represented by an obstetrician. Actually, I thought he did a pretty good job of representing their views, but we created a separate directorate specifically to make sure that the views from the paediatricians were coming across loud and clear.

PROF FORSYTH: Can I just pick up about the [redacted] case? I mean, one of the issues seems to be that the neonatal unit, or the special care baby unit in Barrow was a sub-level one unit.

MR CUMMING: Yes.

PROF FORSYTH: And that's obviously, I think, the reason there is tension

MR CUMMING: Exactly.

PROF FORSYTH: With the obstetricians. You have a consultant led obstetric unit

wanting to look after the patient through their care, then being told by the paediatrician 'Well actually you don't have the facilities to provide the neonatal care.'

MR CUMMING: That's true, and certainly we had, I remember producing a policy on introducing transfers out to the other units, where there was concern about the health of the baby post delivery. Again, I can't remember when this was done, but there was a piece of work done at some stage looking at all the neonatal special care units across the north west, and the designation, and that was when the commissioners... I must have been at the Trust, because I don't remember this from the PCT, but that's when Barrow was designated as a level one unit. I think Lancaster was designated as level two unit, and – from memory – Preston was designated as the level three unit, which to me seems eminently sensible, and seems entirely appropriate, but the obstetricians wanted to provide the service to the best of their ability for people locally. You know, if you send a mum from Barrow to Preston, it is a long way, but safety has to come first.

DR KIRKUP: Anything? We're all done. Is there anything from us? I'll just check.

PROF MONTGOMERY: Can I just check – I haven't asked this because I don't think you'll have anything to tell us on it, but the FT process, you were there for the very beginning discussions of that. I haven't asked you because I assumed it hadn't got very far by the time you left, but I just want to check that that's...

MR CUMMING: No, I don't think I was involved at all in the FT process for the Trust, certainly. Well, sorry, I was involved in the 1A FT process, which is when we were very first going to go as FT, when I was area Chief Exec, I'm going back

to whatever year that was, and just so you know the reasons for not taking that forward were also linked in part to some of the financial numbers in the Trust, that Cumbria became the test ground for Unison for equal value pay claims, and if they had been successful the Trust would have had a liability of £40 million, and we were told there was no way we could proceed with an FT application.

PROF MONTGOMERY: That's what I'd like, I've just seen some documents we had from our earlier discussions, and I had assumed that they hadn't gone anywhere. Just checking, thank you.

MR CUMMING: Can I mention one thing, and I don't want to be controversial, but I wrote to the Regional Office of the NHS in 2000 expressing concerns about governance and maternity services, and particularly in midwifery, because of the role of the LSA office, and I wrote because I was concerned at the time that we'd had an incident, and I can't remember what the incident was, but we'd had an incident in the Trust that hadn't been reported through Trust governance processes, and we had found out about it by accident. It had been reported through the midwifery governance, and I remember sitting down with not Denise Fish, not the director of midwifery, but a senior midwife at the time, and they had a conversation with me that went along the lines of 'Well, you have to understand that midwives first and foremost report for governance through to their local supervisory authority, and their employer falls some way down the line.' And I was really worried and concerned about that, and I wrote to the SHA – sorry, to the Regional Office – in 2000, to the director of nursing at the Regional Office, just expressing concerns about that. I still have those

concerns.

DR KIRKUP: Yes. Did you get a reply?

MR CUMMING: No.

DR KIRKUP: Nothing at all.

MR CUMMING: Nothing at all.

DR KIRKUP: Okay.

PROF MONTGOMERY: What did you do to pick up, or did you pick up those things?

MR CUMMING: I followed it up. I asked why I hadn't had a reply, and I followed it up and they said it had been raised nationally, and that there was a discussion ongoing, but that midwifery was extraordinarily complex and people had to look in two directions, because of the independent practice nature of many of the...

PROF MONTGOMERY: I understand that that conversation is still going on. I actually was asking what you did within the Trust to make sure that...

MR CUMMING: Oh, sorry. Yes, I then saw Denise Fish and I made it absolutely clear that as far as I was concerned the Trust Board was responsible for the quality of care delivered to every single one of our patients by any single one of our employees, and I would consider it would be a disciplinary offence if – I'm perfectly happy with them being reported in two directions, but I would consider it to be a disciplinary offence if we were not notified through the appropriate processes of any SUIs.

DR KIRKUP: it's outside of our terms of reference, but do you remember the nature of the incident?

MR CUMMING: No. It wasn't a really serious one, but it was one that I felt that our medical director and director of nursing and midwifery needed to know about,

and we simply didn't know about it, and I rem we heard about it from the director of nursing at the SHA, who had it brought to her attention. It wasn't a serious, it wasn't a neonate death or a maternal death, but it was a near miss.

PROF MONTGOMERY: But you've been pretty clear, if anything within or timeframe hadn't been reported to the Trust that that would have been after being warned as opposed to because they didn't understand the system.

DR KIRKUP: Yes, that's pretty helpful. Is there anything else you want to tell us?

MR CUMMING: No, I think if there's anything else the panel wants to know at any stage I'm very happy to provide that. I have got, I had a look through – I haven't got any papers really, but I did have a look through what I've got. I have got a series of presentations from around the time, sort of annual reviews of the year, I've got a series of work that we were doing on... I tend to keep a hard copy of every presentation I do for some strange reason, so I've got a few of those if they're of any interest, but they really set out the Chief Exec review of the year, and the ones that may be helpful are one that particularly talk about the maternity services review, and the ones that particularly talk about our approach to clinical governance, use of CHKS, peer review, benchmarking, those sorts of areas.

DR KIRKUP: Okay. That's a helpful offer, and if anything does arise where we think that might be useful, we'll get back to you.

MR CUMMING: Okay. Thank you.

DR KIRKUP: Thank you very much.

[Interview concluded]

THE MORECAMBE BAY INVESTIGATION

Wednesday, 17 September 2014

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

Before:

Mr. Julian Brookes -- Expert adviser on Governance (In the Chair)
Professor Jonathan Montgomery -- Expert adviser on Ethics
Professor Stewart Forsyth -- Expert adviser on Paediatrics
Dr Geraldine Walters -- Expert adviser on Nursing

JANE CUMMINGS

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

MR BROOKES: Good morning. First of all, apologies from Bill Kirkup who chairs this investigation. Unfortunately he cannot be here today. Something has cropped up which is unavoidable. He sends his apologies.

He has asked me to Chair in his absence, we will go through -- there are a couple of things I will go through as part of the introduction, one of them will be to introduce the Panel today, and if you can then formally introduce yourself, that will be extremely helpful.

(Following introductions by the Panel and housekeeping matters)

MR BROOKES: Do you want to say who you are for the record.

MS CUMMINGS: For the record, I am Jane Cummings. I am the Chief Nursing Officer for England.

MR BROOKES: Thank you. As you will be aware, these are sessions which families are invited to you will see there are not any here today, but it is open to them and you will also notice that there is a microphone in front of you. We take a formal record of the interviews, partly for us in terms of our considerations at a later stage but also if families at a later stage want an opportunity to listen to the transcript under controlled conditions, it gives them that opportunity so they do not feel they have to be here for every session.

We have also, for confidentiality reasons, asked for everyone to hand in their phones et cetera. I know people feel bereft but for the purposes of this it will be helpful. That is really, just to explain, so that there are no recordings made of the transcript because it is really important that what is heard in here is taken in total context of the evidence that we have received and can be part of the final considerations. So we do not want snippets coming at that are taken out of context and provide misleading stories or debates.

We are going to start with series of questions, and we will start with Jonathan.

PROF MONTGOMERY: Thank you. Can you just take us through the time line of your involvement with this part of the world? We know where you have got to now. Just take where you came from in this part of the world.

MS CUMMINGS: Okay. So, I was appointed to be the Director of Nursing Quality and Performance at NHS North West and I started in November 2007. I remained at the North West doing that job but also at some point becoming the Director of Commissioning as well for a while, ~~as well as all the~~ as well as taking other roles/responsibilities ~~other things~~. I did that job until April 2011, when Mike Farrar left, I think that was it, I think he left then, and I became the deputy Chief Executive until Octoberish, I think, when we merged into NHS North of England.

So we had the three SHAs merged, at which point I became the Chief Nurse ~~for the North West~~ for the whole of the North of England. I did that until March 2012, when I was pointed to the CNO job of England and I started, I think that was March 16th I was actually appointed and I started immediately working. I did both jobs for a while. Then full-time in June.

PROF MONTGOMERY: Thank you. So if we can go back to November 2007 and have a bit of an understanding of how that role works. There is a lot of things in Director of Nursing Quality and Performance. Can you give us a flavour of what that meant in practice?

MS CUMMINGS: I will do my best. It was quite a long time ago. When I was appointed, it was a new job. There had been there had not been a Director of Nursing at the SHA before in a sort of a formal permanent role. Somebody, I think, had been acting up into it. Most of the quality agenda was covered by Ruth Hussey who was the Medical Director, supported by Mandy ~~(?)~~ Wearne who was one of the other directors, who was also a nurse and a midwife.

I think it is fair to say that the SHA had come under quite a lot of pressure because they had not put a chief nurse in. So the job was advertised and I applied. So I arrived and effectively took parts of other people's responsibility and had to create both the team and the job,

I suppose.

So I appointed some people to work for me, I took some people from other directorates and I effectively had a director that looked after -- that worked with me -- was deputy director that worked with me on nursing and quality and a director that worked with me on -- deputy director, that worked with me on performance.

PROF MONTGOMERY: Okay and the person who worked on quality, who was that?

MS CUMMINGS: Angela Brown.

PROF MONTGOMERY: It is helpful for us to have names as it is much easier to track them through the documents.

MR BROOKES: And, for completeness, the director -- deputy director of performance?

MS CUMMINGS: Karen Campion.

PROF MONTGOMERY: At that handover stage, does this part of the world feature at all in handovers you are given in the mind of equality and performance.

MS CUMMINGS: No.

PROF MONTGOMERY: At what point does it get on your radar?

MS CUMMINGS: It came onto the radar more in -- without going back through every single one of the performance reports, which we cannot access, there were some issues around general performance in terms of delivering some of

the NHS targets. But it certainly was not an organisation that was a major issue, it was sort of middle of the road in terms of the a lot of the performance issues and a lot of the -- just the oversight across the North West.

I am sure you know but it is worth pointing out that the North West SHA was the largest outside of London and had a very large number of organisations both PCTs and Trusts acute, mental health, et cetera. So it was a large and complex system and Morecambe Bay was certainly not anything that was flagged, from my recollection, throughout 2007 or even 2008.

What we did or what I did as part of my role and without going back through -- without -- I have not been able to track through the board papers because they are all -- ~~they are all online now~~ they aren't online now, one of the things we did was create a performance dashboard which, at the time, was probably more than any other SHA had done and we developed it with ~~a PA consulting~~ PA Consulting and with staff within the region.

It ended up looking at a huge range of issues. So pure performance issues but also a lot of quality issues, a lot of prevention issues, and a lot of public health issues and we had we tracked trends as well. We looked -- that was developed and took a while to develop and test and pilot, ~~but~~ and we used that on a monthly basis.

It got presented at board, we looked at it internally

and we were able to identify from that any particular issues, or concerns which I didn't pick up at the time. I cannot remember any -- picking up anything around Morecambe Bay for a while.

PROF MONTGOMERY: What sort of things did raise flags across the regions?

MS CUMMINGS: We had things like -- so there were issues around responses to -- for example, one of the things we did was did a review of quality assurances as it were. So post-Francis one, we did a review. We actually asked organisations to self-assess, against six or seven different criteria. We asked the PCTs to assure and confirm that those assessments were correct. We looked at whether the organisations were well developed, partially developed or not developed around those areas and that would flag any -- some of those would have flagged concerns.

We did have issues. So I can give you examples of other organisations where we took where we took action where we had concerns. The other thing we did was concentrated a lot on what we could do to improve quality. I think it was before I arrived but certainly when I did arrive, the messaging from the rest of the organisation was that when the North West was created, financially, it was in a pretty stable state and actually remained, as a whole, financially stable. But quality was quite variable and the health of

the population was ~~not~~ -- the health of the population was pretty poor. I think it was probably the North-east that was only one that was really worse so we had some really significant issues around that.

We tried to address that through a variety of different mechanisms. When I arrived -- one of the reason I went to the North West from the South West, South and London which is where I was before, was because of the reputation around trying improve quality and that reputation was relatively well-known across the NHS.

So we had a programme called advancing quality and advancing quality -- I do not know how much -- do you know about that or do you want me to --

PROF MONTGOMERY: Mike told us about that.

MS CUMMINGS: Okay, so I do not need to repeat --

PROF MONTGOMERY: I do not think you need to do details. I think we have seen the transcript. I think what would be interesting is a reflection on whether you think there might have been flags there that were not picked up with the benefit of hindsight or whether you do not think --

MS CUMMINGS: I am not -- I have thought -- obviously, clearly thought about this an awful lot. There were not -- there were individual issues so in 2008 -- at the end of the 2008 or towards -- in 2008, there were SUIs. There were the deaths -- Joshua Titcombe being one in November, but the --

PROF MONTGOMERY: Was that the point at which it got on the radar?

MS CUMMINGS: It was certainly on the radar when that happened, absolutely. I mean, you -- absolutely because it was such a significant untoward incident and with such tragic consequences so it was definitely on the radar then.

We were aware of other -- another -- some of the other SUIs but each of those and the view of several people at the time and subsequently was that those were not connected in the sense that, although they were in the same organisation, they were different. They were all tragic and terrible for the families but, at the time, there was not anything obvious that linked them.

PROF MONTGOMERY: What was the process that led you to that -- who was led to reach that view? We are asking ourselves that question as well. It will be helpful to understanding who reached that view and why they reached it and what the process was.

MS CUMMINGS: Well, we -- so each of the -- at the time, again, I am not sure how much of this you know, but part of the relationship that the NHS North West had with 24 PCTs, we had a strong compact with them. The compact basically agreed a set of behaviours, a set of values and a set of, almost ~~under~~ -- I would not say ~~under~~ ?earned autonomy exactly but there was, because it was such a large SHA, geographically

as well as in size, and we had some very strong PCTs Chief Executives.

Mike, I think, Mike Farrar, I think, appointed Sue page to Cumbria because of her background and because of her experience, we -- we actually devolved after a period of assessment, training, support, the management of SUIs, to the PCTs. So, I am pretty certain, although obviously have not got -- we have not been able to access all of the information, I am pretty certain that by the end of 2008, certainly into 2009, the management of SUIs were what had been devolved to Cumbria PCT. So the Joshua Titcombe incident would have been managed initially by them.' I'm not sure this is clear. What I was saying is that the SHA devolved the management of SUIs to PCTs after a period of training, assessment and support. This means Cumbria PCT were responsible for reviewing SUIs.

In terms of the how else we looked at it, there was root cause analysis done, there were investigations done and, you know, some of you --

PROF MONTGOMERY: That is by you or someone else?

MS CUMMINGS: No, some of it is done by the organisations, some of it done by LSAMO or the LSA organisations and some of it done externally.

You will know that we had things like the Pauline Fielding review. We had an external LSAMO review from somebody in Scotland. We had done an internal one, some of our own staff because -- so the Joshua Titcombe one had the initial SHA LSA MO review, then it had external LSAMO review from Scotland with a Scottish LSAMO, then we had an internal

review done by Chris Dent and Angela Brown which looked in detail at the process ~~of~~ that had been undertaken.

That was particularly around James Titcombe and his complaint about the care his son basically had not had.

MR BROOKES: Can I clarify, was that generated by his complaint to the SHA or by your processes picking up this unsatisfactory nature of that particular incident?

MS CUMMINGS: I think it will be safe to say it was -- fair to say it was generated more by his complaint rather than the SHA.

MR BROOKES: Thank you.

MS CUMMINGS: By 2009, the SHA had also appointed a Director of Maternity, Children and Young People's Services who also took oversight of all of that, you know, that aspect of the care. But certainly from my recollection, although I was not involved at all in the James Titcombe complaint because it was handled -- the SHA took a decision to handle it with three people and to keep it very tightly supported so that he only had -- he did not have multiple people that were liaising with him so it was done --

MR BROOKES: Who were the other two?

MS CUMMINGS: Mike Farrar, Chris Dent and Angela Brown and it was -- that was a decision taken, I think, from, you know, feedback from others that when you have got a complex complaint, which is really difficult, actually it helps to

have somebody taking a leadership role so that, you know, family members do not have to deal with lots and lots of different people and you get people -- and individuals get to know the family, get to know the issues and you do not have to keep repeating the story over and over again.

PROF MONTGOMERY: You mentioned the Fielding Report, what was the SHA's involvement in the triggering of the commissioning of the Fielding Report?

MS CUMMINGS: At that point, we -- if, I think, about the sequence of events, so from recollection, we had the original LSA MO review, then the Scottish one, and then we had the review that the SHA had done. The SHA then recommended Dame Pauline Fielding to the Trust so that -- because the Trust agreed to commission an external independent enquiry.

We had used Dame Pauline Fielding previously. She had done a review at Tameside, which was one of our worry Trusts; and so we had already commissioned Dame Pauline before so we --

PROF MONTGOMERY: What was your understanding of what she was going to do?

MS CUMMINGS: That was -- I do not know because it was it 'was proofread' Not sure what I meant – it doesn't make sense. I knew it was happening because -- but I was not involved in the decision to do that because it was outside of my remit.

PROF MONTGOMERY: And when did you see the report itself?

MS CUMMINGS: I am not sure I ever did actually. Certainly when I read it again, or I read it, prior to here, I have no recollection of reading it individually and it was a report that went to the Trust. And my -- again, my recollection is that we thought that the Trust had shared it. I do think that Angela saw it at some point, but I do not remember reading it.

PROF MONTGOMERY: A few things to just test out your impressions now you have read it. What was your impression about how closely she looked out the incidents that had prompted -- you said the question about you satisfied yourselves and I am about to come back for a bit more about that about whether it was (inaudible) things or not. Was that something that you felt that she formed a professional view on with her Panel?

MS CUMMINGS: It is quite difficult to -- I mean, it is quite difficult to be clear about how much detail they went into. The report it relatively short. They clearly did a several interviews with people. There was a -- you could read it, and she would be best placed to answer this but you could read it as an assumption because she makes the point the cases were tragic but not necessarily linked. So you could read it as that was an assumption that was made and,

therefore, it was more about and have all the recommendations that have been made by all the various different investigations been implemented.

PROF MONTGOMERY: If you were reading it, you have read it now, and you had to make a judgment on could I take assurance of this report that someone has looked into that question whether the cases are connected, would you think you would have to ask Dame Pauline about that directly or do you think --

MS CUMMINGS: If I, I think, if I had been given that report and I would have wanted to have, I think, I would have had a wider discussion probably with the author and the Panel that were involved and probably with the Trust to be -- although by the time ~~I~~the SHA got it they were in FT, I would have, I think, I would have challenged and queried it more.
NB: I don't remember seeing it when at the SHA

PROF MONTGOMERY: Someone in the SHA read that report and the SHA started briefing that we could take confidence that the four cases were not connected because Dame Pauline Fielding had looked at that question. Do you know who in the SHA would have had to have read it in order to draft those briefings?

MS CUMMINGS: Most -- I would imagine most of the briefings would have been drafted by Angela. Whether or not that they it would have been seen by Anne Hoskins, I do not know. She was the Director of Maternity and Children and I cannot tell

because without -- I could not -- the information I have got so far does not give me any evidence of that.

Having said that, I mean, Angela -- I know Angela. She worked for me for many years. As an individual she is absolutely dedicated and committed and I would never, never challenge -- I would never feel that she was not doing what she thought was the right thing. She certainly was not slap dash. She was hugely experienced and I would -- if she and she was much closer to the detail.

So I guess but then you could, I suppose, if somebody like Dame Pauline Fielding and the Panel that she had -- and, from memory Rhianna, who was the consultant midwife who is still, I think, in Imperial, is an extremely experienced midwife -- I suppose you would... At what point do you think you know better than some of those experts and I guess that is an issue -- that is a potential learning from this.

PROF MONTGOMERY: I think this is a slightly different question from what is the correct interpretation of what they -- they wrote.

MS CUMMINGS: Yes.

PROF MONTGOMERY: We were going to explore the SHA asked itself the question we would expect it to ask which is are these connected cases that are a pattern or are they a set of unconnected tragedies that we need to explore one by one but, I think, clearly we reached the conclusion that

they were not connected. That is clearly communicated upwards and subsequently later on, the shorthand for that is the Pauline Fielding Report looked at it.

Do you have memory of whether that was part of the reason why at the time, because there is a difference between how you explain things quickly, did it make sense of it -- because we are trying answer how that conditions -- we have asked Dame Pauline (inaudible) that. We now know that she did not ask the question because she was told it had been answered already so we are trying to understand how that how people reached the various conclusions.

You were telling us earlier on that question had been asked, clearly independently of the Fielding Report because one of the thing that happened was that Fielding Report was commissioned. Who would have been asking that question about whether they were connected?

MS CUMMINGS: I think you would have to go back and look at the timeline for the variety of different investigations. What I can remember is that there were three or four different investigations that looked into it and, from memory, not one of them linked any of the SUIs as being something that you -- was a, you know -- something that we should be particularly concerned about.

Yes individually, but there was -- if you look at the individual -- what happened to those individual cases,

nobody at the time so none of the other LSA reviews, none of NMC reviews, they did not pick up any particular issues. Alongside that, we had an organisation that had been given a green rating and a clean Bill of health by CQC. They had -- they were middle of the pack in terms of all the other indicators. There was nothing obvious to indicate that they were massively going off or that we had -- that we should be really concerned.

It is a really difficult balance because it is hard to look at it is hard to look back and be absolutely objective when you are looking at it through the lens of what we know, what we know what then subsequently happened at Morecambe Bay. It is really difficult to be absolutely -- particularly for me when I was not that closely involved in that part of it, certainly from 2009 onwards. So it is quite hard to be --

PROF MONTGOMERY: And your dashboard that you created, was that based on information different from -- if I take the CQC, points that you have made. Some SHA dashboards would essentially have just drawn from, "the CQC says this and this and that is our quality measure for that".

MS CUMMINGS: It was more than that. We included CQC but we also did -- we also tracked things like ~~MALs~~ ?falls, we tracked all of the standard things. So we tracked falls. We also started tracking the work we were doing round advancing

quality. So although advancing quality was -- did not cover any maternity issues, it did cover several other areas and not ~~any~~ only did we track that, we also published it and had comparisons with different organisations.

We had the usual A&E, RTT, cancer waits. We had diagnostics. We had public health issues. We had deprivation and stuff included in that. So we had quite a lot of quite complex measures that we looked at in the round and then we also did other assessments. So I talked earlier about the review that we did, I think it was in 2009, where we reviewed every single organisation, both commissioner and provider against the Francis -- against six areas. I have looked back at that and although we asked organisations to self-assess, that was then followed up by one-to-one conversations with members of the patient safety team and quality team with people asking for evidence. So we asked for evidence, we looked at the evidence and then we triangulated that with a view from the commissioners and the PCTs about whether they felt those organisations that said they had well developed responses that were able to evidence it was actually true.

PROF MONTGOMERY: Do you remember what that showed that about Morecambe Bay?

MS CUMMINGS: Morecambe Bay was -- had well developed across the board and it got signed off by the PCTs.

PROF MONTGOMERY: Okay. So your assessment, your understanding is that PCT assessment was good?

MS CUMMINGS: Yes. I mean, it was 2009 but at that point -- so we had gone with the normal standards things that everybody does, plus ~~at~~ advancing quality which nobody ~~recollection~~ ?else in the country was doing, plus that review. It was really, you know, some of the stuff that we did, back in 2009/10/11, with looking at it now, with what I know now, in terms of the research evidence around what good looks like, the Michael West stuff from Lancaster University, we were looking at stuff in 2009/10 that I do not think many other places were even thinking about. So we did test it.

PROF MONTGOMERY: I think that picture is that you had in comparison to others well developed quality surveillance systems and they did not flag Morecambe Bay, you had a series of tragic events, which you have series of reports into, and that leads to the conclusion that a series of tragic events in the normal pattern.

MS CUMMINGS: Yes.

PROF MONTGOMERY: You have done a stock take after the first Francis Report, and you have the consistency between the Trust and the Commissioners and that has not flagged up anything

MS CUMMINGS: Yes.

PROF MONTGOMERY: -- in particular. If I ask for the

benefit of hindsight now, where we have a Trust that many years later has gone into special measures --

MS CUMMINGS: I know.

PROF MONTGOMERY: -- has it got worse? Is it the same? Do you have a feel for whether the system has, despite all the best efforts, has failed to pick up what was there? Or is it that our monitoring systems have improved and actually they are now covering things that may have been we could have done better before or --

MS CUMMINGS: Well, the first time I think various different issues all came together was ~~in 2000~~ this should be 2011 -- was middle to end of 2011; from around April onwards. I think there is very clear things that happened in 2011, that actually started to raise lots of red flags, I think there is something -- I mean what is quite difficult is that we are in 2014, so this is 2011, we are in 2014 and it is still -- there are still issues. As you said, it has just gone into special measures. I do not -- again, that has been handled, both the combination of CQC, Monitor, and the North Region of NHS England.

Despite all of the efforts, despite all the work, despite changing the management team, despite putting in people that are incredibly experienced, there are still issues. I hope that you, and this team, is able to come up with something about why that is.

Cumbria had been difficult for a while and our concerns were bigger around North Cumbria, to be fair, than they were around for a lot around Morecambe Bay. But the geography around Morecambe Bay and the distance between Furness, Lancaster, et cetera -- Kendal -- was an issue. The PCT in Cumbria was -- and I am sure you will have heard -- was under quite significant challenges. This was PCT was an organisation that put significant amount of money into community services. The SHA gave Cumbria millions to try to sort their financial position out. It was a financially-challenged area as well, which I just wonder whether that had anything to do with it.

We know that staff, particularly the staff in Furness, did not move. It is not easy to get to. One of the difficulties we had when we tried to put people in, in 2011, to wrap support around it -- I mean, we probably did the buddying before Keogh did the buddying in terms of trying to get organisations to support -- but because of where it is and because of how you get to it, we struggled to get people to be able to go. Staff did not move.

We all know that while there is an issue about rapid turn over causing problems in terms of lack of continuity, lack of -- you lose some of the knowledge and some of the consistency, there can be just as many problems about having a static workforce that does not move and, therefore, is not

as up-to-date, is not as forward-thinking as maybe others.

PROF MONTGOMERY: That is an issue about nursing and midwifery staff that would ever have reached you, the Director of Nursing at the SHA; or is that a Trust issue?

MS CUMMINGS: No, it is both. It was an issue and it did get to us. It did get to me and we did something about it.

PROF MONTGOMERY: What was the time line on when it got to you and --

MS CUMMINGS: Essentially it got to me more through when we had when we -- I think it was in 2011 -- when the issues really came to the fore about poor team work, poor relationships. The fact that we had several SUIs, where the midwives had not worked effectively. So I can think of three different events where the individual midwife should have behaved, or should have acted differently.

PROF MONTGOMERY: Help us with that how it came to you. Was it through the supervision process? Was it through the SUIs?

MS CUMMINGS: I think it was a combination of -- all but. You see, the first, again this first one was this individual midwife needs more training; that happened. Second one was this individual midwife, or these midwives, need more training; that happened. I think by the time it got to the third one in 2011, from memory, that was when we were started to say actually we need to look at what is going on

around maternity staffing and we need to look about what is going on around obstetrician support and we need to look at around -- at that point was when we, just before I called Gold, that is when we started to say we need to buddy. We buddied them with Liverpool Women's.

I moved two Deputy Directors of Nursing to go in and work alongside Jackie Holt, from different organisations. We put -- I think we tried to persuade a consultant midwife to go in. We helped Monitor put a service review team in from Manchester. So we that --

PROF MONTGOMERY: Is that wrapped up in Gold or was that a separate process?

MS CUMMINGS: We started because it was Gold that effectively did it. At that point, because I called Gold -- because they are an FT -- we were able to take more control and actually support and be more directive.

PROF MONTGOMERY: Has that calling of Gold, from outside, it is an unusual Gold Command exercise, it lasts for a very long time; I would be glad to understand how it --

MS CUMMINGS: Yes, it was a long time.

I suppose -- because I was the Director of Performance, I had called a Gold major incident on two previous occasions. One was during the winter. I can't remember which year, the year before I think it was when we had -- it

was not the flu or the flu pandemic year, it was the year we had more flu than anybody else. Do you remember it? It was -- I had no choice, so I called Gold then. That enabled me to -- I moved things like perfusionists from different FTs to support ECMO in one of the other FTs. We made decisions about how we were going to manage intensive care beds across the north west of England and I could only do that by calling Gold. Actually the FTS and the Trusts were only supportive to do what they needed to do by me calling Gold. I did that.

I also called Gold when we had the Stockport FT insulin poisoning. Of course, the police had called Gold as well. I did that because that affected quite a lot of the organisations around; we had to make some big decisions. I had experience of doing it and although they were both quite short in the sense they were focused -- I mean, I have to say the Morecambe Bay Gold did go on for quite a long time.

PROF MONTGOMERY: Did you anticipate that when you called it, or did it feel as though --

MS CUMMINGS: Probably not. I think it would have been it was shorter, but it got to the point -- I think back about the build up to that. We had the serious untoward incident, which was in April where a stillbirth and the midwife was subsequently suspended; there was an investigation into that.

We then had the Joshua Titcombe Inquest and the Rule 43 letter. Then in July, I think it was, or certainly later, CQC did an unannounced, or did a review visit of maternity and told us that they were going to -- it took them several months, I have to say, to write the report, which was slightly frustrating -- but they then published in September the report that said they were major and moderate concerns. Three moderate and three major, I think.

We were then told that Dr Foster was about -- was going to publish HMSR, which ~~will~~ would show Morecambe Bay having a high HMSR at Lancaster. ~~for~~ For the previous year had been fine, they had been middle of the pack; that was another one.

Monitor had started to raise concerns about the governance at the Trust. I have to say it was quite messy. There were lots of people involved. CQC, at the time, were -- it was very difficult to manage not only -- or to work with them to manage not only how they were reporting what was going on -- and bearing in mind this was, you know, the post-Francis thing, where they were quite nervous about not being seen to act, which is entirely appropriate in this particular case. However, the way in which that was done, and some of the decisions that they were taking, we were quite concerned about because the knock-on impact and the unintended consequences were potentially quite significant. We were trying to work with them to manage it.

Monitor had similar concerns about some of the things that were happening.

I called a risk summit. You no doubt will have seen some of that. I called a risk summit that included all of the relevant people, including the Trust so --

PROF MONTGOMERY: Anyone from the PCT? Are they part of this as well?

MS CUMMINGS: Yes. We had CQC, Monitor, both Lancashire and Cumbria PCTs, the Trust, and the SHA.

We basically did it because we wanted to put all of the concerns on the table. The other thing that had happened around the time as we are building up to this was that A&E performance had started to go ~~of~~ off at Lancaster. They were really struggling. At the same time we found out, more by accident than design, that a GP had spotted that a patient -- one of his patients with cancer had not had a follow-up out-patient appointment. We then tried to work out why that was. What became clear was that the organisation had had a big issue with follow-up out-patients.

PROF MONTGOMERY: If I have heard this right, a number of early things you talked about were not quite maternity-related; this becomes a Trust-wide --

MS CUMMINGS: It becomes Trust-wide. It became Trust-wide, it involved two counties -- so Cumbria and Lancashire,

because Lancaster is ~~here~~ there, so it was the PCT responsible ~~here~~ there; Cumbria looked after Furness. The other thing -- it was the only Trust in the whole of the North West that did not have a lead commissioner. Every other Trust that had more than one PCT, commissioning, one of them took the lead.

PROF MONTGOMERY: Why not here?

MS CUMMINGS: Because the two PCTs could not decide who would do it. It was a split between of the -- so we... That was quite difficult because whenever you talk about Morecambe Bay --

MR BROOKES: Can I clarify -- I thought there was a lead commissioner, but it operated as 50/50?

MS CUMMINGS: For the Gold? Are you talking about generally?

MR BROOKES: I am talking generally in terms of the commissioning.

MS CUMMINGS: I maybe wrong, but I am almost certain that the 99 percent certain that it was split because I can remember --

MR BROOKES: You remember the exercise going around the country identifying who the lead commissioner was.

MS CUMMINGS: They would probably have said Cumbria was the lead, but I am absolutely certain that I had -- I can remember asking questions about why don't one of you take the lead? I am pretty certain that they did not do that.

PROF MONTGOMERY: Why would they probably have said Cumbria was the lead, do you think?

MS CUMMINGS: Only because -- well only because that was more likely to be the case. Cumbria -- Sue Page was more likely to say, "I will take the lead", than probably the Lancaster one.

PROF MONTGOMERY: We have seen documentation that says formally it was Lancaster that took the lead, but we have also seen evidence that suggested it operating like that.

MS CUMMINGS: I am -- you may have got evidence that I cannot remember, but I genuinely -- I am sure I am right because I can remember the fact that, you know, it was the only organisation in the whole of the North West -- and as I said there were lots of them -- that did not have one clear commissioning lead.

PROF MONTGOMERY: It was the evidence that was not clear; that is not the same as --

MS CUMMINGS: So have I lost the point about where I was.

PROF MONTGOMERY: I was asking about how Gold Command emerged and you were saying you called the risk summit.

MS CUMMINGS: I called the risk summit. We went through all of the different issues. I can remember sitting -- I can remember exactly where it was, I can remember the room and I can remember having -- I had to really push the PCT, Lancashire PCT, to tell us about the out-patient one. I

think it was because they were not really sure how much to go into. They also -- there is an issue some of the GPs had known there was an issue for a while and had not said anything. Therefore, it took -- anyway, we got it we pushed it and -- it out of them. That just -- all of those things together just meant that we agreed. That was on, I think, that was beginning of October.

We did that and we agreed we would have a subsequent follow-up and I -- something else triggered, it was either Monitor, I think it was Monitor had their board meeting at which point they put them in breach. They put them serious breach at that point. They wanted to call -- they wanted two other reviews, at that point I agreed with Mirav from Monitor that we would called Gold and we did.

PROF MONTGOMERY: Do those discussions include an idea of what we are trying to achieve from Gold Command?

MS CUMMINGS: Yes. There was agreed terms of reference. There were agreed outcomes, which will be in the documentation, I am sure. We agreed outcomes. We then split it. We then -- the rules we had in the North West, although it was technically a level three Gold because it covered more than one county, it was one organisation two PCTs.

The SHA then delegated Gold Command to the PCT medical directors. So Mike Bewick took the lead with Jim Gardner,

who was a Medical Director, and the other one is the Deputy' Both Mike Bewick and Jim Gardener were Medical Directors -- we split it into two areas. So we had one group that was Cumbria-led that looked at maternity ~~in~~ and children and one group that looked at the outpatients stuff in particular.

PROF MONTGOMERY: Was your perception that Mike from the PCT thought this was something they were very keen to be involved with as an opportunity to improve the situation or were they resistant?

MS CUMMINGS: I am not -- no, I don't think they -- I cannot remember them resisting it. They might have moaned a bit about amount of extra work because it was quite a lot of work but I do not think that -- I am -- I genuinely don't remember any resistance.

I think in some cases -- one of the big issues about this and one of the lessons for this and probably other big investigations or, you know, Trusts that have got almost intractable problems, is that when you get multiple people involved and you get multiple investigations and multiple reviews, it is absolute nightmare.

It is horrendous for the Trust because they are feeding so many masters in terms of the reports and action plans and responding to this and responding to that, then -- I have seen it in couple of organisations where there has been a lot of attention. Bearing in mind I used to run the

National Intensive Support Team for Emergency Care so I went into lots of organisations and many of the ones we went into had more than one problem. So I had seen it from a sort of a "how do you help these organisations" as well as a SHA as well as -- so I have seen it from a variety of different settings.

One of the purposes of Gold was that that -- they were an FT but they were an FT that was asking for help by this point. They really were asking for help. At that point, it was a way of trying to co-ordinate and trying to co-ordinate Monitor action -- I mean, Monitor action was Monitor's to have. I mean, we were not telling Monitor what to do any more than we were telling CQC what to do, but it was a way of trying to co-ordinate all of the different actions and reviews.

It meant we could prioritise what was going on, it meant that we could have one form of communication, it meant that the briefings and the media and the comms was handled once rather than by multiple organisations. They all got involved but it was just co-ordinated in ~~the~~ a much more straightforward way. That did help.

So we were able to provide support to -- Monitor wanted to do; Monitor I think put one of the big management consultancies into doing the governance review, I can't remember which one it was, PWC, I think. They also wanted

to do two other -- they wanted to do an investigation into maternity and children, a clinical review of maternity and children. So we put them in touch with Manchester Children's and Maternity -- and St Mary's and they provided the clinicians that did the review in that way. We also helped them provide -- we helped provide names for people to go in and work there.

We moved a couple of deputy directors -- ~~and~~ of nursing -- in. I asked Helen ~~Blairs~~ Bellairs to go in and do the out-patient review, et cetera. So we sort of by helping to co-ordinate people, it was Monitor's decision who they put in but we helped them to decide who would be best to do it.

PROF MONTGOMERY: We have had some people the use the phrase "learned helplessness" on behalf of the Trust. Is that a phrase that you might have heard being banded around or one that you would recognise?

MS CUMMINGS: I do not remember it being --

PROF MONTGOMERY: -- they become paralysed and unable to get to grips with systems themselves.

MS CUMMINGS: I do not remember it being banded around but I do think it is a reasonable phrase to use. I think that they felt they were -- they were massive issues and they were being battered by one thing after the other and at the end of the day, they were patients that needed to be cared for and needed -- and you know, we had stories of midwives

being door-stopped by the media and stuff around, so there was a lot of. There are lots issues with individual members of staff feeling very vulnerable, very frightened, very upset, but alongside that, what they were there for was provide good care for patients and some of the patients were not getting that care.

PROF MONTGOMERY: Was there a sense that this was a management team that could do this if you took the pressure off them a bit or was it a management team that -- I guess, I am wanting you said they were looking for help. I wonder what they were looking help with. Do they think that the environment is very hostile, or do they think that they are not up to grappling with it and want some support with it?

MS CUMMINGS: Well, probably the latter with other bit of the former added in. I think the Chief Executive was probably in a position where he was saying, "I need help to get us through this and get us in a better place." I am not sure whether there was insight into, "I do not think I am capable of doing this job" type -- it was only when the -- I think, it was when the governance review happened that --

MR BROOKES: Can I --

PROF MONTGOMERY: Do you know whether SHA had concerns about the capability prior to that? He had been through a Monitor application process that the SHAs had been involved with; we now know from Gold Command a lot of resources were

put in helping the governance review; and there is a sense of had something changed, had it got worse, or do we with hindsight wonder whether the SHA could have spotted things -- at what point does that question get raised about capability?

MS CUMMINGS: The SHA would have done and almost certainly did at least two board to boards. They would have reviewed -- as I said, there were no obvious flags right. I mean, they got authorised in 2010, I think, towards end of the 2010; October -- sometime around September or October 2010. There was nothing, no obvious flags to say we are really concerned about this.

I do think that like many circumstances where people have had a problem or struggled, the sensitivity between the reassurance that action plans have been implemented and true assurance that they are being implemented in a way that gives the right outcome, is a very fine line.

It is possible that if we had looked more into the are they being implemented in this way, then that would have helped, but even when CQC provided -- did their review in September, there is a clear line that says, "CQC are happy --" or "CQC are certain that the FT will be able to deliver all of the actions by November." And they are convinced that this can be sorted. So everything that was being said was that they should be able to manage it, but

they, in the end, did not and could not.

PROF MONTGOMERY: We have heard and seen documentation suggestions that if the Trust had shared the Fielding Report, it all would have been different. They would not have gone through the Monitor process, they would not have been in front of the CQC. Because the SHA is one of the few organisations, which clearly did know that process had been commissioned, because helping them source someone to do it, is that -- does the Fielding Report really have that significance in your mind?

MS CUMMINGS: I mean, that is really hard to say. I am not sure. It may have raised a few more questions. Whether it would have stopped the application, Monitor application, being -- well, the Monitor authorising or CQC.

PROF MONTGOMERY: Someone in the chain knew it was there and presumably like the Trust, did not think it was so important that it should specifically be mentioned.

MS CUMMINGS: My understanding was that -- again, you would have to check with individuals concerned -- but my understanding was that the SHA or Angela believed from something she had from the Trust that they had shared it. So it was not, "we have definitely given it" but there was an implication from what she subsequently said that they had shared it.

There had been couple of occasions, I think, when the

Fielding Report had been mentioned when CQC were in the room, so again there was an assumption that they did know so whether or not there was a "we are telling --" and you know, other than that --

PROF MONTGOMERY: You are not aware they knew but from your understanding they did know and, therefore, there was no need to --

MS CUMMINGS: Yes. I am not conscious that -- I am not -- I genuinely do not know. It will be interesting. Other people looking at it with completely fresh pair of eyes might go, "oh my God, there were so many warning signs in that" but we would have said, "no, no way". I am not convinced that that would have been the case. CQC seeming reasonably happy with what was going -- they signed them off just before authorisation.

PROF MONTGOMERY: Easy with benefit of hindsight (inaudible) I have got another area I want to ask about which is supervision process and I know you have just given evidence to the Select Committee on supervision --

MS CUMMINGS: I have not actually but it was ~~Juliet Bill~~Juliet Beal that did that, my director of nursing for --Quality Improvement and care.

PROF MONTGOMERY: -- and I know there is work going on. There is a particular question in my mind, having read the SHA report we heard from the Chief Executive. I am trying understand what about supervision process and what about the

way it happened to be implemented in this part of the world. We now have a team of supervising midwives who has won a national award and we have a report saying it is about the supervision of midwifes.

I know there is a policy question about that but I wonder from your perspective, having seen the reports as they came through and you described how you looked at those for potential triggers. To disentangle this about what about the whole idea of supervising midwives and what about the way it operated, both locally, within the supervisor, but also as a supervising authority, you have read the HMSO reports on that. I am just trying understand because there are two separate sets of questions we need to get our head round as part of understanding that.

MS CUMMINGS: Okay.

PROF MONTGOMERY: So the policy bit, I think, is coming through and we can understand that has been discussed but your take on whether there was anything different about the way of implemented in this part of the world --

MS CUMMINGS: I do not think it was implemented differently than -- well, in the North West it was not, in Morecambe Bay, generally, no. I think, there is, you know, supervision is something that is loved and wanted by many midwives. As you know the King's Fund are doing a review at the moment. They should report in December.

In terms of the North West, we had had an NMC review' of the LSA function, I think, in 2008, which was very positive and actually put the North West, as I say, ~~you know (inaudible)~~ identified as an area of great -- of really good practice. So from my point of view, and from Anne Hoskins point of view, who then took over as Director of Maternity, there was no major flag that said, "your LSA MO function is not working properly". Then we have a consequent review before I left the North West and that was also very positive, with a different LSA MO in place. So, there were no obvious signs that we were not providing a good service.

The North West had a reasonable number of supervisors and midwives. We had a pretty good ratio of midwives to births in terms of the birth rate plus stuff, one of the best in country and to all intents and purposes, it was working reasonably well.

Having said that, I think Julie Mellor's report and recommendations are very, very reasonable and I think the idea that we have got supervision and regulation tied up together, that you have got supervisors of midwives that are effectively investigating colleagues is something that is not helpful, not healthy and not good practice and should be changed.

So one of the thing that we have done now nationally, is we have asked all of the LSA MO across the country to use

the ombudsman report and to look at the recommendations in terms of the how they do their annual reports and we have started to pilot -- and Geraldine may know more about this, but we have started to pilot in London where we have, in some organisations, a supervisor of midwives, a midwifery supervisor who is full-time. So working doing just that and not investigating any cases in their own Trust or on their own sites. So we are actually looking at people moving across so if they do an investigation, they do it more externally.

The other thing that happened in Morecambe Bay that is not helpful is that because of this confidentiality idea, the Director of Nursing may not be told what is going on. Again, that is just from a clinical governance point of view and is just not acceptable.

Therefore, one of the things we have recommended is that supervisors and midwives actually talk to their -- provide updates to their Director of Nursing on monthly basis which talks about any cases that they are investigating and any of the issues that are coming out of that.

Therefore, we are doing -- we are taking action already nationally to try and address some of the failings that were identified by the ombudsman's report and we have asked the LSAMOs when they do their annual visits and their annual

appraisals to look at not just the numbers of supervisors, but also make sure they sit and interview them, that they talk to patients and get patient experience about what is going on. That they look at leadership and team work, that they look at the documentation around investigations so that they've got a much more granular oversight of what is actually happening on the ground. I think that -- looking at the governance as well.

I am hoping that we are beginning to make some changes in advance of the King's Fund because, you know, the ombudsman report was out at the end of last year. You know, we -- the King's Fund is not going to report until this December. That is a year. You know, if I was James Titcombe I would want to know what I was doing.

PROF MONTGOMERY: We know at least one of the (inaudible) has to be redone because it was not done in accordance with the North West.

You mentioned there about governance. Do you have a sense from the Gold Command experience of what clinical governance -- what state clinical governance is in, in that Trust?

MS CUMMINGS: I cannot remember. I could if I looked back. I genuinely cannot remember.

MR BROOKES: Geraldine?

DR WALTERS: You have got the dashboard that you were

looking at policy. Were you surprised when all these negative swings happened all at once? Could you think of a reason for that because you do not usually become the worst 'SHA' in the country sort of in a year's time period, do you? I think this is inaccurate and Dr Walters meant to say "Trust". Can you check?

MS CUMMINGS: You should not do, no.

DR WALTERS: I wonder if you have thought -- if you had had any thoughts about what that was all about?

MS CUMMINGS: No and I cannot, not without going back. I mean, certainly the -- certainly there was, as I said, it was sort of bouncing along in the middle of a large pack of Trusts. There was no obvious thing that flagged that said this is -- but it was just a combination of things and I just wonder whether -- I just wonder whether things, you know, almost like, and I hate the term "perfect storm", but it almost feels like there were a variety of things that all just started to come together at the same time and once one thing happened, it just fell apart.

What was quite clear, I think, was the more things that became that were uncovered or more things that were flagged as a problem, whether it allowed staff, whether staff just felt they could say more or whether they did -- but it all became obvious. There was -- why? I do not know. You have -- whether there was a way of -- I don't think there was any obvious -- they were obviously trying cover anything.

We were, at the time, getting -- we were seeing over the whole of the North West, we were seeing increase in SUIs being reported which was what we wanted. We were encouraging openness and transparency. We had a -- we set up a transparency pilot where people were publishing both pressure ulcers, falls, et cetera, ~~HDIs~~ HCAIs on a monthly basis. We were using patient and staff experience measures. We were doing quite a lot of stuff in the North West that was encouraging openness and so we did not -- there was nothing -- they were not high or low. They were not so low that we were starting to worry about them not reporting and actually, in the end, certainly once we got Gold, they were reporting absolutely everything. Absolutely everything that sneezed, moved or did anything that was a risk or a problem they were reporting.

So in a nutshell, I do not know why it all came together at that particular time but you would query, I have to say, what happened to make it all go off at one go. Because the LSAMO the previous year and the previous years before that were pretty much the middle of the road or had been either getting better or were static.

DR WALTERS: Did your surveillance systems disaggregate the different hospitals within the Trust? I am just wondering if some of it might have been obscured by the fact that actually Barrow was not so good at midwife to

birth ratio, was not so good at obstetrics and/or just numbers and that sort of thing. I just wonder whether your systems at that high level would ever have picked it up.

MS CUMMINGS: Some of the detailed stuff did actually, yes. Some of it did. So we would -- when we -- some of the performance issues would look at site rather than just organisation. We would look at both. Around the certainly some of the quality issues, we also looked out to build up to it, we would look at it on a site basis and we did look specifically at some of the staffing issues in Barrow.

One of the things I think is an issue and it might -- I do not know whether it is the case but when we looked at the stillbirths and neonatal deaths, the actual numbers were for Barrow and for Morecambe Bay were quite low. So despite the fact that this is an issue where we had had quite a few stillbirths, they were actually -- they were quite low in comparison. So some of the C-Mac stuff did not show them as high at all, but, of course, what they measure is death in -- deaths in that particular site or that particular organisation.

What we know is, for example, Joshua Titcombe was transferred out, and because it was a relatively it was a service that did not have a significant neonatal -- it had special care baby unit but it did not have the facilities or staff to run anything -- a proper critical care. So any

child, any baby that needed intensive support was always moved.

So, I think, there is something a lesson maybe, if it is not been sorted already, a lesson around what -- how we linked deaths in a different organisation back to the origin which might have had an impact and might have shown a higher number.

DR WALTERS: So all your quality surveillance systems at the incidents and Joshua Titcombe and the views you did, what was the communication like with the PCT about sharing all that? Were they aware that all that was going on?

MS CUMMINGS: They should have been, yes. I would be very surprised if they were not. I mean, so I had some conversations with them but certainly Angela would have -- I mean because she was very good at communicating that stuff so she would have done and we had good quite a good close relationship with Moira, who was the Director of Nursing in that organisation, and also with Mike Bewick who was Medical Director at the time.

I mean, there may have been some things that happened that they did not know but I would be very surprised if they did no not know what was going on. We had -- we did, particularly when it came to investigations or the NMC review or LSA reviews, they should have known what was happening.

DR WALTERS: To me, when I read this, and we have also had to dig into data and it really is hard to unpick and it is not until you get really to the case notes that you find where all the linkages are, but do you think that the handling of the James Titcombe complaint was more in line of "let us try and satisfy these complainant" rather than "this complainant might have uncovered quite a difficult issue that we need to take more seriously"? I do not want to put words in your mouth.

MS CUMMINGS: It is a really good question and I -- it is -- I do not know. I think my recollection was that the Trust -- the Trust was clearly at fault. They had admitted that they were at fault very early on, very early on. The Chief Executive went to James Titcombe's house, explained, accepted responsibility, said that they would investigate, lessons learnt, et cetera. So they were very -- my recollection was that they were very up front about the fact that they had failed and that they would do what they could to try and learn lessons from it.

So on one level, I think there was there was an assumption that the Trust had -- it was not like the Trust had been defensive and said, "no, it is not us. There are all these reasons why," you know, trying to find an excuse and they were very -- I think, quite open about it. I do think that there was, you know, all you have to do is read

the story that James talks about and it makes you just want to cry. I mean, in fact, I did when I read -- when I watched -- I have seen some of the pictures and, you know, the description of what happened to his family is just horrendous.

But it got completely, I suppose, aggravated by the fact that, you know, some of the notes went missing, that there was -- some of the midwives behaved appallingly with some of the documents, some of the emails stuff that happened, you know, just appallingly. I guess, as far as he was concerned, it was like, "well, yes, they have apologised and they are going to learn lessons but it is not enough."

So I think knowing Mike Farrah and knowing Angela and Chris Dent who were dealing with that, they would never have done something to just try and shut up a complainant. That is just not in their nature.

DR WALTERS: That is not what I was suggesting. I can see that they wanted for him to be happy with way they looked at it. But, I think, if in the back of your mind, you have got quality dashboard which looks okay, and you have got what looks like low rates of neonatal death and maternal death, it is -- this is about dealing with this one complainant. It is not a trigger of we better do quite an extensive review because he might have something here which is a systematic problem.

MS CUMMINGS: I think when the – from memory, again, I was not -- as I said, it sounds awful because I genuinely was not involved in that, but I do remember them saying that the original LSA MO was not good enough. They had got the Scottish woman to do it and then they had looked out both and they had decided that they wanted to look at it with a fresh air pair of eyes and to just go through it in detail.

My recollection was that they had genuinely tried to get to -- try and find out what had happened and that James Titcombe was very -- was pleased or at least acknowledged that he thought they had tried to deal with it seriously.

So I am -- I do not know. I mean, you would have to ask those -- one of those or all of those three about it but my -- knowing them, my assumption would have been that they would have looked at it with an open mind and if they had uncovered anything that they thought was a systematic failure, are likely to have said, "we think there has more to it."

I am pretty certain that is what they would have done but I cannot, you know, I am sort of, in a way -- I am in a way guessing their motives but, you know, I worked with them quite closely for a number of years so I know the way that they worked and I know their values. So I would be surprised if they would have done anything other than that if they uncovered anything.

DR WALTERS: What was the SHA's view of them becoming an FT?

MS CUMMINGS: I think it was fairly open to -- if they went through all the due process and they were seen to be okay then that was fine. We did have some concerns raised by the PCTs just before they were authorised and so they took and -- the PCT Chief Executives talked to me about that, I talked to Mike about that, Mike talked to the PCT Chief Executives and told them to speak to Monitor and we do not know -- I do not think they did but there was a view that -- at that point Monitor were not that interested in the SHA's view.

As far as they were concerned, it was up to them and we also in position where they had gone through the Secretary of State, I think, from memory and were in the process of about to go into the final stage and it was about that time when we did when all the changes happened post-Francis and then they changed the whole system, didn't they, and we had to put -- FTs went through a much more tougher or potential FTs went through a tougher quality review but it was not retrospectively applied and so Morecambe Bay had already gone through that.

So they had already gone through to that next stage. Whether or not there was anything else done by the SHA in terms of looking at any of the issues, I do not know.

DR WALTERS: What did they raise? What did the PCT raise?

MS CUMMINGS: I can't remember. I thing they -- I genuinely I can't remember. There was -- it was quick -- it was a conversation in my office in Manchester saying, "we are not absolutely sure. We think that -- we are a bit worried about culture, behaviour. We are not sure what is going on. We think -- we are not sure whether they should be an FT" and I said, "who have you told?" and they said, "well, we are telling you". I said, "fine", and "okay" and so I raised it with Mike.

I know Mike spoke to them both and I know that they were advised, because they had to provide feedback to Monitor as part of the authorisation process, to have a conversation with Monitor, to do that.

DR WALTERS: Who is dealing with it at Monitor? Can you remember?

MS CUMMINGS: No, I do not know. I know who was dealing with Monitor -- with them later so Mirav was the one that I dealt with, one of the directors. She was brilliant actually. She was really -- we worked really well together once we got into 2011 and we started doing Gold and stuff, she was fantastic. Really clear and very, very, very informed and very, very supportive around actions and actually, considering it will sound like this is being

recorded but for Monitor, a very open and engaging work.

It was not a case of, "leave it with us", it was, "let us work together." So we, that was well supported and they were very -- I thought they were very good around this.

DR WALTERS: Just going back to Gold, what do you think the real sort of end points were which gave everybody the confident that Gold should be closed down?

MS CUMMINGS: They actually closed Gold after I had gone. So I was not there when they made the decision to close it. I moved to the CNO job. I think it was closed down in April time, I think, from memory but I was effectively working as CNO by then.

From what I have been told, although I was not there, and what I have seen, they had got -- it had got to the point where they felt that the Trust were implementing relevant action plans, that it did not need -- there was no need for Gold and actually Gold was now becoming counter productive because it was causing more confusion about, "well, what is the role of Gold now? It has been going on for several months. What's the role? We do not need it any more."

Actually it is better to have just an oversight to make sure that they are delivering. We have got two regulators, that is the regulator's job and we have got the PCT, or the -- because they were just about PCTs by then. People

just ~~hit~~ ?got into NHS the commissioning board. But you know, it is actually down to they just need to get on with it now. I think they got to the point where they felt they had done enough and Gold was becoming -- was not necessary.

DR WALTERS: When you were still part of it, were you aware of seeing some sort of green shoots you were expecting to see or was it more to do with the actual co-ordination of, "all these different bodies was happening and that was --"

MS CUMMINGS: It was a bit of both, I think, Geraldine. I think, they had -- so, yes, we had the co-ordinations but they were also beginning to act and to deliver on some of the things that they said they would deliver on. So from memory, they sorted things like the medical rotas and the paediatric rotas, they had more -- they were delivering more of what they said they would deliver. They had accepted help around urgent emergency care, they sorted ~~at~~ out some of the out-patient issues, they had changed quite a lot of the staff.

So at this point we had -- there was a new Chair, there was a new Interim Chief Executive, there was a new Interim Director of Operations, there was a couple of -- there was a new Medical Director, there were couple of Deputy Directors of Nursing that were working with Jackie.

So they were beginning to start to develop what they

needed to develop and the point, I think, somebody made earlier is that sometimes, you just need to get people get on with it. Otherwise you just -- if you cannot do it, if they do not ever get on with it, you just end up causing more of an issue.

DR WALTERS: Thank you.

PROF FORSYTH: Just couple of points, you mentioned couple of times in relation to the Titcombe incident about these reviews and you talked about the Scottish review. Do you know -- I do not know if we are familiar with that -- who led that, do you know?

MS CUMMINGS: So, what happened, I think, was that the Trust did a review, an LSA MO review, of the what happened with the case. James Titcombe was not happy with that review, did not think it uncovered what he needed to uncover and our assessment was that was correct. Therefore, we then asked for an LSA MO from Scotland whose name I can't remember but Yvonne somebody, I think. We asked somebody else, an LSA MO external to the North West to come and do a review. So she came and did a review and that was we think more thorough, but James was not happy with that one.

It was at that point that we or the SHA agreed we would, that Angela and Chris Dent -- Chris Dent was our governance corporate person, lead person -- did an external, they did a "let us just review what happened with this and

let us see if we can uncover what happened, what was going on." So that is where the Scottish one came from.

PROF FORSYTH: Thank you. Secondly, one of the terms of reference is to identify learning which might be of interest to the wider NHS. This issue of small units, of relatively isolated geography, how do you identify what is actually going on in these units because clearly, as I think we have touched upon, broader statistics may not pick some of the issues which seem to be around culture in a unit, behaviour and attitudes as well as clinical competence.

These may not be reflected in mortality rates or even SUIs. I wondered what your views are today of this and if there are units elsewhere around -- how would detect that behaviour?

MS CUMMINGS: Well, I suppose firstly I would say that it is the responsibility of that Board to make sure that they are providing high-quality safe, effective services where people get a good experience and staff get a good experience and that is, at the end of the day, that is their job.

In terms of the assurance and checking that is the case, I suppose, I mean, one of the things that we are doing now and, you know, who knows whether this is absolutely going to have the impact that everybody hopes it will but we are now doing the, we are now asking women at three stages of a pregnancy and birth what their views are about the

services that they received. So they are being asked at antenatal, perinatal, post-natal what were their experiences through the F FT and we are also and from April we have been asking staff what they think.

The two best the two best ways of assessing what's really going on is often is perceived by many to be staff experience, and patient experience. If you look at those two things in detail, then you should potentially -- you may not pick up -- the women and their families may not pick up some of the, necessarily, some of the cultural or the effectiveness issues but they will know how they feel. They will know -- they may not understand everything but they will know what it felt like to have a child, have a baby there and whether the staff looked after them well and whether they felt well supported, but staff in an anonymous survey that says, "what do you think? Would you recommend this" -- would you, if you asked a midwife, "would you recommend this unit for your sister or your loved one to have a child?" and they go, "no", then that to me is of the biggest red flags you can possibly have. It was certainly one of the red flags in Mid-Staffs.

That is one way we are looking it now and 'we are not any other way' This isn't accurate at CQC has very different assessment regime too. I guess, one of the other options we can look at is the idea that people have started moving ~~out~~ on is some of the buddying systems. So how can an isolated small

unit actually buddy with either another small unit somewhere else or a bigger one so they've got a better? How do we move -- how do you get better movement of staff? How do you get better sharing of ideas? How are you sure as a head of midwifery in Furness or, you know, wherever, that actually what you are doing is high quality, latest, most effective?

On the basis that you are from Scotland you have lots of isolated areas, please, let know if you have got any good examples because, you know, we have got places -- we have got places in different part of the country in England that are isolated but probably not to the extent that they are in parts of Scotland.

PROF FORSYTH: Well, what we do have is very close working networks and that is why I was wondering whether, again, looking retrospectively in terms of more effective networking across country, for example, with larger centres out of there.

MS CUMMINGS: Well, we have got the strategic clinical networks in place and there are, there is one around maternity and children which, I have to say, I think if we think through what those networks are doing --

MR BROOKES: Apparently they are do things very differently.

MS CUMMINGS: I know, but it is whether what they are doing is effective which is something that they are looking at, at the moment. But, I think, that is, you know, that is an

opportunity.

PROF FORSYTH: Configuration of services, integrational services in particular, I wonder again whether -- retrospective in relation to looking at that both in hindsight, do you think you are really enabling clinicians to work more effectively together across Cumbria pooling their resources effectively and not trying to establish -- resources in isolation will never be achievable.

MS CUMMINGS: We had a very good -- whether it was at a more junior level is I suppose less obvious -- but we had a very good network, nursing network at senior level. I had, we had all PCT directors of nursing, acute directors and mental health of nursing, together on monthly basis. We had a huge network of support where we were -- and people were very open about providing each other with support. So, that does, of course, rely on individual directors of nursing to say, "we have got an issue" or "can you help?"

We also appointed in the SHA a consultant midwife with a specific remit around maternity care working to Anne Hoskins, and she was very good at getting networks out with heads of midwifery and trying to find -- trying support them, trying support that network of midwives across the North West.

Could we have done more? Possibly. Possibly. We did quite a bit around maternity services as an SHA so we did a

significant reconfiguration of maternity services in Manchester, which was one of the biggest in the country, deliberately aimed at trying save lives which we did or least evidence shows that we did.

We also did 'a big reconfiguration in east Lancashire' as This reconfiguration moved services between two sites in Blackburn and Burnley. General paediatrics went to Blackburn where there was a midwife led unit. In Burnley there was an obstetric unit, a neo-natal unit and a midwife led unit. well which ended up with a -- we switched it from one end to the other -- one part of East Lancs to another part, but we ended up with midwife led unit in one part and much bigger obstetrician neonatal plus midwife led in the other. So we have done quite a lot of work around maternity across the North West and we have also been the lead SHA for maternity matters before I arrived, it was before I arrived.

So we have done quite a lot. Whether we had relied, with the benefit of hindsight, on people volunteering to be involved as opposed to deliberately going out and searching wore them to be involved is another matter.

PROF FORSYTH: Okay. Thank you.

MR BROOKES: Just couple, you will be glad to know.

I am trying to get a feel for the approach the SHA had to performance management because I know it changes -- very different in different or was very different in different parts of the country. Could you just described briefly how you saw as an SHA the roll of the performance management at SHA level?

MS CUMMINGS: It was, well, it was highly significant. It

was something we took very seriously. It was complex and it was difficult because it is so big. We -- so I had an associate director, a deputy, and I had -- we put -- I put into place -- and I did the same with patient safety -- I put into place assistant directors of performance who had subject matter expertise and geographical links.

Therefore, we had somebody that would have been -- that would have been allocated to Cumbria and Lancashire, Greater Manchester and Cheshire and Merseyside and so they those assistants directors of performance got to know their patches well. So they got -- they built the relationships with Trusts and commissioners but they also have subject matter expertise. So one led on, one would lead on A&E and other ~~units~~ ?issues for example.

I did the same with patient safety. So in terms of the patient safety team, we had people that led on mental health, we had somebody else that lead on safe guarding, for example, with three -- we had another one who did more general acute. We basically, they also had a geographical identity but a subject matter expertise so there was a lot of matrix working across the patch. That was the only way we could manage 24 PCTs and something like 60 or 70 other Trusts too -- in the sense.

We expected PCTs to do quite a bit of local performance management and we were there to support them,

but we also did quite a lot of intervention. So as an example of that, when I arrived in the North West the winter 2007/8 winter A&E performance across the North West was terrible and many organisations were failing, 98 percent. Some of ~~the~~ you may know, if you don't, I will tell you. In a previous life, I had been national lead for emergency care. I am an A&E nurse by background and I had led the team that had eventually taken the country to 98 percent. So I knew quite a lot about it.

We put in place quite a lot of dedicated support to the organisations that were struggling because I understood -- it was relatively straightforward for me to do because I understood it. Then I commissioned a review, so we commissioned an urgent care review which was led by Aidan Keogh who is now the Chief Executive at Royal Liverpool. He was the Director of Operations at Blackpool FT which was one of the best performing organisations in the country for A&E performance.

He led a review with clinicians and others and did it like a peer review. So they went round and assessed or talked to organisations that had done well, organisations that had not and then wrote a report of recommendations around what -- how to improve and, subsequently, that meant that there was much more focus.

In a nutshell -- I'm sorry, I suppose this is a

slightly longwinded way of saying we monitored it very closely, we provided help and support, we encouraged the PCTs to do a lot of the performance management locally because that is their job, and there was only four of us, five of us in total and I, as you know, had nursing quality and subsequently commissioning to do as well. So we managed that out but we were very clear about the need to intervene if and when necessary.

Another example of that is Lancashire. We intervened in East Lancashire as well where their performance, in a variety of different settings, went off significantly. We were concerned about it. We brought -- there was a whole system approach to it, with PCTs involved. I led it, and we brought in external experts to go in and support. So it was a bit like the IMAS services that continues to exist. I built on what I developed nationally which was the first intensive support team for emergency care, which was then followed in 18 weeks, and cancer and others; we brought experts in to go and support.

So it was a combination of personal intervention, external expert intervention, and support to enable both the Trusts and the commissioners to actually develop -- improve and the approach I took was that I did not differentiate between non-FTs and FTs. So, the relationship I developed with the FTs was good enough for FT Chief Executives to ring

me up and say, "we have got a problem, can you help?" And when they did not ring me up and say, "I have got a problem, can you help?" I would ring them and say, "you have got a problem, would you like some help?"

In the fast majority of cases they said, "yes, please." Because we did not do it in a "we are beating you up and you're crap", it was a "I understand issues what, can we do to help you?" and that involved, often involved me having meetings with local authorities, commissioners, finance, the whole lot to actually get an agreement about how we do it.

One of the things I have always been very clear about ever since I worked in the Department of Health and I did A&E, is that a target is only good if you do it in the right way. So there is nothing more irritating for me than people hitting the target and missing the point and I have many examples of my time at a national level of watching people hit 98 percent but do it in a way patients are not treated appropriately and I always act, I always, always took action when that was the case.

MR BROOKES: So as part of your approach, you would have formed the view of the quality of the leadership of the organisation?

MS CUMMINGS: Yes.

MR BROOKES: What your view of the leadership with Barrow at this time?

MS CUMMINGS: Do you mean Morecambe Bay?

MR BROOKES: Morecambe Bay.

MS CUMMINGS: I thought that Tony Halsall, this is -- I better not say that ... He was he was not the easiest to engage with initially. He did not -- he was not -- he did not accept -- early on, did not accept help initially very well. So certainly when some of the CQC original reviews -- essentials, not essential standards, when they had the standards, they were only partially met for some of the national priorities but that was because some of their performance was off.

I can remember having quite a lot of conversations with him at Chief Executive meetings we held about "your A&E performance is not very good. What are you doing about it? Would you like some help?" and he would go, "oh no, I am fine, I am fine" but that only happened for so long then I would say, "you have to have to have help" and he did it before he was an FT so that was more about his personality. But he did actually, have some insight and did ring me up a few times and say, "I need help."

MR BROOKES: Two brief things. One, I am trying to understand what the LSA review, Scottish review, and internal review that generates the Fielding review, there is clearly something of concern or you would not have done so or there would not have been so many reports and also,

clearly a feeling of dissatisfaction that you have not quite got to the route of it or you would not have done the next one.

You get the Fielding Report, it is not widely circulated. As an SHA who knew about the report and was engaged in making recommendations about the individuals to lead the piece of work, what was your -- what did you do in terms of the recommendations? Did you feel this was something, given the concerns of so many reports that you should be directly intervening with the organisation?

MS CUMMINGS: Go back to it, I do not remember seeing the report. It was not my area, although -- because I didn't cover maternity, and although I did quality and SUIs and stuff were mine, I do not remember ~~saying~~ seeing it. Whether it went --

MR BROOKES: Were you doing performance at that time?

MS CUMMINGS: Yes, I was doing performance, but I do not remember seeing it and I do not remember having that discussion. It is not to say I didn't but I genuinely cannot remember. When I read the Fielding Report more recently, prior to coming here again because I knew I was going to come here, I did not recognise it and, I think, that I would have done if I had read it before.

MR BROOKES: For some reason, it did not get into performance system?

MS CUMMINGS: It did not get into performance system that I can recall at all and the other -- I guess the other thing is that this was a Trust report, I think -- again, without talking to Angela which I have not done, I do not know. Whether she saw the -- whether she was given the final report, whether she saw a draft, before it was finalised, I do not know. But for whatever reason, it did not get raised and it did not get -- we knew it was happening, but it did not get raised as an issue.

One of the lessons, I think, for me in this looking back and it is slightly easier for me to do it because I was not as involved in the detail of the, particularly, around the James Titcombe complaint or in maternity as such, because it was not my, particularly by 2010, it was not -- or from 2009 onwards, was not my area. But I would say that, firstly, we need to learn some lessons about the number of reviews.

What we should have done, and what maybe one of the things I would like to see in the future is rather than just having lots of incremental reviews, where we do an internal review, followed by another review, followed by an NMC review, followed by CQC review, followed by independent review is that there is a decision taken where you are bring all of the relevant parties together and say, "is this incident so serious that we should go straight for, you

know, an external independent review or we agree that it is going to be a review that is like this?" Rather than and we absolutely and we have got everybody involved to sign off and it would be, with the benefit of hindsight, if I had been involved a bit more, I may have said, "this is ~~and~~ an SHA commissioned review, not a Trust commissioned review."

If it had been ~~and~~ a SHA commissioned review, and it had come back to us, we would have had -- we would have been -- we would have had the Trust input in terms of what they said or what they agreed in the factual accuracy et cetera but that would have been very clearly sitting with the commissioners and the SHA as a way of making sure that those, that that was implemented. I think that probably, with benefit of hindsight, at that stage, three reviews in or four if you include the NMC review, we that would have been better to do it completely externally to the Trust.

MR BROOKES: Just one final thing, I absolutely accept it is Monitor's responsibility to make a judgment in terms of FT. However, you have got local -- from what we have heard, you have concerns being raised by the PCT, or PCTs. We do know that they raised that with Monitor itself and significant concerns, not just about the organisation, the quality of the issues, but also an alignment issue in terms of the commissioning plans and intention of the business plans of reorganisation, which is the fundamental issue which is,

from my experience of FTs applications is something which you always look at, concerns raised with yourself, and I am lightly surprised that with that level of concern in the system that Monitor would go ahead.

I do not know what your view of that is. It seems unusual to me, without the main commissioners support, that let alone the SHA support that there will be a feeling that they would -- sufficient information in confidence that they should be given FT status. I know in retrospect we can say, "yes, that was right". I am surprised by that and I will be interested in knowing your views.

MS CUMMINGS: I think if the PCTs had conversations with the -- I mean, the relationship between the PCTs and the Trust were not good. Therefore, they were definitely quite challenging and there was -- yes, the relationship was not very good. They were quite -- the PCTs could be quite aggressive, certainly Cumbria. They could be quite difficult and so, I think that -- so whether or not -- I do not know whether that -- that could have -- that would have been played out in, you know, poor relationships.

Now, with the CQC well led -- well led to Monitor having a much stronger quality oversight in terms of the what the -- relationships is a really key issue. That may have flagged more concerns. I do not know. It would not have surprised me if Morecambe Bay management team would

have said, "well, they would say that, would they not, because, you know, look at all of this history. We have had where we have been trying to --" We know that level of funding that particularly Cumbria PCT put into Morecambe Bay was quite low as a percentage in comparison to others. So there was quite a lot of antagonism I think which took a fair bit of managing from people like Mike and our Finance Director. But having said all of that, yes, it is, you know, with looking -- sitting here, sitting where you are looking back, you might want to query what they did authorise at that time.

MR BROOKES: Thank you. Anyone else?

PROF MONTGOMERY: I have two questions. I am touched by the point about the incidental reviews because we had a thing about seven on our -- we have now come upon -- we may even have found a new one today with the Scottish review.

MS CUMMINGS: I am sure that is right. Now, you are making me make me question when I am right or not.

PROF MONTGOMERY: I think the idea is that there is a trigger that says, "we have not yet got to the bottom of, it needs to be got grips on." You describe that as an SHA role. There are no longer any SHAs, where would it sit in the new system?

MS CUMMINGS: QSGs. So the quality surveillance groups, I think, have a significant role to play. So they are, I

mean, whether it will change as we make the next iteration to the management structure in the admin structure of NHS England which ~~I~~is about to go through a massive reduction, but we have got both local QSGs and also regional ones and the quality surveillance groups are currently chaired usually by NHS England. In the future some of those maybe chaired by CQC but I would say that that sort of issue should go there. I do think the QSGs have had a positive impact. There is a lot of more ability to pick stuff up at an earlier stage and to flag issues and to either deal with it at an earlier stage or to identify what needs to happen.

PROF MONTGOMERY: Just to check, it is principally a commissioning as opposed to regulatory issue. Is that where it sits?

MS CUMMINGS: Well, partly it was --

PROF MONTGOMERY: I appreciate it overlaps.

MS CUMMINGS: The reason -- the QSGs have been in place for about two years, I think. When they were set up, the -- well, the NHS England or NHS Commissioning Board Authority was probably in a stronger position to be able to take it forward than CQC were. CQC were going through massive changes.

I think that now they have got the three chief inspectors, they have got their teams in place, I think that they are probably better placed to be involved now than they

were. I think it is unlikely that Monitor would ever chair those. I think Monitor should be there but I do not think they will ever chair them. I think, it will be either be commissioners or CQC and the risks -- if any of the QSGs recommend a risk summit, they are usually chaired by either the regional medical or nurse director or the regional director of NHS England at the moment.

PROF MONTGOMERY: Thank you.

I just wanted to get -- check that the account of who called the Gold Command has varied --

MS CUMMINGS: I bet. I am very clear it was me.

PROF MONTGOMERY: That is quite helpful.

I will pick up from the minutes of the risk summit. Just before you called it "an air of frustration about fact people were not moving upwards as much as you would have expected." Just to be clear --

MS CUMMINGS: That was related to one individual person.

PROF MONTGOMERY: -- it was called by the SHA. It was -- we have been told it was called by you because it could only be called by an SHA and was driven by elsewhere. That is not your understanding of the process. There were things going on in it sits with you to call the --

MS CUMMINGS: Yes, it is our responsibility to call it. I one of the -- somebody in the PCT did suggest it. At that point, we had not got all the evidence and I was -- it is a

significant thing to do. So I said I wanted to review the evidence and call a risk summit and then we would make decision.

I was very clear that it was my decision to call it. I had done them before, it was my job and so I did call it. But because of the way that it works, it was very clear that the best people to run it were the local -- well, the medical directors were stepped up to it. Mike Bewick did it and he was supported by Jim Gardner and they did, I think, a good job.

My frustration about the police investigation at the time was that there was one member of the PCT team that attended that but did not communicate at all and that was quite frustrating.

PROF MONTGOMERY: And you have gone off the back of Stockport so you knew what could go wrong.

MS CUMMINGS: Exactly and I had attended police Gold so I knew system, I knew that you could get -- I knew the S L A arrangements you could have, I understood that a lot of what the police said was confidential, but there was still something about being able to keep a limited number of people close.

The other thing I did was I was very clear that when we did -- we did telly conferences quite a bit because of the geographical distance, and I was also very clear that we

needed to keep Gold some of the teleconferences quite tight and the reason for that was people -- you know what it like. You get lots of people involved, people start chatting and telling people and then it gets leaked, the media get it and it was just -- we are going to be discussing some really big issues here and this is about people. It is about names, it is about individuals -- about patients. We are talking about individual cases, if there are SUIs, actually, we have to be we have to respect confidentiality and we have to manage that in a way that is clear. So I was quite strict about that as well. I would not always say I was very popular but you know.

DR WALTERS: When you said that it was not your area to follow up to the end point of the James Titcombe reviews and reports, who was that?

MS CUMMINGS: So, in terms of James -- in terms of the James Titcombe links with the SHA that was Mike, Mike Farrar with Chris Dent and Angela Brown. And in terms of the maternity services generally, Anne Hoskins who was a public health consultant was the Director of Maternity, Children and Young People and so any -- she managed the consultant midwife and had been that lead for child safe guarding and, you know, stillbirth and neonatal deaths, all of that. Clearly there was an overlap with me because Angela Brown who did a lot of that work was in my team and she managed the LSA MO so there

was clearly a responsibility in my team and I had a role but I didn't have the overall executive director responsibility.

DR WALTERS: That is helpful.

MR BROOKES: I am conscious you have got a train to catch.

MS CUMMINGS: I have no idea what time it is.

DR WALTERS: You will be there in five minutes.

MR BROOKES: We will not keep you any longer. Thank you very much for your time. Thank you.
