THE MORECAMBE BAY INVESTIGATION

Wednesday, 1 October 2014

Held at:
Park Hotel,
East Cliff,
Preston.

Before:

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

JO BORTHWICK

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

DR KIRKUP: Thank you. Please, sit take a seat. Thank you for coming. I am Bill Kirkup. I am the Head of the Investigation Panel and I will ask my two colleagues to introduce themselves.

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

PROF MONTGOMERY: I am Jonathan Montgomery, I'm a Professor of Care Law at University College, London and I Chair the Health Research Authority. In the past I have chaired PCTs and SHAs for the provider Trust.

DR KIRKUP: You will notice that we are wired for sound and we make a recording of the proceedings to produce an agreed record at the end of the process. You are aware that we open the proceedings to family members, as it happens we have some family members present today. Others may listen to the recording subsequently if they wish to.

You will also know that we have asked you to leave behind any mobile phones, tablets, other recording devices just to reinforce the fact that nothing goes out of the room until we produce the final report with everything considered in the context.

Do you have any questions?

MS BORTHWICK: No, it is absolutely fine.

DR KIRKUP: I will start with a general question and then hand over to Julian. My general question is can you just outline when you were first associated with the Trust and the different things that you have done in your time there?

MS BORTHWICK: Yes, yes. I Joined ~~joint~~ the Trust first in July 2008, came from a PCT, as head of business planning to work on the Foundation Trust application and also the contracting for the Trust just as acute contracts were introduced.

DR KIRKUP: What have you done since?

MS BORTHWICK: Since then I have worked, since 2012, I have worked as the Aassistant Chief Executive working with the chief Executives that we have had since then supporting the Chief Executive, working on some of the governance issues that we have had to face ~~in place~~, helping them in some of the liaison and responses that they had to do to various people and organisations and latterly, as of September, I am Associate Director of Transformation at the Trust looking after the Better Care Together implementation programme from Trust perspective.

DR KIRKUP: Okay. That is very helpful. Thank you. I just I realised I omitted to mention one particular point. I have got a standard introduction, it is the

same for everybody. I should have mentioned that the are two family members may have to leave during the proceedings just because of scheduling. If they do they will try to do it discretely. Thank you. Now, Julian.

MR BROOKES: Thank you. I would like to focus initially on your involvement in the FT application. Can you just give me a little more about what your role was and how that was handled?

MS BORTHWICK: Yes, two. Aaspects to it probably. I helped prepare the Trust integrated business plan which was our submission firstly to the SHAs, then to the Secretary of State, then to Monitor. Once we had gone through that stage I was actually coordinating the information requests that we received from Monitor., So.se pulling together from various people, asking them for information to respond to those and then sending that on to Monitor and making sure that we had a record of what we had sent and any more requests that came from that.

MR BROOKES: If we start on the integrated business plan. Tell us a little bit about how you went about creating the plan, your engagement with partners and so forth?

MS BORTHWICK: The document was actually created before

I started. So, I think that the Trust had started working on it in about 2007. When I joined we were refreshing it, so we were updating it. The Trust had begun to do a clinical strategy which they were, I understand, to engage their partners with. That was with a company called Matrix. They were working clinical strategy that informed our ~~clinical strategy for the~~ way forward. The document, itself (Intergrated Business Plan) was comprised of a number of chapters, I think that is probably the best way to describe it, which outlined where the Trust was now, how the Trust performed, the Trust's approach to governance, to finance, to risk and its strategy and market forces as well. So what other organisations were aligned to us, other organisations where patients could go to, rather than to us, travel time, all that sort of demographic information in terms of how the populations might change and what we might need to do with services in that respect.

MR BROOKES: What kind of discussions did you have with your main Commissioners.

MS BORTHWICK: The main commissioners, I am trying to remember now, it is quite a long time ago. The main Commissioner would have received the document, I am sure they received the document to comment~~commend~~ on. It was Submitted twice in the period that I was there. So we

did two IBPs.

MR BROOKES: You were involved before the pause and after the pause?

MS BORTHWICK: Absolutely, yes. They responded to that. There would be contracting discussions as well. Not specifically about the IBP but about what services we may or may not provide ~~respond~~ and also discussions with them so that our activity modelling in the integrated plan matched their expectations or not.

MR BROOKES: Did it?

MS BORTHWICK: Not all the time. The Trust did not necessarily think that the demographic reductions that the PCTs thought would come would come, so we actually had higher activity levels. So, some of their demand management schemes we did not think they would achieve what they thought they would achieve.

MR BROOKES: So their demanding management schemes you thought were optimistic?

MS BORTHWICK: Yes.

MR BROOKES: So it is normal practice for that business plan to be supported by its main commissioners ~~clinicians~~ in terms of their application. Did you receive that level of support?

MS BORTHWICK: As far as I can I am remember, yes, we did, certainly for the first submission. I am sure we

did have letters of support but I would have to check back to the files really to confirm that.

DR KIRKUP: Was that both PCTs that supported it?

MS BORTHWICK: I mean, I think that some of it would be at my level, as far as I am aware they did but there would be Board to Board discussion that I may not have been party to.

MR BROOKES: Surely those letters of support would have been part of the core pack of information?

MS BORTHWICK: From recollection I am sure they were but to give you definitive I would have to look at the files again.* Appendix 14a/14b Cumbria PCT LTR FROM SUE PAGE 5 DEC 2008, NORTH LANCASHIRE PCT LTR FROM IAN CUMMING 2 DEC 2008

MR BROOKES: You would be surprised if they didn't?

MS BORTHWICK: I will be surprised if they didn't, yes.

MR BROOKES: Okay. You have got your integrated business plan. Were you involved in the Board memorandum of quality of governance assurance?

MS BORTHWICK: I help to co-ordinate with that submissions from the directors.

MR BROOKES: Can you give me a little more about how it was put together?

MS BORTHWICK: That was for the second submission.

MR BROOKES: It was. They changed the rules.

MS BORTHWICK: They did, they were just coming in, I think, as we went into that. Our application was

reignited, that is not the right word but restarted, I think, in the April of that year and then those rules were coming in. So, that was co-ordinated the information from some of the information we had in the submissions that we had given to Monitor. So Monitor requested a lot of the information from us in different area such as governance, such as quality, such as serious untoward incidents, things like that. They had come in and they had talked to our staff as well. So much of the information that we used to inform our quality governance statement was based on the information from those submissions. In addition the directors would all review that and it was approved ~~approve~~ at a Board meeting.

MR BROOKES: Okay. So you were instrumental in putting it together?

MS BORTHWICK: From the information provided, yes.

MR BROOKES: So the information has been provided. Who before it gets to the Board signs it off? Who says this is an accurate representation of the organisation?

MS BORTHWICK: All the directors had a draft and they all reviewed it before it went to the Board meeting, so the executive directors and then it went to Board for formal approval.

MR BROOKES: My understanding is that you didn't

actually go to the meeting of the Board?

MS BORTHWICK: I didn't, no.

MR BROOKES: Who actually presented the report do, you know? Can you remember?

MS BORTHWICK: From recollection I would think it would be the Director of Services and Commercial development but I do not know.

MR BROOKES: For the record, that would be?

MS BORTHWICK: Patrick McGAHON ~~McGann~~ but I cannot be sure about that because I was not at the meeting.

MR BROOKES: I understand we can check that. So there is a document, a memorandum which outlines in a range of areas the governance arrangement in the organisation and provides high level of set of evidence. In terms of how it is meeting those requirements?

MS BORTHWICK: Yes.

MR BROOKES: Also organograms of governance systems, if I am correct?

MS BORTHWICK: That is right, there was a clinical governance organogram.

MR BROOKES: Again for clarity, that is signed off by the individual directors and then taken to the Board and the Board approves that self-assessment?

MS BORTHWICK: Yes they did.

MR BROOKES: That is quite importantee I understood that

because I am just trying to reconcile that then with the independent governance review that was taken 18 months later which described an organisation with incredibly poor governance systems, poor risk management, poor Board information, poor – can you just try to shed some light on why an FT application will go forward when the situation was so different 18 months later in terms of an independent assessment?

MS BORTHWICK: I think that is a really difficult question for me to answer from the position that I was in in the organisation. I think it is a very valid one. I think that there were elements when – it is really difficult. There were elements when we were pulling together the quality governance, so there were things that were being really being developed that they would use, such as the *MQAT *Midwifery Quality Assessment Tool ~~M part~~ and the* NQAT~~N parts~~.*Nursing Quality Assessment Tool. So when I first started the new Director of Nursing started a few months after myself and she introduced quite a lot of new quality governance systems. So there was the nursing quality assessment tool, the midwifery quality assessment tool and a ward ~~an award~~ based assessment tool called Guru which, as I understand it, went to the Clinical Governance and Quality Committee. I think, that the impression I had at the time was that certainly they were well received within the

organisation but I think that in hindsight, I think, that from my position, because I have looked at a lot on hindsight, I think that the communication was not as always as open and honest in the organisation as it could have been. So necessarily, you know, so people did not necessarily give honest answers in terms of if they felt things were not right. That maybe there was not the challenge that there could have been to things. So it made you feel that the key question is; is it assurance or reassurance, which are you taking? So if people said things were okay then was that accepted at face value rather than the scrutiny in the systems beneath it that could have challenged that.

MR BROOKES: So when the information that was being put to the Board, again, who was providing that information?

MS BORTHWICK: It was wide range right across the organisation, because Monitor asked for an absolutely, to me, absolutely wide depth of information ~~organisation~~, across the whole organisation. So they would ask for estates information, they would ask for quality information and they were provided by either the director or the people within the departments. It would generally be signed off by a director before it went through to Monitor. The relevant director would say, "Yes, that is right.

That is the information from my department."

MR BROOKES: I am struggling because it is so different from the picture that was then produced 18 months later.

MS BORTHWICK: Absolutely.

MR BROOKES: So I am trying to understand whether or not the questionnaire does not ask the right questions or that the information provided was inaccurate.

MS BORTHWICK: I think the information provided was all based on Board ~~onboard~~ reports, reports that had been before Board committees and sub-Committees and, I think that is probably quite a relevant question because the second time that we went through the process, the first time we sent to Monitor the Board reports and all the associated papers. The second time we sent Monitor the Board agendas and they asked us for information off those.

So there was a slightly different approach to the two but you had the new quality governance framework done alongside that. So a lot of the information we provided to Monitor in the second assessment was updates and refreshments of the first information. So we would -- incidents we would provide them lists of, high level summary lists and of, incidents that had happened and they were refreshed monthly to Monitor but there

was not any granular detail behind that unless Monitor asked for that granular detail.* SOME 250 EMAIL SUBMISSIONS WERE MADE TO MONITOR BETWEEN 26/4/2010 AND SEPTEMBER 2010. THE QUALITY GOVERNANCE FRAMEWORK WAS REQUESTED ON 2 AUGUST 2010 AND APPROVED BY BOARD ON 13/9/2010

MR BROOKES: Again, I am– struggling to understand. Stepping back from the processes around FT, you are working in that organisation, you have worked there for a number of years. Did you feel that what was coming up through those reports was an accurate representation of the position of the organisation?

MS BORTHWICK: I felt when we got to the point, and I think I put it in the information that I wrote to you, in the October of 2011 I did a report which outlined my views on governance to the then Chief Executive, which is my personal view of where there were potential areas that we needed to strength then.

MR BROOKES: Can you summarise some of the content of that?

MS BORTHWICK: Some of the content of that. They were very similar to some of the things that came out through the final governance review. It is actually "were we clear about who was responsible for which areas", so in terms of governance was there that clarity of who actually held the ring from a director level on that. Was our Committee structure right? Did we take assurance rather than reassurance? Sorry, other way round. Did we have document management systems in there

that allowed us to have the right information in the right place at the right time? So it was along those things. Were people accountable?

MR BROOKES: Remind me, when did you write that?

MS BORTHWICK: October 2011.

MR BROOKES: October 2011. So this was after FT application?

MS BORTHWICK: It was after FT application. Yes.

MR BROOKES: What brought you to that understanding of the situation compared with where you would have been around the time the Matrix was being completed?

MS BORTHWICK: There were a number of key events that happened in 2011. There was an inquest in respect of a baby who had died in 2008. There was the launch of the police investigation and we became subject to further scrutiny from Monitor. As part of that scrutiny from Monitor I had to go back through and provide them with additional information, submissions, looking at information again and some of the challenges of getting that information at that point in time, which was different, it seemed a lot harder than it had previously, led me to write that report and actually say to the Chief Executive that I had some concerns.

MR BROOKES: Were you aware during the time working in the FT application of the Fielding Report?

MS BORTHWICK: No.

MR BROOKES: It never came up in any discussions that you recall?

MS BORTHWICK: It didn't come up in any discussion that I was involved in, no. I am aware of it ~~that~~ with hindsight, I am aware that it was shared as part of an inquest process and I am also aware that, as part of when we started to come under scrutiny that, it was part of the women and children's sustainability plan which was something not referred to as the Fielding Report in that plan. * For Clarity *the report was not referenced as the Fielding Report in the Women and Children's Sustainability Plan. However the invention to undertake an external review and the Terms of Reference associated with it were. But the terms of reference were referenced and that was shared through the due diligence of PWC as part of Monitor process. ~~B~~but, I was not aware of the report.

MR BROOKES: You are not aware of that, that is clear. What was your understanding of the reasons for the FT application process to be paused?

MS BORTHWICK: I think, I mean, at time in 2009 when that happened it was -- it came as quite a shock to me because I think that all the signs from the organisation had been quite positive and certainly I had felt it was going to be successful, I had no reason not to think that. I think that the impression that I got at the time was that the Healthcare Commission and the CQC, that there was that change in organisational

structure., Wwe were,[The Trust] I think, I had been not rated green, I think, we were rated amber. I think there were ~~that was~~ the concerns from that.

I have subsequently seen correspondence that it may have been for a different reason but that was, you know, subsequently as part of putting information together for other purposes.

MR BROOKES: At the time you were not aware of the their concern around serious incidents that had happened in maternity services?

MS BORTHWICK: No.

MR BROOKES: That was never discussed in any association with the FT application?

MS BORTHWICK: No.

MR BROOKES: Does that surprise you knowing what you know now?

MS BORTHWICK: It may have been discussed at Board level. It may be because I was not privy to any Board or Board or Board sub-committee meetings that they may have had those discussions at that level but certainly, it is not -- they would not necessarily have discussed the main reasons for the application with myself who was not a Board member. FOR COMPLETENESS: A COPY OF 'REVIEW OF OVERALL MANAGEMENT ARRANGEMENTS MATERNITY SERVICES' BY CHARLES FLYN WAS SENT TO MONITOR, BY ME, ON 13 AUGUST 2009. THE APPENDICIES TO THIS REPORT WERE SUBSEQUENTLY SENT ON 18/8/2009 BY PATRICK McGAHON

MR BROOKES: Okay.

So the pause finishes. Were you given an

explanation why the pause is finished?

MS BORTHWICK: My understanding is that we had done ourselves self-certification for the Care Quality Commission registration, we were registered without conditions in the April, which meant that then they [Monitor] could restart the process.

MR BROOKES: We have received some discussion which has indicated that there was a feeling of a fast tracking of the FT from there onwards because it got so far, it paused, now you wanted to move ahead with that. Is that an accurate description?

MS BORTHWICK: It was certainly a relatively fast process. That may have been, as I say, Monitor asked us for specific information requests, so we updated them on all the Board information, we sent information about areas that they asked for, keeping them updated all the time on any relevant information that I was aware of that people asked me to forward on to them and I think that I just assumed that because we had got to a certain point -- the pause had been for a specific reason, that had been addressed because we had the registration without conditions, there was the CQC inspection of the FGH in June 2010 as well, which on the conditions that they inspected had come back that the Trust was compliant, that the view was that we were

ready to move forward.

MR BROOKES: So from your understanding, let me see if I understood that, it was the clean bill of health from CQC, in effect, which re-triggered the process?

MS BORTHWICK: Yes, that was my understanding I think. Certainly, I mean, if I was looking at it, that if we had not had that I do not know that we would have restarted the process if we had not had that but that is a personal opinion.

DR KIRKUP: I am struggling to understand the relevance of the registration without conditions because that happened in April 2010, so that is before the pause.

MS BORTHWICK: That was after the pause. That is when we restarted in April 1010. In May 2009 the pause started, in April 2010 that is when it restarted.

DR KIRKUP: Beg your pardon. My mistake.

MR BROOKES: Again, so you have restarted, you are on a relatively fast track in terms of the moving the process forward. Again, what kind of external scrutiny is based from the local system, not just from Monitor, in terms of the your application?

MS BORTHWICK: From memory both PCTs had copies of it. I know that there were letters from one PCT to the Chief Executive about some concerns they had. I may have seen sight of the letter through work that I have

done, whether the FT application was referenced but certainly there were quality issues referenced in that letter to which the Trust responded. I think that they were raised with Monitor at that time, so that would be in 2010, in June 2010. THIS CORRESPONDENCE WAS SHARED WITH MONITOR ON 22/6/2010. I UNDERSTAND MONITOR INTERVIEWED THE CHIEF EXECUTIVES OF BOTH PCTs AS PART OF THE PROCESS- ON 15 JUNE 2010

MR BROOKES: There is a concern raised by Commissioners, there is copies of your strategic business case gone to them. Can you recall whether at that stage there was formal agreement by the Commissioners to the FT application process?

MS BORTHWICK: I cannot recall definitely. I would have assumed they would have had to have been for the process to progress but I understand that there may have been discussions between Monitor and the PCT but I do not know that for definite. I know that from my perspective I was able to carry on with the process.

MR BROOKES: I am checking about the kind of key things that would be in place there. What kind of scrutiny was there from the Strategic Health Authority?

MS BORTHWICK: Certainly there was a -- the first time that we went through the process there was a board-to-board. They reviewed our submission in terms of the integrate business plan and there was a board-to-board, and I am trying to rack my brains now and remember if there was a board-to-board the second

time. I certainly can remember people from the SHA coming into the Trust but I am -- I have to say, to be the honest I am at a loss to think which process it was in.

MR BROOKES: The involvement of the SHA was predominantly around the board-to-board?

MS BORTHWICK: Yes, from my recollection from my --

MR BROOKES: Okay. I will pause there if that is okay.

DR KIRKUP: Sure.

PROF MONTGOMERY: You talk about being asked for information from the Monitor. Did the SHA ask for any information any in that process preparing for their board-to-board?

MS BORTHWICK: Not from myself. I think, they had the IBP, I do not know, I certainly was not involved in such an extensive information submission as we did through Monitor. I don't know if they had that information from other people or not but certainly not from myself that I can recall. LOOKING AT MY EMAIL CORRESPONDENCE FROM THE TIME THE TRUST RECEIVED INITIAL FEEDBACK FROM THE SHA IN OCT 2008, THE TRUST COMPLETED A SUBMISSION- 'NEXT STAGE REVIEW' ON 28/NOV/2008 FOR THE SHA FOLLOWING A VISIT BY THEM ON 13/NOV. I UNDERSTAND THAT A NUMBER OF EXECUTIVES/ CHAIR ATTENDED THE SHA APPLICATIONS COMMITTEE ON 6/1/09 PRIOR TO THE DECISION TO PROCEED TO MONITOR BEING MADE.

PROF MONTGOMERY: Do you recall what information you were asked for about SUIs by Monitor? You mentioned that you were asked some--

MS BORTHWICK: Initially we were asked for our serious incidents, so summary information on that. I think that then subsequently from memory, I may be wrong, I

think that this was between the pause period and when we restarted. We kept them updated on serious indents and on particular incidents we sent some more detail but in general it was anonymised detail, so we did not share any patient sensitive information in that. The key response from the Director of Nursing and from the governance people would be about the key parts of the incident.

PROF MONTGOMERY: Were you asked for any information about maternity SUIs specifically?

MS BORTHWICK: As part of that process the maternity SUIs would have been included in that. In that I was referring to maternity SUIs.

PROF MONTGOMERY: Were you asked by Board members to provide any particular briefing on maternity SUIs on the basis of the information you had been asked for?

MS BORTHWICK: The briefings were -- I cannot now, the would have the information would have been come from the governance department on that and from the Director of Nursing because I do not have a clinical background so although I may make people's -- correct people's English, I cannot correct the facts of that.

PROF MONTGOMERY: There was a specific question asked by Monitor at the board-to-board about the maternity SUIs. Was that fed back to you at all that

that had been a particular question?

MS BORTHWICK: Was that in the first board-to-board or the second one?

PROF MONTGOMERY: First one.

MS BORTHWICK: I did not attend the first board-to-board. That was not fed back, no.

PROF MONTGOMERY: No-one asked for any further information?

MS BORTHWICK: Not that I can recall a specific request after that. I think it was after the board-to-board, maybe the day after or two days after that we were told we were not progressing.

PROF MONTGOMERY: Okay. You were at the second board-to-board?

MS BORTHWICK: I observed the second board-to-board.

PROF MONTGOMERY: Tell us about what you observed?

MS BORTHWICK: There was a lot of scrutiny; it was a big meeting, there were quite a lot of people around the table and there was quite a lot of scrutiny. I am trying think who was there from Monitor. This was this was in -- I think it was September 2010, so you are testing my memory about who was there. There was scrutiny about incident, scrutiny of some of the non-executive directors, particularly, from memory, I think the Chair of the clinical governance and Clinical

Quality and Safety Committee, as it was then. We have changed the name of the Committee since. There was quite lot of scrutiny. I can't remember the specifics that were discussed at that meeting.

PROF MONTGOMERY: You do not recall whether that focused on maternity?

MS BORTHWICK: I cannot remember any specific population focus on maternity. I can remember a focus on SUIs and the chair of the Clinical Government Quality Committee being asked about things.

PROF MONTGOMERY: As part of the preparation for filling in of the pro formas, you talk about fact that there is a Quality Safety Committee in place. Did that involve a review of the minutes of those committees by you? Or did you just know that there was one? Or were you reviewing what was in the papers?

MS BORTHWICK: I did not necessarily review everything that was in the papers because there were – if you can imagine you pull in information from the whole organisation, that responsibility to sign off was with the directors.

PROF MONTGOMERY: You might have looked at some of them?

MS BORTHWICK: I might have looked at some of them but whether I could recall now. I have looked at some of

them, certainly Clinical Quality and Safety Committee meeting I have looked in detail afterwards. In September 2011 when we started going to escalation meetings with Monitor and pulling forward the matrix of evidence when they were considering whether to take us into significant breach, then I have done some extensive retrospective reviews of information for that and one of those, from my perspective, was to track through when the Fielding Report went to particular meetings.

PROF MONTGOMERY: That was going to be the next question. When did Fielding go to particular meetings?

MS BORTHWICK: Yes. Well, actually one of the things that I could not find was evidence of it having been to any formal meetings. That was one of the things that I actually struggled–

MR BROOKES: I missed that. So there was no evidence of Fielding?

MS BORTHWICK: Fielding going to any formal Committees. It may have been discussed. There have a regular Chief Executive meeting, which I was not party to but which was an informal meeting. It may have been discussed there but I do not know whether it was or not but in terms of the formal Clinical Quality and Safety Committee I actually think it went in 2011.

PROF MONTGOMERY: So you have a clinical governance system and you have a major incident which has three external reports and it never makes it into the clinical governance system. Is that a fair summary of what you have just described?

MS BORTHWICK: I think that in terms of that one particular report, the one that you asked me about, I think that there were other reports on the incident, in some particular incidents that may have gone through the clinical governance system but I do not particularly know. I know there were audit reports and I am sure we could check through in our systems where they went to but in terms of the Fielding I could not see it going anywhere.

PROF MONTGOMERY: That is really helpful to have clarified, particularly that you have done a retrospective look. It came on your radar in 2011 but when you look back it did not appear at the time it went into the Trust?

MS BORTHWICK: Yes.

PROF MONTGOMERY: Do you have any evidence for trawl back of where it did go? Who did know about it at that point?

MS BORTHWICK: No, I am assuming it went to the Chief Executive and Director of Nursing who commissioned the

review. One of the things that I found, which was one of the issues that I brought up in the governance review that did, how difficult it was to actually track something like that through and actually say -- because I found out since there were a number of drafts of the document and to actually track through when it came through and where it should go and actually one of the things that I started doing after that was keeping my own little log of what I knew in terms of corporate reports just so that I could find things and one of the recommendations was that we had a central repository and actually track through properly.

MR BROOKES: Sorry, it is just a clarification when you were talking about finding the evidence around the Fielding Report or lack of it in terms of Board.

Just the other end of the process, did you find any evidence of the terms of reference or the commissioning of the report being reported to the Board?

MS BORTHWICK: Yes I think that was as part of the Women and Children's Sustainability Plan. So there was * COMMENT ON PAGE 14 REFERS Women and Children's Sustainability Plan which was a joint plan from 2008/2009 with the Healthcare Commission.

MR BROOKES: There has been a report, independent

report about serious problems or concerns being raised around the maternity services. Independent person coming in to look at that. I am surprised that that was not a particular discussion by the Board and an agreement in terms of reference.

MS BORTHWICK: I cannot say for – I am struggling to remember.

MR BROOKES: If you did not find anything that is fine.

MS BORTHWICK: I think there may have been something but I cannot give you 100 percent guarantee. I have a feeling that that went to the Board separately but I cannot 100 percent clarify that. I can go back and check. I will have to say that.

DR KIRKUP: We appreciate that.

MR BROOKES: That will be helpful. It raises two things. If it did not go, why not? If it did not go, why was there not later questions asked about where it had got to. So it is really helpful if you could, thank you.

PROF MONTGOMERY: You were just saying that when you did the review in 2011 you started keeping tab of the various reports. Give us a sense of the volume of the reports?

MS BORTHWICK: Yes. There are quite a lot. I would keep records of the various Care Quality Commission

reports in terms of any inspections. We started, you can imagine at that time, we started getting a lot more reports, so things like the out-patient report, the central Manchester review reports, just so that there was somewhere where we had a record of those reports. There has been various reports into mortality because you will be aware that at time there was a mortality review and I went through because there were concerns about mortality in 2011 as well. So I just started as part of that process just to have – if I knew there was a report then I would keep it somewhere centrally.

PROF MONTGOMERY: This might be slightly round about but I think you will see what I am trying to say. You said you came from a PCT before, you did not say which one. Was it a local PCT?

MS BORTHWICK: It was Cumbria PCT.

PROF MONTGOMERY: Okay. I am trying get a sense of whether what you saw when you did that surprised you? Or what your sense of the volume of those reports from other places might be? I am also interested to know when you were doing the work on the FT were you in touch with other people doing similar sorts of work or was it all done internally?

MS BORTHWICK: First, the first part, my role at Cumbria PCT was very different. I am an accountant by

background, I tried to keep it quite now. So I was a Finance Manager, I was actually head of systems and planning at the PCT but very much involved in financial side of it.

So when moved to Morecambe Bay it was a very different role to a ~~be~~ move into contracting and to be doing the FT application.

In terms of what we went through the FT process, I personally attended a number of [external] events where people were talking about the FT experience and how they found it and just that awareness of the volume and the nature of the information that Monitor might ask you for and actually how to co-ordinate, just tips and about how to co-ordinate it, keeping records and just knowing where your information was that that they may or may not ask for you.

PROF MONTGOMERY: Did you come back from those with a sense that Morecambe Bay was very similar to other places? Or were your challenges different in collecting Morecambe Bay?

MS BORTHWICK: No, at that time, this is probably very early on in the process, I think that it was more as gathering the information to actually know what we could learn from their experiences to help us set up our systems to respond and just to get that sense of

what do Monitor ask for. There were a number of myths or perceptions in the system about what it would be like dealing with Monitor and this, you know, if Monitor ask you for information you have to get it by return and just those tips and how to deal with them.

PROF MONTGOMERY: Going back to your October 2011, to stocktake, did you have a sense when you looked at that, that things had changed since 2010 when you had been preparing it?

MS BORTHWICK: Yes.

PROF MONTGOMERY: Talk us through what changed and any assessment you might have had and why?

MS BORTHWICK: I mean, this is very personal view. I don't think that we were as organised as we had been. I think that the environment was changing around FTs and I think already in 2010 it was becoming - the need to become a FT was less. I think, the need to be an FT is very different to what it was then. I think that we were -- the Trust was very busy. I think that the relationships in terms of contracting with the PCTs were changing and there was a lot of pressure on the Trust in terms of CIP, in terms of moving forward, in terms of just in quality and general. So I think it was that challenges of the three site organisation and we just did not seem as, from my perception, as on the

ball as we had been. I cannot -- it is a very gut feeling -- a very ...

PROF MONTGOMERY: Sorry, had the changes happened internally or externally? Was the external environment more challenging?

MS BORTHWICK: Yes, external environment was challenging. I think that it was challenging. There was a delivery, it was challenging. I am trying to think of what was happening in 2010. We had just put in our new computer system, which, you know, when you do major changes it is always a difficult thing to do. So there were a number of issues that were happening.

I think clinically, I am not a clinician, that I cannot really talk about that. So I think that there were challenges that you could tell in the system. There were a number of inquests that were coming up that people were preparing for. So I think that there was -- it seemed more challenging than it had done previously.

Vic start

PROF MONTGOMERY: So you think that if you had done your review in October 2010, you would have been less anxious?

MS BORTHWICK: I think so, yes. I think, so.

PROF MONTGOMERY: Yet you could not find the Fielding Report --

MS BORTHWICK: I did not know the Fielding Report existed then, so I didn't know I had anything to be anxious about.

PROF MONTGOMERY: If I ask you now, are you confident that you know of all the reports that there are around the organisation now?

MS BORTHWICK: I think there is definitely much more openness around the organisation; I think that we have come a long way in the last two years. I don't think that we are there yet. I think that it has been challenging. We have seen a huge amount of change, as an organisation. In terms of -- I think there is much more openness about if reports are commissioned, I think that people know that is happening. I think there are mechanisms now where they are coming back. We are strengthening the governance structures; continuing to strengthen, them. I think that some of the new people that have joined the organisation are bringing in the level of challenge and bringing in the learning that they have from other places, that they are actually -- they want that openness and they want to learn, they want the organisation to improve. I would say -- I cannot give you a categoric, "Yes, we

would know about everything", I think we would. I would be much more confident now than I was.

PROF MONTGOMERY: How do you test that out? What makes you think that?

MS BORTHWICK: What makes me think that?

PROF MONTGOMERY: I can see why you like to think that. You must be asking yourself: Is it true?

MS BORTHWICK: I think that the more rigorous structures, where you see the executive directors meeting, which meets weekly, it is a formal meeting, it is minuted, there is actions, there is follow-up on that. We actually have commissioners and people – the commissioners now join some of our meetings, so we have got our Serious Incidents Requiring Investigation Panel that meets to look at serious incidents. Commissioners are in on that meeting with us, in the room to actually scrutinise that.

I think that level of inter-organisational dialogue is much more open and much more transparent than it used to be, which gives you confidence. I think that there still is challenge, but I do think that there is more openness. The organisation -- the intent certainly is there to be as open as possible. I do not think that – I would not like to say we get it right every time but, I think, from what I have seen

there is definitely a move towards that. There is much more transparency in terms of the Board meeting. We have actually changed our structures so that we have non-executive directors on all our committees now, where previously we either had no non-executive directors on them, or they were almost like mini-board meetings. You can actually get more challenge in meetings.

I think that -- the system-wide working that is going on now, in terms if some of the areas, I think it does help to have that transparency.

PROF MONTGOMERY: You say the "intent" is to be open now; what was the intent in 2010?

MS BORTHWICK: I think – I mean I had no perception that we were not trying to be open but, I think, there is a real perception that we have to have that as our explicit intent now because, I think, that where we have been as an organisation we have to demonstrate that that is how we are, that is how we want to be perceived as an organisation that we do not hide things. Whether, rightly or wrongly, I do not -- I mean, I do not know the reasons why Fielding was not shared, but actually it does not matter now because we just need to do it right from now; from here on in we need to be open, transparent and honest with people.

PROF MONTGOMERY: What was your perception of Gold Command? Just after did that governance stocktake, you have Gold Command emerging. How was your connection with that, if any?

MS BORTHWICK: I didn't really have a connection with Gold Command. I think that probably was going on alongside. That started at the beginning of October 2011 -- get my years right. That was co-ordinated by the-then Director of Nursing, so I was not really involved in those meetings at all.

PROF MONTGOMERY: Was there any connection between the things that were being learnt from that, and the governance questions you had picked up? Did anybody discuss with you the possible connections?

MS BORTHWICK: No. I think that the work that I done very -- I think it was towards the end of October that I shared that with the Chief Executive -- it was very, that was my view. But we then had the PWC governance review. They came in and I worked closely with that team in actually helping them on their review and sharing with them information.

PROF MONTGOMERY: Did their report surprise you at all.

MS BORTHWICK: Not really, no. I don't think there were --

PROF MONTGOMERY: Do you think it surprised your colleagues?

MS BORTHWICK: I think you would need to ask them that. I think probably not at the time, I do not think so. I think, probably -- it is a difficult one for me to answer to see how somebody else perceives a report.

MR BROOKES: If you had seen that report 18 months earlier would it have surprised you?

MS BORTHWICK: Yes.

PROF MONTGOMERY: We then get -- you take on this Assistant Chief Executive role at a fairly turbulent time. You talked about that involving liaison. Was that including the Care Quality Commission? Were you handling liaison with them?

MS BORTHWICK: I was not directly involved with that; that will be from the Director of Nursing, but I was aware, from the Chief Executive's point of view, some of what would be going on.

PROF MONTGOMERY: What was your perception?

MS BORTHWICK: That -- gosh... What was my perception at the time? I think that at sometimes I think that it was difficult to manage the various requests from the huge amount of organisations that the Trust was getting. That was one of the real challenges at the time. The Trust was being asked from Monitor, from the

Care Quality Commission, from other organisations all at the same time. I could not talk about personal relationships between the directors -- and we had a number of chief executives in that initial period, who all had slightly different personal approaches. I think the Trust did try to work with the Care Quality Commission, from my perception of it, but I think that relationships are probably improving now in terms of --

PROF MONTGOMERY: Did your governance roles at that stage include taking stock of the various important warning notices and things that were coming --

MS BORTHWICK: Yes.

PROF MONTGOMERY: -- through. Can you take us through your understanding of the CQC's warning notice processes?

MS BORTHWICK: Their processes?

PROF MONTGOMERY: What they meant to you in the Trust, the various notices that were coming through because there is a little sheaf piling up as I try to track them all down; there seems to be a lot of them.

MS BORTHWICK: There were a lot of them. They were -- let me try to remember. The first one that we received was in, I think, it was September 2011 -- I do have an accountant brain sometimes about dates. It was

September 2011. That was following the maternity visit; that looked at risk management in maternity. I think that was the maintenance of risk registers. I think there may have been something else on that one as well. That was the first one.

The CQC then visit again in December of that year, and that was to the A&E Department at, I think it was the RLI. There was a warning notice on staffing issued at that point in time.

The CQC then came again in February at the start of their Section 48 investigation. There were two warning notices issued at that point in time.

That is when my role actually changed and I became -- I started in February of that year as the Assistant Chief Executive just supporting the Chief Executive.

PROF MONTGOMERY: Were all those warning notices still in force at that point?

MS BORTHWICK: Yes -- yes. Yes, I think they were. Yes.

PROF MONTGOMERY: The Trust had written in November, I think, about the first one, indicating it thought it was compliant --

MS BORTHWICK: I think the Trust thought it was compliant but I do not think, from memory, there had

been a response from the CQC or a reinspection to say that had been lifted because, I think, my understanding is that the Trust can submit its action plan, and its evidence, but until it receives confirmation or another visit, that warning notice stays in place. I think it is only when the CQC actually accept the evidence that that then – the warning notice is removed.

PROF MONTGOMERY: How were those notices communicated to the Board? How were they discussed by the Board? Do you remember?

MS BORTHWICK: They were certainly circulated to all the Board members. From memory the action plan that was derived after the September one was shared with the Board. The process of action that will then take place, they were also discussed, I think from memory, with Monitor because once that warning notice had been received it went through the process of escalation with Monitor to move through a significant breach.

The January one, I think, went to Board. Then we received the two in February. There was a change with Sir David Henshaw ~~Henshall~~ joined the Trust in the February as well at that time, and I am fairly sure that they went to the Board although I did not attend the Board meetings at that time.

PROF MONTGOMERY: Do you recall what the public

communications were around those warning notices?
MS BORTHWICK: From memory there was quite a lot of communications about them that the Trust put out, but I couldn't tell you exactly what they said at that point in time. There was, from memory, that we did communicate that we had received the warning notices.
PROF MONTGOMERY: Who would you have communicated that to? Who was the public for these purposes?
MS BORTHWICK: I think there were press releases effectively and staff communications as well so that staff -- that is certainly our processes now. So there will be a press release is either reactive or proactive and staff communications so that staff were aware before the event.
PROF MONTGOMERY: I think that is all I have.
DR KIRKUP: Thank you. I want to pick up some specific points that have come up in the conversations.

You did not, in the early years, routinely attend Board meetings and you were not at the two that the self-assessment was discussed. Did you attend any other Board meetings?
MS BORTHWICK: I didn't attend Board meetings.
DR KIRKUP: You didn't attend any --
MS BORTHWICK: I didn't attend --
DR KIRKUP: Did you get any feedback on the meetings

where the assessments were presented during September?
MS BORTHWICK: In September it was certainly just that it had been approved by the Board.
DR KIRKUP: Was there any comment on the amount of challenge there had been or discussion --
MS BORTHWICK: Not that I can recall, just that it was approved.
DR KIRKUP: In your first experience of attending Board meetings, which I guess had been in 2012 then, was it a Board that did discuss and challenge?
MS BORTHWICK: It was very different. The first Board meeting that I attended in 2012 were when Sir David Henshaw ~~Henshall~~ and Eric Morton had just been appointed.
DR KIRKUP: You got the impression that was a pretty new set up; it was a new approach --
MS BORTHWICK: It was a new set up. We had seen quite a number of Board members had left, including non-executive directors. There were, I think it was May -- I think it was early May will be the first Board meeting I attended, so I think that it was a very small initial Board meeting with some of the interim staff supporting Sir David in attendance.

I have seen Board meetings evolve a lot since that time in terms of once we appointed quite a significant number of new non-executive directors in the June, and

through that the challenge that they brought, as being new to the organisation they asked a huge amount of questions, and as did a number of the new executives.

DR KIRKUP: Okay.

Looking back at that self-assessment process in 2010, what is your view of it now?

MS BORTHWICK: Well, I think, that we -- we must would have been -- you know we should have been able to do it more robustly so that we should have had some better systems in that we could have flagged up the issues that happened. It seemed robust enough at the time. We had challenge, we had feedback from Monitor that it was positive, but obviously given, you know, with hindsight and where the Trust is now, we must have missed something in it and we would need to put something much more robust in place.

DR KIRKUP: The approach that you took, was it an approach that sought to find out what the position was; or was it an approach that sought to demonstrate that you were ticking boxes?

MS BORTHWICK: No. I think, that we tried to answer the questions to actually say -- for those, I think, from memory 12 or 13 questions that Monitor asked you as part of the process, we tried to find the evidence that we did that would answer those questions, to

actually say where we would do that. Whether we probed as deeply as we could do, in terms of how effective some of those committees were, then you would have to say, with hindsight, that we did not.

PROF MONTGOMERY: Did you find anything there that you then went back and had to improve before you could submit the --

MS BORTHWICK: Before we could submit it? I cannot recall. It was --

DR KIRKUP: Some of the questions are about how the Board tackles some of the issues. Does it discuss them? Does it challenge? Does it seek proper assurance? You have just described a Board that, before it was changed in 2012, did not really do that.

MS BORTHWICK: I do not know. I think what I said was I didn't attend Board meetings, so it is difficult for me to know what challenge went on in those meetings. There may have been challenge and they did not feedback to me. It would not necessarily -- you know, they may have been challenging meetings but that would not be shared with somebody at my level. I do not know.

DR KIRKUP: Yes, but you prepared a paper that said that they did so that is not really compatible with you did not know whether they did or not --

MS BORTHWICK: I prepared a paper?

DR KIRKUP: They did challenge, they did discuss and challenge, yes, that would be part of the assessment.

MS BORTHWICK: And that would have been the perception that I had at the time, that they did that; that would have been the feedback that they gave me. I mean, I cannot recall the paper; I would have to read it again in terms of I did say they actually challenged. But I am going from memory here, from 2010, but certainly I would not have been -- you know, I would not have attempted to be disingenuous with it; I would have dealt with the facts of actually this is the evidence that we gave to meet those criteria.

DR KIRKUP: Okay. Thank you. That is helpful.

Prior to the Fielding Report there was not one maternity SUI was there; there were at least five. Were you aware that there were at least five at the time, or is that something that you learned about afterwards?

MS BORTHWICK: There were -- as part of the Monitor process I was aware that there were five, which, I think, the information that I had at the time were that they were unconnected --

DR KIRKUP: I am particularly interested in how that view was arrived at. Do you know who was responsible for saying they were unconnected?

MS BORTHWICK: I think they would have been reviews that were done but the governance team and the Director of Nursing to look at those from a clinical perspective, but I am assuming that view was derived clinically. It is not one that I would be able to give.

DR KIRKUP: I understand that. Are you aware of the reasons for deeming they were unrelated?

MS BORTHWICK: As I understand it there were RCAs undertaken. They were looked at in a number of cases -- they were inquests -- and that is why they looked at the information, as far as I understood it, and that is how they found that out.

DR KIRKUP: Okay. But you think that the person who would have decided that would have been the head of the governance team, which was the Director of Nursing at the time --

MS BORTHWICK: It was Director of Nursing, shared with the Medical Director.

DR KIRKUP: Thank you.

You have described a process where people were really rather keen to become a Foundation Trust at the outset. What was the driver for that? What was the push to become a Foundation Trust?

MS BORTHWICK: I think it was a national driver. I do

not think it was one that was distinct to just Morecambe Bay. I think it was the advantage that you could have in terms of some of the freedoms in terms of being able to invest money back into services, and that autonomy that you could get as a Foundation Trust. I think it was a national -- there was a national drive for as many Trusts as possible to become Foundation Trusts.

DR KIRKUP: Was that an impression you worked out yourself, or was that because that was an explicit part of the strategy of the Trust?

MS BORTHWICK: It was an explicit --

DR KIRKUP: Set by Board --

MS BORTHWICK: -- the Trust would be --

DR KIRKUP: -- we want to be an FT because --

MS BORTHWICK: Yes.

DR KIRKUP: When would that have occurred?

MS BORTHWICK: I think that was in train before I started. That was one of the reasons --

DR KIRKUP: You were brought in.

MS BORTHWICK: Yes.

DR KIRKUP: Thank you. Any more from --

MR BROOKES: A couple of things.

Just for the record; who did you report to?

MS BORTHWICK: I reported to Patrick McGahon ~~McGann~~ the

Director of Services and Commercial Development.

MR BROOKES: He reported to?

MS BORTHWICK: The Chief Executive -- one of the Board members.

MR BROOKES: It was just for information.

How much of Monitor's time was actually filled with research? In other words did they come to the Trust and how much did they come to the Trust?

MS BORTHWICK: They came to the Trust quite extensively. I think probably about -- there were a core team, certainly the first time, was about three people. I think they probably, in all, spent maybe 10 days at the Trust, from memory.

MR BROOKES: What did they look at?

MS BORTHWICK: All three sites. They spoke to a lot of people. I coordinated all the interviews, which is why I have got a memory of this. They spoke to all the executives, all the non-executives. They spoke to governance teams, finance teams; a whole variety of people.* NB I have provided you with copies of the meeting schedules for both phases of the Trusts assessment. Having reviewed these since I can confirm that I met the Monitor team on the following occasions ;- Project Planning Meeting 5/3/2009. Service Development Meeting 16 March 2009. Contracts Meeting 17 March 2009

MR BROOKES: Did you sit in on any of the interviews?

MS BORTHWICK: No.

MR BROOKES: You have no idea what they actually asked --

MS BORTHWICK: We did get feedback from people after

the interviews, which we collated and shared so people knew which key themes were being looked at.

DR CALDERWOOD: What kind of things did they look at?

MS BORTHWICK: It is difficult to remember now because I mean, it was --

MR BROOKES: Were there any major concerns they were raising specific areas of enquiry?

MS BORTHWICK: I don't think so. Quite often what came out were additional information requests. Somebody would be spoken to and they would mention a document or some information and Monitor would then come back and request that. I do have all the files with all the information if you need them.

MR BROOKES: One last thing. I get the real sense from what you've said -- I want to know if it is right -- this was very much a paper-based exercise. You provided information, they did something, they asked you for more information, they asked for --

MS BORTHWICK: Yes.

MR BROOKES: Is that right?

MS BORTHWICK: To a large extent it was, yes.

MR BROOKES: Thank you.

DR KIRKUP: Okay. Is there anything you want to tell us that we have not covered?

MS BORTHWICK: I do not think so. I think that -- I am

quite happy to share my governance review that I did with you, if you have not already got that, if that has not been at the part of the information request but --

MR BROOKES: Thank you.

MS BORTHWICK: I will be happy for you to have that.

DR KIRKUP: Thank you very much for coming. We appreciate it. That is the end of the interview. Thank you.

THE MORECAMBE BAY INVESTIGATION

Tuesday, 22 July 2014

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

Before:

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

CYNTHIA BOWER

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DR KIRKUP: Right, okay, we're in a position to start, so I'll say that we have met previously, but I'll say for the record that my name is Bill Kirkup and I'm chairing the Panel. I'll ask my colleagues to introduce themselves.

PROF FORSYTH: Good afternoon, my name's Stewart Forsyth and I'm a paediatrician and medical director from Dundee.

PROF MONTGOMERY: I'm Jonathan Montgomery, I'm Professor of Healthcare Law at University College London, Chair of the Health Research Authority and in the past I've chaired PCTs, a couple of other trusts and an SHA.

DR KIRKUP: And you'll have seen that we're recording sound. We will produce an agreed record of proceedings. We've also got family members in attendance at the session as observers, and other family members may listen to the recording in due course, and you'll know that we've removed mobile phones, laptops, tablets and all of that, just to underline the importance that nothing goes out of the room until we're ready to produce a report that's got everything considered properly in context.

MS BOWER: Yes.

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

MS BOWER: No – thank you very much, no.

DR KIRKUP: Okay, I'll start off with a very general question, which is: just take us through when you started at the CQC and how long you were there.

MS BOWER: I started at CQC in August 2008. At that point, the organisation was in a fairly brief period of transition up until April 2009 when CSCI and the Healthcare Commission were formally abolished – and the ~~MENTAL~~Mental Health Act Commission, sorry, were formally abolished, and so we took up our

role in April 2009 and I left in July 2012.

DR KIRKUP: Okay, that's great, thank you. I'll hand you over to Jonathan.

PROF MONTGOMERY: Thank you very much. I wonder if I could start by just getting you to sort of explain how the jigsaw fits together. It may take a little while, but if you could just sort of set out key roles in the CQC and how it related to particularly the trusts, SHA, Monitor, Department of Health.

MS BOWER: Wow. Okay, well I'll do my best. Well, CQC was established by the 2008 Health and Social Care Act and we were the first formal regulator of the health service, so although we were replacing the Healthcare Commission that had itself replaced CHAI with an 'A' and then CHAI with an 'I' before it, we were the first formal regulator of the health service, so we were the first organisation that had legal powers embodied in the Act that were statements about the quality of care. So we were the first organisation who had that ability to require of organisations both to register as being competent to provide services, and thereafter be subject to the requirements of the legislation, largely in terms of quality.

So that was – so the regulations that we were enforcing or upholding or whatever the correct legal expression would be were all enshrined in the Act, and we were a non-departmental public body, as quangos became to be known, so we were a creature, a body of the Department of Health, and so we had an annual accountability agreement with the Department of Health that was managed through senior civil servants in the department as well as having a board that we were accountable to.

The chair of CQC was, I think, selected by the Secretary of State but

had to appear in front of the Health Select Committee and they had to agree to the appointment of the chair, and thereafter the chair had a formal annual accountability meeting with the Health Select Committee, so there was the sort of – on the one hand there was a line that came down from the Health Select Committee, and the chair had to pitch up once a year and be deemed to be competent to do the job by the Health Select Committee.

There was a line of accountability through the Department of Health, as a non departmental public body, and there was a framework of accountability that was largely managed at an officer level with myself and my senior managers, and then, of course, was the line with the board, and other than that the relationships with – the key critical relationships, in terms of how we related to the strategic health authorities, Monitor, the performance team particularly at the Department of Health under David Flory in those days, were a matter of how we established working relationships with one another.

In those days – and forgive me, I'm out two years now so I don't know if what of these mechanics still exist, but there was a National Quality Board that had been established – I don't know whether that still exists, I can't even remember who chaired it, but –

DR KIRKUP: I think –

MS BOWER: [Cross talk] chaired it, and that was set up to – for us all to sign up to a framework in how – in terms of how we informed one another, worked together on issues of quality. So my chair Jo Williams, Barbara Young before her, sat on that board and that sort of prescribed and produced documentation, particularly in the wake of sort of the first Francis inquiry into how those big

organisations were supposed to share information and work together in order to, you know, make sure that organisations weren't falling between the cracks, and then beyond that there was – just to sort of cement that there was, I think weekly and sometimes formerly monthly meetings which we ourselves, Monitor and the performance team at the Department of Health, somebody from David Flory's team, which was Alan Hall usually, Merav Dover I think from Monitor and Amanda Sherlock on behalf of CQC, they met – they spoke I think weekly, they met, I think in the end monthly, to make sure we were all sharing our concerns, so those are the formal bits of the structure. Of course, there were informal things, various board to board meetings, but that's sort of how the jigsaw fitted together.

PROF MONTGOMERY: Thank you. If I could tease out a few little bits.

MS BOWER: Of course.

PROF MONTGOMERY: In a bit more detail. So just talk us through the sort of start off phase, where it sometimes was said that because of the resources used you had to register a lot more closely afterwards. I wonder what the proper line was from that. Because you had the whole of the NHS to get into this new structure –

MS BOWER: Well, it was – I don't want to sound like I'm making excuses, although I'm sure I will on occasion, but it was an extremely difficult, challenging set up for the organisation. So we – I – the chair was only appointed in July and I was appointed in August and we weren't really making director appointments until the early part of 2009, so we were – we were trying to invent this new organisation very very rapidly. ~~It~~ The Legislation that set CQC up had The

Royal Assent in July 2008 had only had the Royal Assent in July, so there was very very little start up and preparation time.

And I think that there was – all of those organisations, I mentioned a bit about the forerunners of the health service, but of course that was only part of it. There were the forerunners to CSCI, the Social Care regulator, so there was the National Care Standards Commission, that had only existed for 17 days before it's abolition was announced. Before that, local authorities and health authorities had been regulators of nursing home care.

So the staff coming into the organisation on 1 April 2009 were – I mean, I'm not saying they were all hostile and cynical, because that's not true. Some of them could really see the need for a new regulator, but there was an enormous amount of scepticism and wariness and weariness of being endlessly re-organised and, yet again, somebody coming along and saying, 'Yeah, well that was then, this is now, this is going to be the great new dawn for regulation.'

So we had a huge amount of anxiety and concern and unwillingness to let go of tried and trusted and well-established ways of working, all of which, at one level, is entirely understandable. This was a new piece of legislation. We were given less money than the three predecessor organisations to get the thing on the road because the general view was always that there's a premium that comes from mergers and that you can take money out. So even though we were bringing into regulation bits of the NHS particularly that had never been regulated before, we were given less money to do it.

So staff were coming into this organisation, they were having to learn

the legislation as they went along, because it was new to all of us. The regulations that underpinned the legislation hadn't been written, so we were trying desperately to -- they were going through Parliament themselves. We had less money. We had a fairly disenfranchised staff team, many of whom didn't know whether they would have jobs. We had to take a lot of money out in the first instance but, more particularly as you said, we'd not just got the NHS, we'd then got a Parliamentary timescale that said, 'Unless you've registered these organisations under the new legislation by this date then legally they can't go on providing services.'

So there was a series of ~~some set~~ SUNSET clauses in the legislation that meant a total of 44,000 organisations had to come into regulation. Now, in the end, it got pushed back and GP surgeries, that were the last 10,000, didn't come into 2013 by which time I'd gone, but the NHS were only the first 400.

Later that same year we had to register 24,000 providers of social care. The staff didn't know the legislation that well, the providers themselves didn't know the legislation, it was completely different to the legislation that they were accustomed to dealing with, and so I have to say, as -- and then -- but start of 2010 when the new government came in, and the scale of the financial crisis facing the country became clear, there was a freeze on our jobs, so we just got going as a regulator, we'd registered the NHS at the start of 2010, April 2010, we were moving to register adult social care in the September 2010 and the jobs freeze came on us. Our staff weren't considered frontline staff by the Department of Health and so we couldn't recruit.

So looking back, it was an extremely challenging and difficult birth for

the organisation, with a lot of staff feeling very disenfranchised and angry about the changes that we were forcing through, that had to be forced through in order to get this legislation through and, of course, we were criticised for being obsessed with the paperwork, but unless we got everybody into this new system of registration which, in itself, was quite complicated because to register you had to spell out exactly what services you were running from exactly what locations and if by some chance you got it wrong, you couldn't then provide that service from that location. So trying to explain to complex organisations like mental health trusts how to do that, when our staff ourselves often weren't very sure about it, was very very difficult.

PROF MONTGOMERY: So when you're trying to explain that to your staff, you were learning it, I mean what's the key question that had to be asked about when they're saying, 'Can we or can we not register this organisation?' Let's assume it's an NHS Trust, because that's what we need to get onto obviously later on.

MS BOWER: Yes, well, what they were doing, so the NHS was the most straightforward really of all of them. We had something that I don't think exists now but was called a quality and risk profile, so we populated information about every trust with all the background information that we'd got on it.

So we took the – I think it was 16 quality standards, you know I've forgotten, but the quality standards, so that was sort of down one side of the page, and all the data that we had sort of sat along the other, so if it was about health care associated ~~inspections~~ infections, to pick a fairly straightforward example, the Healthcare Commission had done a program of inspection on HCAIs so we could say, 'They failed the last inspection, they didn't have proper

hand washing routines, the staff hadn't been appropriately trained, so we think you're at risk of not meeting that standard.'

PROF MONTGOMERY: This is bringing together information which you'd like in the public or in the old system...

MS BOWER: Absolutely. So everything that we knew about that organisation we put onto the first edition of the quality and risk profile, and we sent it to the trust, and we said, 'You're about to apply to register...' so registration opened in January 2010 for NHS organisations, 'This is what we know about your organisation', and it might be a load of green – you know, it might – of course, there were some bits of the legislation of which there would be probably very little information, but what we would have to do is take Standards for Better Health, which had been the system that the Healthcare Commission used, the targets, what – there was only a minimal inspection regime which was just around HCAIs, things in the ether and put into the..

PROF MONTGOMERY: Standards for Better Health was a self-declaration process [inaudible] sample look, wasn't it, at the Mental Health Care Commission if they weren't convinced.

MS BOWER: Well registration is an application, so to that extent it's self assessment, you know, you apply to be registered under the Act, and every organisation that was currently providing services, all 44,000 of them, at some point had to fill in an application. I mean by the time you did the GPs, again after my time, but we set up a system that it was all online and it was very straightforward, but in the early days it was very, very clunky.

PROF MONTGOMERY: And how common was it not to get registered in that first

phase of NHS trusts?

MS BOWER: Well there was a – the legislation assumed that you would be registered. The transition legislation – because it would say, 'If you're currently competent to provide services we have to assume that you can go on providing them', but there was a one off facility within the registration process that said, 'If you don't think you meet the standards...', I mean, the classic would be accommodation in Mental Health Trust. If they were still working out of old psychiatric ~~home~~ hospitals, they might not have met all the health and safety requirements.

There was an opportunity for you to say – declare some non-compliance and say, 'But this is what we're doing about it.' And at that point CQC could take a view about whether or not you should be registered with conditions. So either we said that, 'Yes, okay, you've given us enough assurance you can go through' or we could say, 'You know what? It's still looking a bit dicky and you're saying it's going to take you three years to get a plan in place to close down all your psychiatric hospitals' or whatever it might have been, 'So we're going to put a condition on your registration that says by such and such a date you've got to have sorted this out.' So I forget the number but something like 28 – somewhere between 25 and 30 I believe it was, trusts were registered with conditions.

PROF MONTGOMERY: But nobody didn't get registered at all?

MS BOWER: No, no, no. No-one – there was nobody we said, 'Look, you're so unsafe and you've no prospect of making it safe so we're going to close you down.'

PROF MONTGOMERY: And the internal intelligence, which wasn't sort of quantifiable in terms of getting particular assessments on – did that feed into the ~~URP~~ QRP or not?

MS BOWER: I believe it did, but I – so it wasn't just quantitative information. We literally piled into it as much as we humanly possibly could, no, I mean we inherited from the Healthcare Commission a system of RAG rating – red amber green rating of trusts, and so we would have taken that intelligence, we inherited a risk register from the Healthcare Commission, so we would have taken that into account.

PROF MONTGOMERY: Okay, I may have to go back to some of that more general things to understand some things later, but I wonder if I could ask you about the 2009 to 2010 bits around Morecambe Bay and the – we'll come to registration questions in a minute, but there's a decision taken towards the end of the year not to investigate unless it's referred by the regional team as a question – it's a theme we'll come back to regularly about systemic questions and individual cases.

MS BOWER: Yes.

PROF MONTGOMERY: And one of the differences, as I understand it, between the old system and new system is that you no longer handle individual complaint issues, you deal with organisations...

MS BOWER: Yes, so complaints that had been – the sort of – it was a staged complaint function that the Healthcare Commission had handled, but that was passed to the Parliamentary Health Services Ombudsman, so we never took that responsibility for complaints.

PROF MONTGOMERY: Okay, I'll come back to that later on. So there's this internal structure, from what Amanda Sherlock told us, I can partly relate it to transitional phases where you've got the regional staff concerned that there might be an issue that needs investigation and it goes to the national team, and the national team doesn't think it meets the threshold. So can you just take us through that – how that process works and then –

MS BOWER: Well, I – to be perfectly – in terms of the specifics of Morecambe Bay I had no – it wasn't until much later on that I realised that that referral had been made to the central team. I can't remember when I knew, but it certainly wasn't a current thing, so it wasn't something that they discussed with me or was elevated to my level in the organisation, if that's the appropriate expression. It was much, much later when I realised that that referral had been made by the regional team, and it was the normal – my understanding, but there were very few investigations in my time, because of course the investigations team went as part of the change, but what – the one I can think of is actually we were asked by the Strategic Health Authority to do an investigation, and that was the Take Care Now, the German doctor and the overdose of morphine I think it was, and that was a request that came in that we agreed to, but there was a tried and trusted – which I can't, in all honesty, remember, but it was the way in which the investigation team had always worked.

So issues of concern were referred to the team, the team had very strict or particular criteria about which complaints they investigated, which issues they took up and which they didn't, and it's my understanding now that they looked at this request that had come in from Alan Jefferson, who was the

Regional Director at that time in the Northwest, and believed that it didn't meet the criteria.

The team was accustomed to making its own decisions. It was very much an organisation within the organisation, so my understanding is that was custom and practice for how they worked.

PROF MONTGOMERY: I appreciate you didn't know that at the time but when, as Chief Executive, you discovered that it's been raised as an issue you presumably assured yourself as to whether or not the process –

MS BOWER: Well at the time, to be perfectly honest, at the time I – it was – I became aware of it, we were already – it was literally years later. It was while we were already doing the investigation into – it might even have been as late as 2011 when we'd already kicked off – or we were talking about kicking off the investigation. The team didn't exist any more.

PROF MONTGOMERY: So the regional tier – I think we're [inaudible] to say that and not allowed to say that, the regional level of your organisation has pushed it up, a position is taken it's not appropriate for investigation against the criteria at the time, but how would the regional group leads on concerns get recorded in the CQC? Would it find it's way up the queue up to you?

MS BOWER: At that – at that time, I mean don't forget – I mean again, just going back to the period when the Morecambe Bay request or whatever it was came in, we didn't have regulatory powers in relation to the NHS at that point, so it was still 2009, so those powers didn't exist.

So at that point we had a regional risk register, and the way that they were constructed in the first instance, it was that, as I said in my opening

remarks, we – we inherited a risk register from the Healthcare Commission, so they told us the trusts that they were concerned about and they became part of the regional risk process. I should have noted here that UHMB was not on the risk register we inherited from HCC.

They – we didn't – I don't know that we developed formal risk registers until 2010, so they would have just been on the radar of the local teams, but to be perfectly honest we – the only power we would have had in 2009 was to do the investigation, which an investigation team, rightly or wrongly – I mean I – you know, I imagine wrongly. I think that was one of the mistakes that we did make. I think they should have picked that up and done an investigation.

They seemed to be taking some assurance, as we kept doing throughout 2009 and in 2010, that the Trust was doing what it needed to do in order to learn the lessons that – of the mistakes that it had made and the SHA had oversight of all of that. So other than that, we didn't have any powers in relation to the NHS. I mean, we would be doing – we published the annual health check, the standards for better health, but we didn't have regulatory powers.

So we didn't set up a formal risk management system until April 2010, May 2010, when we took on – when we'd registered the NHS. So at that point we had a regional risk register, which was constructed of those trusts – or organisations, don't forget slowly and surely social care came into that – those organisations which were organisations of concern, and they'd be organisations either because of what we knew or what we'd seen or the intelligence we were getting, we believed were non-compliant with legislation,

because from that point on the thing that mattered most to us, that you were compliant under the 2008 Act, we had reason to believe or we had no reason to believe that you were, you know, you were meeting the requirements of the regulations.

PROF MONTGOMERY: So at that stage the regulator responsibilities sit with the SHA do they?

MS BOWER: At which stage sorry?

PROF MONTGOMERY: Before you get the power to regulate.

MS BOWER: Well there weren't ~~regulate~~ regulators. There were powers to intervene, and the – I can't remember when the National Quality Board was pronouncing all of that, the National Quality Board was very clear that the SHA – again following Francis when there was more of a push to be clearer about who was taking the lead on a lot of this – that the SHA held the ring, and that the SHA would make sure that various organisations were coordinating with one another.

So no doubt during the course of that year we were talking to people about organisations that were causing us concern, as I say, we certainly conducted at least one if not two investigations to the best of my knowledge, we also completed a third investigation because I can remember publishing that as a legacy piece of work from the Healthcare Commission, so that work was going on, but by and large 2009 was our preparation year for the registration process.

PROF MONTGOMERY: So if your regional manager has referred it, doesn't meet the threshold for investigation, would you have expected him to have passed

his concerns to the SHA to consider the intervention?

MS BOWER: Well I would have certainly – I would have expected him to be both talking to the SHA about what they were doing, I mean there seemed to be – again, looking back and trying to piece together what was happening, there seemed to be assurance that the regional teem were taking from the SHA, and from the legacy staff who'd come in from the Healthcare Commission, that matters were in hand.

Yes, there had been concerns at the Trust, but that they were dealing with them, which was the view that the investigations team was taking – had also taken, sorry. But I can't recall – but, you know, there wasn't a lot else that we could do otherwise, other than raise our – we didn't have the power to inspect at that point, we didn't have the power to require them to improve at that point. All these are things that came with the legislation.

PROF MONTGOMERY: Just before I leave that then, when you say, 'Assurance' you're – are you talking about sort of formal thing or something you'd expect people to record that they've tested out and had reason to –?

MS BOWER: Well, I would have expected certainly if – if Alan Jefferson, and I don't know whether you're seeing Alan or indeed Sue McMillan the regional manager who took over from him, but if Alan Jefferson was so concerned about this Trust that he had referred it for an investigation – which after all only a handful of investigations were ever done, it's not like this was a regular event – then I would imagine that that was recorded, that he would talk to the SHA about his concerns, that he would talk to his manager about their concerns.

Again, all I've done is gone back and talked to people after the event

and, you know, the only thing that I got back was always that 'We believed that in this period the Trust were doing the right things and the SHA had oversight of this.'

PROF MONTGOMERY: So if we move from then through to the registration – the application for registration. Did Alan Jefferson's concerns feed into the question about registration? From outside we need to ask that question. How did you get from that situation where there was enough concern to refer the investigation team to a registration without –?

MS BOWER: Yes, well again – again, I'm going – I can tell – well...

PROF MONTGOMERY: I appreciate at the time that [inaudible].

MS BOWER: At the time I'd – I wasn't aware of this. I'm conscious that there was the meeting with Ann Abraham in the middle of all this, which I don't know whether you're going to come back to, but my recollection is the first consciousness I had about Morecambe Bay as the Trust as a whole wasn't until the following year. No, sorry, later that year. Later in 2010.

But anyway, so at the point when we were looking at registration, UHMB as a Trust applied. They declared – the chief executive signed to declare full compliance, and I mean again I just pause on that for a moment, you know, it's the legal requirement of the Trust to make sure it's compliant with the law, not the regulator, and he was saying though, the chief executive at the time was saying, 'Yes, we are fully compliant. We meet these standards.'

Now, Alan – I now know, I didn't know at the time, that Alan Jefferson's concerns fed into a concern around maternity staffing. So were there issues

on maternity staffing? And that was – raises a moderate concern. Now we had a way – and I can't remember what it would be, I'm – I don't know whether, again, Linda Hutchinson was the director of registration for CQC who oversaw all of these processes, it might be worth you talking to her at some point about this, but so we had a way of registering concerns as major, moderate or minor.

This was flagged as a minor concern by the – so that's all they, the region, said it was. It was a minor concern. Again, I'm assuming on the back of assurance they were getting that the staffing issues in maternity services had been resolved.

DR KIRKUP: Doesn't that strike you as a rather large jump? They'd gone from requesting –

MS BOWER: Well, indeed it does, I mean I do think, you know, looking back these – you know, I can see the mistakes we made. I think the first mistake we made was, you know, given that the investigations team were – they were the ones who pushed to uncover Stafford when everyone else in the system thought Stafford was alright, including myself and many others, you know, so this was – this was not a team who was used to being sort of easily persuaded. But nevertheless I think it was a mistake and delayed us uncovering problems at the Trust that we didn't do that investigation. But – and it was a mistake that we registered them without conditions. This was – this was flagged up as a minor concern.

Any NHS trust with concerns attached to their registration at all, it went to a national team for moderation. So the national team looked at it and said, 'This is a moderate concern, this isn't a minor concern' and if it's a moderate

concern they'll be registered with conditions. And so the national team said to the team in the region, 'This is a Trust that should be registered with the conditions' and again the regional team said, - now I don't know whether Alan Jefferson had gone by now and Sue McMillan had become the regional manager. At some point they changed. Alan Jefferson didn't stay that long.

But again, the regional team assured – gave assurances that the issues on maternity staffing had been resolved and so the national team said, 'Well you're the ones out there, you know better than us', and so they accepted it was a minor concern and they were registered without conditions. And I think that was our second mistake.

PROF MONTGOMERY: And would your expectation be that the regional team would have taken that view, consulting with the SHA [inaudible].

MS BOWER: Yes, to consult with the SHA and with the Trust. So you know, this was – this was post – I know the NHS is obsessed with saying, 'Post Stafford' but as far as I was concerned, after Stafford, when one of the issue had been how the poor communication – I would have assumed that we were all talking endlessly to one another about trusts that we thought there was concerns about.

And, I mean, as far as I could see, the SHA were the ones that the assurance was coming from, was that the issues had been dealt with or they were supporting the Trust in saying that those issues had been dealt with. So they were registered without conditions. They did, I believe, get an improvement letter which was a letter that went with their registration which said, 'Well fair enough, but you've got to do better on this.'

PROF MONTGOMERY: And just to check that, because I know the Grant Thornton Report said they couldn't –

MS BOWER: They could never find it.

PROF MONTGOMERY: But you're satisfied it was sent?

MS BOWER: Well that would have been the norm. All I can say is that was the normal process. That would have been the normal – there's no earthly reason why we should – there's no earthly reason we shouldn't have registered them with conditions. 28 or however many trusts it was were.

There was no – we weren't under any pressure to not register trust with conditions. I can remember telling David Flory that up to 10% of trusts might be registered with conditions. Well that would have been 40. Well in the end it was nowhere near that number, so there was nothing that prevented us from putting conditions on it, and it was a mistake.

Because it was a mistake for two reasons – because we sent the wrong message into the system that everything in the Trust was alright, and it was a mistake because Amanda Sherlock would have had it more on her – the point then we began regulating the NHS, those 28 trusts were the ones that everybody was fretting about.

PROF MONTGOMERY: 22 I think.

MS BOWER: Was it 22? There you go, I got the number wrong, but there was a number in its 20s that we were focussing on.

PROF MONTGOMERY: Well before we leave that material, there are a couple of other things that you would have expected I think, from what we know now, to be part of that decision. We'll come back to the Ann Abrahams meeting issue,

but CQC is aware by this stage of the concerns that Mr [inaudible] raised with you, albeit that it takes some time to work out what the right response to that is, but it's in the system that there were concerns that had been raised. So how would you expect that to feed into the registration question? Would that be information held at the regional team?

MS BOWER: That was information that was held at the regional team. Certainly whether that ever – ever got onto the radar of the national team – I mean I'd subsequently spoken to Linda Hutchinson informally and said, 'Rack your brains, rack your brains' rack your brains, can you ever remember raising UHMB with me...' because I regularly met with her. We talked about the trusts of concern at the point of registration.

I don't remember her ever raising UHMB in those – in that context, so I wasn't aware of those concerns that were being raised or that indeed that specific problems were, you know, evidence of a generic issue within the organisation, which they clearly were but we weren't picking up at the time.

PROF MONTGOMERY: So you'd have expected the place where this would brought together would have been with the regional team –

MS BOWER: Absolutely. Talking to the strategic health authority, and indeed talking to the performance team as we did regularly. The performance team, the Department of Health who were themselves have oversight of what the SHA's are doing.

PROF MONTGOMERY: And I think it's the last bit before we get to registration questions around Fielding reports, and I understand it wasn't known that until later, but in terms of the application process, I mean how clear do you think it

should have been to the Trust that that should have been disclosed to the CQC?

MS BOWER: Absolutely crystal clear. It's without doubt the responsibility of the provider of services, whether you're running a care home with three beds in it or a huge teaching hospital, that if there's any issues that make you believe that you will not be compliant with the law, then it is your responsibility to inform the regulator.

PROF MONTGOMERY: So what should their disclosure – they've given the regional team a copy of the report, would it be flagged up in the application documents?

MS BOWER: Whether it would have been flagged up in the application documents I don't know. But undoubtedly they should have passed information straight away to the regional team as far as I'm concerned.

PROF MONTGOMERY: And I'm sure you now have seen the Fielding Report. I mean there were reports that were already known, so the Flynn Report was already known, I think, to the CQC by that stage, and I think there's a question around what extra information the Fielding report has in it –

MS BOWER: Okay, that's a good point.

PROF MONTGOMERY: – your take on that, with hindsight, I appreciate you didn't have –

MS BOWER: What I think is that – I mean, without a shadow of a doubt we made mistakes. In the early part of our regulation. And in the lead up to the registration in our early part of the regulation of UHMB, for which I am deeply deeply sorry. We made mistakes and we should have exercised better

judgment at a number of key points.

But – and the buck – which managers always come up with, don't we, which again I apologise for, is that you have to try and see that in two contexts: One was the – I'm struggling not to use the word, 'Chaos' but the disruption that was caused by the implementation of this new piece of legislation and bringing together three organisations that didn't want to be merged, with all the attendant problems that that brings, and I'm sure you have much experience of and many of us do.

But we were – but we believed very strongly, and I believe to this day, that the – that bringing in a regulator, and the legislation that was going to underpin that, and the requirement to fulfil quality standards and the legal power that – powers – that uniquely belong to the regulator was worth the disruption.

So we saw, yes, registration was not a perfect exercise by any stretch of the imagination, I'm sure you could look back on others of the 400 and say, 'Why on earth did you not register them with conditions', but we saw this as the beginning of a much better system of quality assurance for the healthcare system and that the short term disruption, and the sense therefore that people were using this system that they felt unfamiliar with, was worth the gain.

PROF MONTGOMERY: I think the thing I'm trying to get my head round about the Fielding Report particularly, because this is all part of the jigsaw of piecing together and it's – one possible account is: had the Fielding Report being there, a different decision would have been taken. Another plausible account is actually the substance of the issues was already available in the system, and

they were doing an extra report but it really wasn't a picture that relayed to the SHA, to the Trust and on to the local team.

MS BOWER: Well, what – I can't argue with your position, because your position is the right position, which is that they should have been registered with conditions. It wouldn't have made any difference on a day to day basis with the Trust, it would have elevated them up our list of concerns.

At the time when we were trying to register them there was so much going on in the organisation. You're absolutely right, we should have looked for more assurance and, frankly, the fact that other people were producing reports, whether it was the Fielding Report or the Flynn Report or a report from the ~~NHSALA~~ NHSLA or whoever it was, were neither here nor there, we should have been seeking our own assurances. But we did a very limited amount of that at the time of registration, and frankly, I mean I know – I don't want to move us off registration, but we went out and we did an inspection in June 2010 and we were assured then – that was our next mistake – that the staffing levels were fine.

Now again, the methodologies that CQC are now using – and were using in my day but certainly are using now, would have exposed that problem. But we took assurance too quickly and, you know, the immaturity of the organisation and struggling to deal with new things didn't help.

PROF MONTGOMERY: So when you look now, with the benefit of seeing the Fielding Report, and one thing that seemed to have happened later on in the process is that the Fielding Report and the associated action plans begin to give some reassurance that the Trust is thinking about the problem moving

forward. Would you think that's a fair perception?

MS BOWER: Well I think that we – I was looking at the weekend at the NMC investigation that we did with them, and I felt that we were always at a point of optimism, which we shouldn't have been, that yes, but a new leader had come into this part of the organisation or there was a new chair or a new head of midwifery or whatever – I mean, I'm just saying these things, so we seem – I don't know whether it's in the genes of an organisation, but we were too optimistic. We weren't sceptical enough to say, 'Well yes, but how many times have you said that things are getting better?'

And I guess some of that is losing history, you know, that we were new coming to UHMB, we weren't the Healthcare Commission, although as I said the Healthcare Commission didn't flag UHMB up as a particular concern for us.

PROF MONTGOMERY: And I think that's a very interesting observation because one of the things that you can see is that people took different types of assurance with the various activities reports that came on, and similarly from the new chair going in or whatever –

MS BOWER: Yes, it's – there's always a moment when you think things are going to get better.

PROF MONTGOMERY: – is this moving in the right direction or not moving in the right direction.

MS BOWER: Yes.

PROF MONTGOMERY: Can I move us on a little bit there to the Trust's FT application, and can you explain what contribution CQC made to –

MS BOWER: Well, and this is my – as I say notwithstanding the Ann Abraham

meeting which I know you're going to come back to, the - my first aware - my first conscious awareness of the Trust is in either the late summer or the autumn of 2010 when David Bennett wrote to us, and I believe the question was quite specific. He asked that the issues that had been flagged up at registration, which were around maternity staffing, had been dealt with and the Trust was therefore compliant in terms of the legislation.

And we had done an inspection of the Trust – now we had followed up the moderate – the minor concerns, sorry, on maternity staffing, so that was followed up by a very early inspection, so that would have been one of the first inspections that we did. We went to Morecambe Bay to – well we went to Furness General Hospital to look at staffing in the maternity unit and this was when Sue McMillan was the regional director and that staff were assured, you know, that great word again sorry, you've already picked me up on that once, but they were – whatever they saw, they were therefore convinced that that problem had gone away.

PROF MONTGOMERY: The reason I'm asking this question is whether, when you say, 'Staff were short' is it they've made a judgment or were they told something by other people?

MS BOWER: Well, that's a very good question and, as I say, in – over the course of 2011 and 2012 and certainly beyond I know the inspection model is changed again, and involves many, many, many more staff than we had access to, what - our expectations of doing an inspection changed, so for example by 2011 or '12 or I can't remember now when it was, we would certainly be saying, 'You go in...', 'If you're going to do an inspection go with a topic expert.' So if you're

going to an A&E you take an expert in emergency ~~meds~~ medicine and if you're going to paediatrics you take a paediatrician.

But these were some of the very first inspections that we were doing, so I don't – to be perfectly frank, I ~~don't know~~ cannot specifically recall what they would have done. They would have looked at the rotas, they would have asked whether or not those staffing vacancies are filled, they may well have gone onto the wards and spoken to the midwifery staff, but whatever they did, and you would need to as the compliance inspector at the time, you weren't as prescriptive.

PROF MONTGOMERY: But you are expecting them to exercise –

MS BOWER: Yes, it wasn't just... Well, I mean, we can come back to that as well, but certainly I didn't expect them to turn up and say, 'Bill, tell me everything in maternity staffing is fine', and Bill says, 'Fine' and we say, 'Well thank god, we can give you a big tick for that and go away.' There is a judgment. You are exercising a judgment, and all the time we were publishing judgment frameworks, to give guidance to the staff about how – and particularly, another thing we got better at, again these were very early days, is third party assurance. So if Bill says to me something's right, how do I triangulate that information so I'm not just taking one person's word for it?

PROF MONTGOMERY: You've used the term, 'Maternity staffing' a couple of times now. It seems pretty clear that the issues were not just about levels of staffing, and not even just about maternity staffing...

MS BOWER: Yes, yes indeed.

PROF MONTGOMERY: It – are you using the term –

MS BOWER: Yes, I apologise, I do accept and understand that it was something far more complicated than that, but in terms – and I can't now, I can't now remember the letter that I wrote to David Bennett, and I can't actually remember if it was me who wrote it, because Amanda Sherlock thinks she wrote it and I think I wrote it, but one of us, following that – going back to your question about the FT process – following that minor concern on maternity staffing, I accept that's a shorthand, we went out, we inspected against – specifically on that issue, on nothing else, David Bennett asked us about that issue and nothing else, and we said, 'Yes, as far as we're concerned it's fine.' So that was our – that was our next mistake. That was our third mistake as far as I'm concerned, which is we gave assurance to Monitor.

PROF MONTGOMERY: And the mistake was giving that assurance?

MS BOWER: Yes, the mistake was giving that assurance.

PROF MONTGOMERY: And not investigating more widely?

MS BOWER: Well, I mean, I think it was that culmination of those three things by this point. We've got an investigation that we probably should have done and we didn't, we've then got an opportunity to put conditions on their registration, which we didn't do, which would have sent a message into the system and also would have elevated it up Amanda Sherlock's concerns, and we didn't, and the third thing is that then, off the back of that very early inspection, we then gave assurance to Monitor.

PROF MONTGOMERY: And with – and it's obviously the benefit of hindsight, looking at it, those feel like separate mistakes or cumulative – and the reason, one area of that is had you lost the memory because of the personnel changes

that there had been an investigation request that had been turned down? Were you starting from scratch in that?

MS BOWER: Well, I don't know, I think that's a good question. I don't know that we should have lost the memory given that the regional – I can't – how many hospitals would be in the northwest region, you know? We were regulating – CQC regulates 44,000 organisations. We were regulating more organisations, but the NHS is always a huge priority and issues – particularly if something's going wrong, so I don't think we lost that memory. I don't think it's that. I think there was a huge amount of disruption and change as the organisation bedded in. I think we probably made mistakes that a more mature organisation wouldn't have made...

PROF MONTGOMERY: So, on that basis it's a more disappointing mistake each time you go through because you have the ability to bring the information you had to bear before?

MS BOWER: It's that, but again that combination of optimism that yourself or Bill was picking up a few moments ago, saying, 'Well hang on a minute, yes, yes, yes, there's another new *x*, you know, *x* will lead us the way to...' and the sense of standing back and taking that longer picture. Now the registration process was an opportunity to say it's - that's why we gave the first phase of the QRP, you know, 'What is it? What's everything that we know about this organisation?'

It seemed to me that there seemed to be a history of believing that this organisation was competent and knew what it was doing and had resolved its problems, and I think that's what we were – so yes, yes, there may have been

issues but this was a – this was a – the sort of problem that hospitals have, it wasn't symptomatic of a longer term issue.

PROF MONTGOMERY: And the government's question about competence of the management – is that part of your remit or was that principally in Monitor?

MS BOWER: That's not really our – I mean we would make comments and, as Bill indicated, you know when we did the Section 48 investigation then you start to see that there's a disconnect between the managers and the staff, you know, you would make comments on those things, but from our point of view, CQC's trying to focus on the outcomes of the patients. So we'll say, you know, if patients are getting good outcomes, that's all we care about. We don't care about them – we only drill back and look at things like clinical governance processes or whatever if things look like they're going wrong.

PROF MONTGOMERY: This is an age old problem. Are you really measuring – have access to outcomes? Or have you got various –

MS BOWER: Well, I mean, what we did, right at the beginning, is we – so you get the legislation, you know, which we virtually did, you know, as we started out, and then you have an opportunity to then create the guidance about compliance to start to talk about how you, as an organisation, will make judgments, and both CSCI and the Healthcare Commission, the social care and the health care regulators in inverted commas, were focussed on inputs. So for the health service it was standards for better health, it was targets. That's how judgments were made.

We very very consciously tried to make it about outcomes for patients, so we would say, 'If you are compliant with the standard of infection control,

this is what you should see as a patient, you should see nurses washing their hands, you should see doctors not going from one bed to another...' So we tried to speak about it in terms of what it looks like from the patient's or the service user's point of view.

PROF MONTGOMERY: So if we move forward to when the optimism begins to run out...

MS BOWER: Finally, the optimism ran out, yes.

PROF MONTGOMERY: So we're in 2011, we find ourselves asking –

MS BOWER: Well, so we give assurance at the end of – and I believe it became a foundation trust in October 2010 was it? And then in April 2011 we go into – we do an inspection that's part of our normal round of inspections of trusts, so it wasn't anything that was particularly provoked by anything, not as far as I can recall, or have managed to find out in preparing for today, and we go – so that's at A&E in Royal Lancaster Infirmary, and we find the whole range of issues and problems there.

I think we find them non – as we would used the – non-compliant on, again, I think it was staffing, handling complaints, nutrition, I'm just trying to remember now off the top of my head, but I know that there were three key areas where we said they weren't compliant, and then there were five other areas where we said that there were causes for complaint, so at that point we put a warning notice on the Trust, on those three areas of non-compliance and we then, at that point, we got – we've now, by this point, we've got our own system of risk monitoring in CQC rather than inheriting the one from Healthcare Commission, so this is now elevated to National Risk Register, and I believe

the Trust stayed on the Risk Register when I left in July 2012. So at that point it's elevated to the National Risk Register, and we put requirements on them in terms of, again, staffing, I think – I'm sure complaints handling was one of them as well.

PROF MONTGOMERY: I thought that came after the second –

MS BOWER: Okay, well that might – I've got it written down somewhere. Staffing, nutrition and complaints. No it was in April.

PROF MONTGOMERY: April 2012?

MS BOWER: Yes.

PROF MONTGOMERY: So there's something 2011 isn't there, because there's –

MS BOWER: No, that's April 2011. April 2011 there was an inspection of A&E and there was three areas of non-compliance I think. Staffing, nutrition and complaints, and we issued a warning notice that summer.

PROF MONTGOMERY: Okay, and tell us about warning notices and how...

MS BOWER: Well they are – well, I mean we have, of course, we had – and I mean I'm not as – two years since I left, so I'm not as strong on this as I used to be, but essentially you have two – CQC had two ways in which they could take action against organisations. There were sort of civil line and a criminal line. So you could fine – I think even imprisonment actually might have been attached to it – is attached to the legislation, but the sort of quality requirements, that a warning notice – which is essentially a requirement to do something, so you now have got a set period of time in which you have to improve your staffing, train your staff, sort out your complaints process, whatever. Do something about your mixed sex accommodation.

So, and we would put timescales on them depending what the issue was. So if it was, sorry Bill, but if it was insufficient numbers of staff there's no point in saying, 'You've got a week to sort it out', you know, you've got to give people time to do it. So a warning notice is a legal requirement to improve in order to become compliant with the law, and then – oh sorry ...

PROF MONTGOMERY: I was wondering what happens at – so you get a period to try and comply. What happens if you don't manage?

MS BOWER: Well, we – we then have the – well this is where it becomes very difficult. We have the – you know, so the legislation goes up, so then we can put restrictions on your ability to trade, if you like, for want of a better way of saying it, so that we can say – and we did do this in my time but it was very rare, we could say, 'Your A&E isn't competent to run, to take...' So when you get to so many people in A&E you've got to go on divert.

So we can put restrictions on your ability to run your services, because we don't think – or we could say, 'You can have so many births' or whatever, 'Because beyond a certain number we don't think this is a safe service'. Or we could say, 'You can't...' – we could say, although we didn't do it in my time, I don't know whether CQC has done it subsequently, we could say, 'Your cancer services in this area, so we are restricting, you know, a particular sort of service' so you can put restrictions on peoples' – and then beyond that you can suspend a service, which we never did in my time. I don't know whether CQC subsequently done, and then you can close it. But you can only close - my recollection is you can only close the entire trust. So you'd have to close the whole kit and caboodle down.

PROF MONTGOMERY: And are there examples in your time where you got to the end of the first warning period, there wasn't compliance and you extended further?

MS BOWER: Yes, we did, because it became extremely – one of the frustrations of being in that position was what some of the alternatives became more difficult. So say you did this – I mean we did, at one point, I think, put restrictions on maternity services. Now, it was a London hospital, so there were more local options, but even so it was an extremely difficult thing to do, because maternity services in London were creaking, you could say, 'Well this one's creaking worse than most so we'll put a cap on the number of births that you can have.' All that meant was the local hospitals got more pressure on them, so to suspend any rural areas of course...

PROF MONTGOMERY: It's very hard to [inaudible].

MS BOWER: It's – becomes very, very difficult. So we felt we had a load of powers, but it was very difficult to use them.

PROF MONTGOMERY: So you said you'd got to – you thought something would take three months, and it was a –

MS BOWER: Well, not at the time, we put another one, yes...

PROF MONTGOMERY: So you'd expect there to be another defined period?

MS BOWER: Yes.

PROF MONTGOMERY: So we now get to maternity care. Triggered, I think, by the Joshua Titcombe inquest.

MS BOWER: The Coroner's inquest, yes.

PROF MONTGOMERY: And you go do an unannounced visit, and you get another

warning notice [inaudible] – sorry for my confusion about my earlier...

MS BOWER: No it's alright, it is confusing.

PROF MONTGOMERY: The thing I find most confusing is what I just touched on, we'll come to some other things, but you get to the end of the warning period and there doesn't seem to be a regulatory action at the end of that period about maternity.

MS BOWER: I can't tell you why that was, because I can't remember if I ever – if I did know. I probably did know, but – this is going to sound really mad, but under law there isn't a requirement for us to do that, you know. We issue you with a warning notice and say, 'By 16 January you should have done this...' there isn't an expectation that we go back on the 17th and see that you've done it. There's an expectation we might go back in March and say, 'Well, it expired on 16 January, that was a legal requirement for you to do it...'

PROF MONTGOMERY: And where – does the warning notice expire at the end of that?

MS BOWER: Yes, the warning notice has gone. To the best of my knowledge, but I don't want to mislead you. But you know, the warning notice sits there until such time as it's ... no, no, no, I think it actually sits there beyond that, until such time as we choose to take it off, but my friend who's the lawyer could probably answer it better, I'm sorry I've forgotten.

PROF MONTGOMERY: We might need to come back to this –

MS BOWER: I'm sure we can. My friend the lawyer is over there, yes, sorry. I...

PROF MONTGOMERY: Because we're trying – you know perfectly well we're trying to get to the bottom of this.

MS BOWER: I apologise that I can't remember.

PROF MONTGOMERY: I mean I'm trying to understand what the missed signal is to the system, I mean as you'd indicated earlier on in some of the [inaudible] questions, you're clearly very aware that people take note of CQC statements and they read things into it which may or may not be your reasoning, and I'm trying to understand the message that's given, when you get to the end of the expiry period on the notice, and you don't have any satisfactory evidence of compliance, what's the signal that you're giving when it appears that you're not to take any further regulatory action? But if I just – if I just take the story on, which is what I'm very confused about is, what you do do at that stage is you move to a Section 48 inquiry?

MS BOWER: Right on that, yes, we did.

PROF MONTGOMERY: Well, pretty much at the same time.

MS BOWER: Yes, yes, yes, at the end of the summer we did, yes, yes...

PROF MONTGOMERY: And we know that you can do Section 48 enquiries with maternity and inpatient care because you did that in Barking and Havering.

MS BOWER: We did.

PROF MONTGOMERY: So I'm trying to understand why we have a warning notice in place, you didn't include maternity in that Section 48 investigation?

MS BOWER: Well, if I can just go back a bit to your first question, your earlier – the implication. I mean what we did on more than one occasion with UHMB as I still think of it, but at those hospitals, was think again about, you know, we thought about – yes, there's nothing more frustrating than feeling like you're issuing a warning notice, nothing happens, you issue another warning notice,

nothing happens, you go back. Every time we issued warning notices we'd press release them, so we tried to put – so we had to get special permissions to press release warning notices, because we weren't supposed to, we'd...

PROF MONTGOMERY: You would take special permission –?

MS BOWER: Well because in the legislation I think there wasn't an expectation that these would be public – a warning notice wouldn't be a public document, but we – we got the DH to retrospectively fix it so we could make them public documents, so that when we issued a warning notice we automatically – so there was a bit of naming and shaming as well, for want of less of a cliché, to go back and say, 'Look, we've issued this warning notice, this is saying that, you know, it's handling of complaints, it's the dignity of the patients isn't good enough...' so we tried to do that.

On more than one occasion with this group of hospitals we sat down and we tried to think – I think when we went in with the NMC I think we did it later on in the year. By this time Gold ~~Control~~ Command was on we tried to think about what else we could possibly do. I notice now CQC has a special measures provision. That didn't exist for us, so that's been brought in. But, as I say, suspending or – suspending services, or restricting services, is a phenomenally difficult thing to do.

MS BOWER: As I say, suspending – suspending services or restricting services is a phenomenally difficult thing to do, particularly in a place like this where it means that people then have to travel. So it was very, very hard to know what to do really. But it wasn't out of any lack of determination to try and use the

powers that we got to drive up standards of care. It was just knowing what we could do.

PROF MONTGOMERY: Can I push you a bit because I can see two really easy things to do: one is issue another notice –

MS BOWER: Yes, well we did issue more than one.

PROF MONTGOMERY: And the other is to include maternity in the context of [crosstalk] –

MS BOWER: Yes, well, I mean, all I can do is say should we have included maternity? Did that send the wrong message? Possibly, I mean I think, don't forget, as you yourself pointed out, it was barely after we'd done the work with the NMC and I suppose the biggest – I mean I think the suggestion actually came from the Risk and Escalation Committee who looked at the terms of reference for the Section 48 investigation [inaudible] They felt that we'd looked at maternity – I don't know whether this is yet another statement of optimism, the SHA were monitoring, the NMC had said they would keep an eye on it as well, Central Manchester I believe, somebody who was in the Trust, I believe it was Central Manchester, trying to prop up maternity services, that might be later.

Certainly I think the SHA were moving staff in to try and support. So I think that, whether this was the right decision, it was probably the wrong decision, I've only got us down as – this might be the fourth mistake we made, not including maternity, but I think we believed that the warning notice was still extant, there was a lot of attention on maternity services and I think just, again, picking – we had just done that work with the NMC but also picking up the point

that Bill made earlier that we believed that looking at the emergency care pathway could be a proxy for looking at those broader issues in the Trust. So it wasn't just, as you've rightly pointed out, this isn't just about staffing. So we were very clear when we issued the terms of reference that this was a proxy for looking at the so called culture of the organisation, the management of the organisation, so it wasn't just going to be sitting in A&E.

PROF MONTGOMERY: I think I understand that. It's the 'Why not also maternity?' I remain confused on. But do you think that if the reason for the risk escalation was principally that actually what value would the Section 48 being extended add to Gold Command and to [inaudible].

MS BOWER: Yes.

PROF MONTGOMERY: Do you think that was communicated to the Trust that you still had concerns?

MS BOWER: I believe that – I mean I would have to look at the press releases and the things that we were issuing at the time but I cannot believe at that point the Trust was saying 'Okay, this means you've got a big tick for maternity services', because that's not what the NMC report says. So I don't believe, I certainly didn't think at the time that this was a mixed message that was saying 'Yes, okay, fine, we can now draw a line under maternity'. I think we thought well let's look at something else here because we've already looked maternity very, very recently.

PROF MONTGOMERY: Okay, that's helpful. And was that, by this stage, on the whole CQC Board Register? I mean –

MS BOWER: Well it was on, it was certainly on – at some point, I can't remember what point it was, so our way of managing risk is that it went to the Risk and Escalation Committee, that they held the national risk register, they looked at the national risk register

PROF MONTGOMERY: And is that a board committee or a management committee?

MS BOWER: That's an officer, if you might say, committee.

PROF MONTGOMERY: Officer committee, right.

MS BOWER: But before I left we certainly had a process of reporting to the Audit Risk Committee and then on to the Board. I can't remember at what point that came in but I had a weekly meeting where I looked at the risk register with somebody from the Chair's office and we then, if there were issues that we wanted to escalate to the Board, and we always did if we were taking action with the NHS, so we made sure the Board knew, the NHS Trust, and certainly if we were launching an investigation or publishing warning notices or whatever, we would always let the Board know.

PROF MONTGOMERY: Thank you. Can I ask you about Gold Command and what involvements CQC might have had in the discussions about whether it was a good idea to set up Gold Command?

MS BOWER: Well I don't know – I don't know is the answer to that.

PROF MONTGOMERY: You don't know.

MS BOWER: I don't know whether – I mean I'm sure we had conversations about it. It was probably by that stage at Amanda Sherlock's level. It would certainly be with the regional director as well who was still, I think, at that point, Sue

McMillan but we subsequently moved her to a non-operational post. But I think in 2011 that she was – it was the end of 2011 wasn't it gold ~~control~~ command? It was still Sue McMillan in that role. So certainly we would be a part of those discussions and once it got going of course we were part of the sort of daily, weekly meetings.

PROF MONTGOMERY: Of course. Because I think one of the questions in my mind is whether that papers over the problems? If the problems are in the Trust's ability to get it sorted, does Gold Command solve them or does it just hold [inaudible]. I mean, if you hadn't use the regulator –

MS BOWER: Yes, it's a very interesting question. I mean in my time at CQC, and honestly I've no idea what's happened since – this was a unique experience. I'd never known anybody use that sort of Gold Command which is a sort of, I remember it from my local authority days, the sort of response to an emergency, I'd never known. So that seemed to me to be the system saying as seriously as it possibly could that these problems were completely unacceptable and whilst I take your point that it does take out from the Trust the responsibility of doing something about it, it seemed to me we were at the point where people were saying 'It's got beyond that. We've got to get this system right before we just can trust – ' to endlessly keep saying to the Trust, 'Are you getting this better?' and they're saying 'Yes' but actually it's not improving. So you get to the point where you just have to take it off them, don't you and say 'We'll sort that out' and then – so I mean I'd never known that happen before.

PROF MONTGOMERY: Okay, thank you. It's a question rather than a conclusion. I think I'm done except for the discussion of the PHSO. I didn't know whether you wanted to do this in the general bit or wanted to keep it at the end.

DR KIRKUP: No, no, I think we need to pick it up because there will be some matters arising from that so go ahead.

PROF MONTGOMERY: Thank you. So, can we then move to – you mention the Ann Abraham's meeting.

MS BOWER: Yes, Ann.

PROF MONTGOMERY: I think the best way into it really is can you tell us the story as you understand it.

MS BOWER: I'll tell you the story. Well going back to what I said at the beginning about how difficult this was as a setup, and we'd had a very early meeting with the Parliamentary and Health Services Ombudsman, and when I say we I mean myself and the Chair, Barbara Young, and then we had a subsequent meeting – and one of the things that we agreed, in order to make sure that we were passing information appropriately between the organisations, that we needed a memorandum of understanding between the two organisations which was clear about how we were going to work together. And myself and Barbara Young, myself it would have been, I set somebody, I can't remember who it was, on the job of getting going and doing that. We duly went back to meet with the Parliamentary Health Service Ombudsman, I've no idea when it was. It would have been, given that this second meeting I think was in August, it would have been June/July time or whatever. So we're talking about still very early days in terms of CQC and Barbara Young and I went into this meeting

convinced that we had been briefed saying yes progress was being made on this piece of work and when we got there Ann Abrahams was very clear that absolutely nothing had happened to progress it. Now, I have to say I wasn't totally surprised. We were sort of setting up camp in the most difficult of circumstances so the fact that we hadn't nailed this memorandum of understanding with the Parliamentary Health Service Ombudsman, I wasn't wholly surprised by to be honest. But she was very angry with us that we hadn't progressed it in the way that we should have done and we left very chastened by that.

She then asked to come over to see me and she came and she had a cup of tea. Now in the Grant Thornton investigation they make much of the fact that this wasn't a minuted meeting and my meetings usually were minuted with her and it's true, we did have minuted meetings, but this was literally a cup of tea. So it wasn't a meeting. She came over to have a cup of tea with me so that we could pour oil on troubled waters and I could apologise again for us not making progress and we could all – I can't even remember if it was just me and her and whether other people were with me but we agreed that we needed now to expedite this process. And to be perfectly honest, that's all I remember about that meeting.

Now subsequently, after the Grant Thornton investigation completed, because I didn't talk to her at the time because I didn't think it was appropriate, I did ask her if she was going to be involved in it and she said yes but I didn't ask her about the meeting but I have subsequently seen her, after the Grant Thornton report was published, and what she tells me is that at the end of the

meeting, I think it might have even been literally we were on our way to the door or whatever, she told me about this outstanding complaint and that she was still considering whether or not to investigate it and could I give her a contact to speak to, or give the PHSO's office, a contact to speak to about this organisation and I gave her Amanda Sherlock's contact details and that's it.

Now I have no recollection of that bit of the conversation but Ann Abraham's is very clear that that's all it was and that I had no sense that she was giving me some major hot potato, that this was a big issue. She just said that there was this outstanding complaint and they were making a judgement. I certainly didn't have any further conversation with her. I just gave her Amanda Sherlock – I either at the time or subsequently emailed her and gave her Amanda Sherlock's contact number and that was that. And I believe Catherine Hudson, who was the deputy, made contact with Amanda and Amanda referred her to the – and I had no recollection of that bit of the – I can remember coming over and having the cup of the tea but I have no recollection of that bit of the conversation but Ann is clear that that's all it was.

DR KIRKUP: Was that the first time you'd heard of the complaint?

MS BOWER: Yes, absolutely, yes, yes, yes.

DR KIRKUP: Okay, sorry.

MS BOWER: I don't even know that she mentioned a name or anything or any detail about it but I don't know. She might have done. But certainly I had no impression that this was something that should be flashing on my radar.

PROF MONTGOMERY: Okay, so I've got the discussion on the particular conversation and how far that went. I'd like to look at it from two sides. I'd like

to understand how the memo of understanding eventually developed, or how the understanding without a memorandum developed on the handling of cases which are both PHSO territory and regulatory territory and what the process was for trying to make sure that things didn't fall between the two stools and were not done in conflict with each other. So that in a sense is a general discussion and I would like to move back to how the CQC as an organisation dealt with the particular inquiry. So –

MS BOWER: Well, I mean, forgive me, but I can't remember that clearly what we did but essentially we had an information sharing agreement in the way we had an information sharing agreement with many organisations but obviously I don't want to trivialise it. The information sharing with PHSO is more significant than most of the ones that we had.

I then had a lead director who was Louise Guss who was the Director of Governance and Legal Services, so the CQC's head lawyer then became the main point of contact for the PHSO and she worked with her equivalents. And then I had an officer, Susannah Burden, who dealt with complaints for CQC, worked at an officer level with somebody more junior, if I can use that expression, but someone else who was on more day to day work. So we knitted together at the senior officer and a more junior officer level people who would meet regularly, discuss areas of concern and that's what the memorandum would say. And then, twice a year, or quarterly or whatever I would meet with Ann Abrahams just as much as anything to make sure that the system was working well. She may well then tell me about Trusts where she had particular concerns and that's the way it worked.

PROF MONTGOMERY: So if I've understood that rightly there are two main functions that that arrangement should deliver for you. It should make sure that you contribute the information that you hold that's relevant to the PHSO inquiry –

MS BOWER: Yes.

PROF MONTGOMERY: So to make sure that nothing is lost if you like to those investigations and, secondly, it should be the mechanism by which if it wasn't clear whose jurisdiction it fell under there's a way of discussing the best way forward. Is that –

MS BOWER: No I don't think I would agree with that. I think that the PHSO was very clear – so we didn't, there wasn't a mechanism that says 'Okay, let's sit down. There's this complaint. Are you going to do it or should I?' I can never remember having a single conversation like that. We both were very, very clear about our legal responsibilities and it was as much to say 'I'm not comfortable with what's happening in X or Y or Z' or 'I've got a cluster of complaints'. I mean the thing that we were most concerned about, again post Stafford, was that there would be a cluster of complaints that somebody wasn't – so that's that endless desire to put together a picture, it's as much that we would do that and understand that between one another because she had a very discrete set of responsibilities and so did CQC.

PROF MONTGOMERY: So were there examples where you both had to operate on the same incidents with a different responsibility?

MS BOWER: Well we didn't operate so much on incidents. You know, our view was that we were looking at – we didn't have a complaints function. I mean the

complaints really were complaints about the CQC. We were concerned is 'Does this Trust meet a regulatory standard?' You know, things could go very, very badly wrong for individuals but the Trust still say that, on the whole, yes that was a terrible mistake but on the whole we are compliant with the law and we would agree. That doesn't mean to say that the Parliamentary Health Services Ombudsman wouldn't be very concerned about what had happened in a specific case.

PROF MONTGOMERY: But one of the things that seems to have happened in this case, is that the views fluctuated with different people looking at them was whether we had a cluster of incidents –

MS BOWER: Indeed, yes, I realise that now, yes.

PROF MONTGOMERY: So that that pulls it into a CQC type question –

MS BOWER: Without a shadow of a doubt.

PROF MONTGOMERY: Or whether [inaudible] unconnected ones so you need to be asking those questions.

MS BOWER: Yes.

PROF MONTGOMERY: Perhaps you can take us through what you understand, and I appreciate that you didn't know about it by name at the time, but you've now had a chance to see the investigations that have been done internally. What's your understanding of how that question, 'Do we have five separate incidents? Do we have a cluster of incidents? Do we have a system problem or do we have a set of individual problems?' How did that work its way through the CQC?

MS BOWER: Well I would say the biggest way that we had of doing that is through the quality and risk profile which I mentioned earlier because, I mean again the current management of CQC have abandoned this. No doubt they have put something better or different at least in place but that was the way of saying 'We are looking at the data all the time'. And this is something we very much inherited from the Healthcare Commission so we have ways of looking at data that says 'This is a cluster of events, this is an elevated rate of mortality in this area and this is flagging up a red like in this organisation'.

So, as you know, the NHS is a data rich organisation. You could learn a lot, I mean certainly, I don't want to put words into his mouth, but certainly Ian Kennedy's view from the Healthcare Commission was certainly that the more you could look at the data the more you could pinpoint problems which is exactly what they did with Stafford. And so I would say the biggest way we looked at it was to say 'What's the data telling us?' The data would show us that serious untoward incidents are being flagged up in particular areas.

So I think it was the quality and risk profile which became the repository of all the intelligence we had on any organisation whether it was a dental surgery or a hospital and it should be that that's flagging up issues and we had a group of staff, the name of whom right now completely escapes me, whose job it was to work on the interface between the intelligence directorate as it was called in my day and the inspectors on the ground. So they would say 'Hang on a minute, there's a cluster of children's deaths here. This wasn't just a one off. This is – 'But again, we're talking about something that took a while to mature.

PROF MONTGOMERY: I understand that and there's evidence of the regional team being anxious of it being a cluster. There's evidence of the investigation team turning down the one that we've been over in Blackpool[?].

MS BOWER: Yes.

PROF MONTGOMERY: Would that have found its way to the Risk Escalation Committee because of the data analysts?

MS BOWER: Well the data analysts sat on the Risk and Escalation Committee, so they were the head of intelligence, I can't remember his name, I can remember his name, I can't remember his title, but he would sit there. So part of his job would be to make sure that the systems and processes particularly whereby intelligence for picking up data from across – he would take data from the national information centre or whatever it's called, I can't remember, but we weren't collecting data in our own right. We were taking cuts of data. We took from the Dr Foster, from the Dr Foster Unit at Imperial as well as taking it from the NHS data systems, the name of which I've now completely forgotten, but to make sure that the systems and processes that were flagging up then were being raised properly with intelligence staff, with inspection staff on the ground.

PROF MONTGOMERY: And would that include intelligence as to what other organisations were doing? So, for example, what the SHA was doing?

MS BOWER: The softer stuff, yes, but I can't tell you how that worked. But I mean we – I believed that central to our ways of working was that we had that regular sharing. We would expect the regional managers to be talking to the SHAs all the time and Amanda Sherlock was talking to Alan Hall and monitor and [inaudible] monitor so that that soft data sharing – we weren't just looking at a

graph waiting for the graph to tell us we'd better go and have a look at Furness General Hospital although some might say we'd have done better if we did. But –

PROF MONTGOMERY: And would you have any way of tracking through something that seemed to be 'lost to follow-up' to use a phrase from a different health service? I'm thinking if the PHSO decides not to investigate something, it has been on your radar early. Would there be some brought forward system that would enable you to flag it up?

MS BOWER: I don't know. I don't know. There might have been, but I don't know. There's no point in me telling you there was if there wasn't. I can't remember.

DR KIRKUP: The Ombudsman's view of the handover was that she had declined to investigate on the grounds that this was a system issue not an individual complaint issue and therefore a matter for you. But from what you're saying, that message didn't reach you?

MS BOWER: At no point, unless somebody can show me a memo that I – an email that I had or whatever, I can never ever remember having any conversation that ran 'This is not a –' you know, about – I can't remember having that conversation about any organisation because I would have directed them to talk to the regional teams or whatever. It was very much a devolved decision making structure but I certainly have no recollection, I do not believe anybody ever said to me 'We have decided that in the case of Furness General Hospital or UHMB as a whole these are systemic issues and we expect you to investigate them'.

Now, if that conversation took place somewhere lower down in the organisation, that might have happened. But we weren't in the habit of saying with the Ombudsman, or I don't know with anybody, but I can't remember a situation where we said 'I'm not doing this, you've got to do it'. You know, we said 'I have arrived at this judgement about this situation'. But certainly no-one ever got on – Ann Abrahams didn't get on the phone and say to me 'Look, we're not looking at this because this is a much wider systemic problem. We expect you to pick it up'. I never had that conversation.

DR KIRKUP: There's internal documentary evidence from the PHSO that they did say that.

MS BOWER: To me? Well I – what from Ann Abraham saying that Ann Abraham said that to me?

DR KIRKUP: Ann Abraham and Catherine Hudson.

MS BOWER: Sorry?

DR KIRKUP: Ann Abraham and Catherine Hudson.

MS BOWER: I've seen a – the point of the Grant Thornton investigation –

DR KIRKUP: I'm not just relying on Grant Thornton here but –

MS BOWER: Yes, no, no, no, but I saw an email and they showed me an email that Catherine Hudson had said that Ann had spoken to me and I had offered her different ways of handling the complaint about – Mr Titcombe's complaint, but that must have been in that conversation that we had, that tea conversation. I cannot remember that but I don't have – I can absolutely, I had no desire not to follow up anything that people were giving me. I mean, I'm sure we made mistakes, we've probably made a lot more than the ones that were made about

Morecambe Bay, but we made them in absolutely good faith and with integrity and all the time we were trying to prove we could be an effective regulator of the healthcare system. So if I had got the message saying 'We are expecting you now to do an investigation' I would have gone to the investigations team and said 'Why are we not doing this investigation?' At no point, as far as I am concerned, did I ever [have that?]?

DR KIRKUP: I don't think the word investigation was used but I think 'robust action' was the way it was captured in that email that you are describing.

MS BOWER: Well I don't remember ever seeing that email.

DR KIRKUP: Yes sure, no, you wouldn't have done, it was an internal PHSO one.

MS BOWER: Yes okay.

DR KIRKUP: But it's describing somebody's view of the conversation that had taken place.

MS BOWER: Well that's not –

DR KIRKUP: I'm just concerned that the two participants in the conversation appear to have such a different view of –

MS BOWER: Indeed, but I can't give you any more than, any better account than I've already given you. When I became aware that this was concerning Mr Titcombe's – because I read it as part of the start of the Grant Thornton investigation, I had no, I could not remember a single conversation I'd had with Ann Abraham about his complaint. When I was shown the email by Grant Thornton, the Catherine Hudson email it was.

DR KIRKUP: Yes.

MS BOWER: That didn't prompt any memory that I'd had about – I mean the only thing I can possibly say is I might have had a general conversation with Ann Abraham about the sorts of powers that CQC were going to have but in 2009, when this conversation took place, we didn't have any powers in relation to the NHS.

DR KIRKUP: Yes, okay.

MS BOWER: The only power we would have had at that stage was to conduct the investigation. As I said, I had no I have no recollection of ever having that conversation. The only conversation that Ann Abraham tells me she had was just to ask for a contact. Certainly in other conversations with Ann Abraham we would have talked in general terms about the powers that were coming in for the regulator, what we would be able to do –

DR KIRKUP: Yes, okay, but what was your impression then of the reason that she asked for the contact? I think you mentioned Amanda Sherlock as the person that –

MS BOWER: I think she wanted – I can't remember, I can't remember. I think it was just to talk to the regional team about – because I think at that point they were still deciding whether or not they were going to investigate it. So I think they wanted to get the – Well I don't know, I'm speculating. I was going to say they wanted to get the impression of what the local team thought about the hospital but I'm speculating now, I've no idea.

DR KIRKUP: No, I'm not asking you to speculate. I'm asking if you can recollect when you went to Amanda Sherlock and said 'The PHSO's looking for a

contact and it's you'. What did you tell her that the contact was in connection with?

MS BOWER: Well I don't think I did that. I think I just gave, the PHSO asks for a contact and I gave her Amanda Sherlock. I don't think – I didn't come away from that conversation believing that there was a big issue that I was being expected to follow up. I was asked for a contact. If I subsequently discussed it with Amanda Sherlock, what would have happened is what we were discussing earlier which is I would have probably been told that the regional team were sure that everything is going well but I certainly – certainly that wasn't a conversation where Ann Abraham was saying to me 'We need you to pick this up' or 'we need you to do certain things'. And if she had of done, I would have done it. There was no earthly reason why I wouldn't do it. That's not the impression I got from that discussion.

As I say, we certainly had general conversations about what the new powers of CQC would be so that the Ombudsman would be clear about them. But I never remember having any conversation with Ann Abraham about that in relation to this complaint and, as I say, we were desperate to prove we could do the right thing. I had no motivation whatsoever to not follow that up.

DR KIRKUP: I understand what you're saying. You understand that I'm having to keep reflecting back to you –

MS BOWER: Of course, of course you do.

DR KIRKUP: That she is very definite that there's an alternative version of events.

MS BOWER: Well, Catherine Hudson is. I don't know that Ann Abraham is. I don't know but –

DR KIRKUP: Well I think she has subsequently been but that's an issue for us I think. She's subsequently backed that up. Okay, I mean you've said you have a different view of events. When did you find out that she had declined to investigate the complaint?

MS BOWER: I can't remember. I can't remember.

DR KIRKUP: What was your interpretation when you did hear?

MS BOWER: I can't remember that either. I can't – because I don't remember the specifics of the – I don't remember her telling me any of the specifics of the complaint. I just remember – well I don't remember any of it. But as I say, when I've subsequently spoken to her about it all she said is 'I asked for the contact' so I didn't have a view of whether or not she was going to investigate the complaint or not.

DR KIRKUP: And your regional director didn't report back to you that there'd been a conversation between the PHSO and himself?

MS BOWER: It would have been myself to Amanda Sherlock and Amanda Sherlock didn't know.

DR KIRKUP: No, there was then a conversation I believe between the PHSO's office, I'm not sure who, and Jefferson, the original director.

MS BOWER: Oh, yes I now –

DR KIRKUP: Were you aware of that?

MS BOWER: No, I now know that because I've looked at the narrative but I didn't know that at the time.

DR KIRKUP: Right, okay.

MS BOWER: And what Amanda Sherlock told me, and we're talking months and months later, probably even when we were engaged in the Grant Thornton investigation, that she had just referred Catherine Hudson – Catherine Hudson had then contacted her following and she had just referred to the regional team. And the message coming up seemed to be that we were confident, however ill advised that might have been, but we were confident about the Trust. So none of this was on my radar as a big issue. If it had been, I would have done something about it. I had no motivation whatsoever to sit on information, particularly not after Stafford. We were desperate to prove that we could be effective and we would pick things up.

DR KIRKUP: Did you – and I think I know the answer to this, but did it occur to you that you might want to follow up with Jefferson and find out what the conversation had been about?

MS BOWER: No, it didn't. Perhaps it should have done but, no, it didn't. But, as a I say, I had no sense – I mean I can't remember the conversation of course but I can't help but think that if I had realised the seriousness now of it, that I wouldn't have followed that up in some way. But as I say I might have followed it up with Amanda but all Amanda would have told me is that the region is saying that – and why there's that mismatch between apparently the region taking some assurance but at the same time Alan Jefferson trying to get it dealt with as an investigation, I can't explain. The only thing I can say to you Bill is that the – it was all in the morass of setting up. You know, this was a –

DR KIRKUP: Yes, I appreciate the distractions.

MS BOWER: Alan Jefferson didn't hold that job for very long. It was a very, very difficult time for us. No doubt we didn't follow things through in that way that in a couple of years time we were doing it in a more rigorous and systematic way.

DR KIRKUP: And did the Ombudsman appreciate how chaotic things were for the organisation when she's talking about 'robust action' in relation to Morecambe Bay?

MS BOWER: Well she knew that we had struggled to do the thing that she had asked us to do. I made absolutely no bones to anybody about how tough it was to get the thing up and running. I can't believe that she thought on 1 April 2009 we were born fully fledged as a competent organisation. That just isn't what happens.

DR KIRKUP: It doesn't seem likely. All right, I'll pause for a minute and hand you over to Stewart. I have a couple of other things I want to come back to.

PROF FORSYTH: Just one thing that's crossed my mind is that, I mean, you have been talking about 2009, we're now in 2014, five years have passed by and clearly your organisation is still very much involved with this Trust.

MS BOWER: Yes.

PROF FORSYTH: I mean why do you think that is? I mean it's disappointing. I'm sure the general public would be very concerned in a way to find that all those various organisations around healthcare, health standards, quality care etc have been unable to fix a problem in probably one of the smallest Trusts in the country, with small hospitals in a rural area?

MS BOWER: I wish I knew the answer to that question. I can speculate, I can speculate based on what our – I mean the last thing that I was involved in was

the Section 48 investigation, you know I can speculate based on the conclusions about that. But these are out of date ideas I'm talking about two years ago when there were concerns about the merger and I know that anybody who has worked in merged organisations of course of which CQC was one, 10 years on people can tell you who came from which hospital and who came from which organisation and never – they're easy things to talk about but difficult, difficult things to pull off.

And I wonder whether – I mean I was a passionate believer in the regulator, I know this is now what you're asking me, a passionate believer that this was the right thing to do, but I wonder whether the gain has been worth the pain in terms of setting up CQC and the trauma that we went through and the disruption and therefore the opportunities to miss things and make mistakes that you wouldn't make in a more mature organisation. So I know there were merger issues, I know there were issues about the culture between, you know, disconnect, I believe I'm told that there was a culture of disconnect between the leadership of the organisation and the clinical staff on the ground, well these are not uncommon problems are they?

PROF FORSYTH: Well do you think that all the other agencies are really all working together effectively to try and resolve these issues or do you think that somehow they are making life difficult for the Trust?

MS BOWER: Well, I wonder whether – I mean it's really interesting one of the things that I set up before I left, which no doubt David Behan has taken on and done more of and done more interesting things around, is to try and look at evaluating the impact of the regulator. Can you stand back and say – can you

demonstrate that in the end the regulator made a difference? Has it improved the quality of care? Can you think of instances, can you look across the piece at the NHS and say the regulator really improved things? Because that's the question you really have to answer. And of course by the time I left we didn't know and by the time I left, the organisation was just about getting over the trauma of its birth and was getting going as a proper regulator in my view.

Does that sort of oversight help improve the quality of care? Is it better that you leave the local staff to get on with it? I mean what I believe passionately is that the only people who really improve the quality of care are the clinicians on the ground. It's the doctors and nurses and the healthcare assistants, or the care staff in care homes or whatever, it's the staff on the ground who improve things. I must have said this a thousand times when I was Chief Executive of CQC. The rest of us are trying to use what leverage we've got to influence that behaviour and, to be perfectly frank, if you keep doing the same things over and over and over again and you're not making the improvement you have to start asking questions about whether that's the right thing. Are there specific recruitment issues in this area? Is it not the sort of area people want to work in? I don't know what the issues are that produce the specific challenges but what I do know is that in the end the only people who improve the quality of care at the hospitals are the clinical staff who are working there, supported by their managers and boards. All the regulators try to do is use the leverage it's got, it's ability to name and shame, it's ability to require things, to try and generate and to try and talk to patients and to clinical staff, to try and generate that improvement, to open things up. But I read, I still

look at the HSJ online, I read that there are still issues in the Trust. It's not a happy account to read.

PROF FORSYTH: Okay, thank you.

DR KIRKUP: Okay two more specific things from me. The first one is, I want to raise with you a kind of general theme that's emerging from all of this that nobody seems clear whose job it is to reassure who about what's going on.

MS BOWER: Right. [Indicating I understood the question, not indicating agreement]

DR KIRKUP: And it seems to develop into a sort of mutual reassurance society.

MS BOWER: Well – yes.

DR KIRKUP: The CQC is taking reassurance from the SHA that the Trust's improving. The SHA says 'No, that's not our role. We take reassurance from the fact that the CQC, the regulator tell us it's getting better. The PHSO takes reassurance from the fact that the CQC is going to do a robust investigation and the CQC takes reassurance from the fact that the PHSO isn't progressing with the complaint. How do you see your way through all that?

MS BOWER: Well, at its most – well I mean there are a number of answers to that question aren't there. Certainly in my day, one of the reasons the National Quality Board was set up was to try and say 'This is how people should work together. This is how you have to share information. This is how you do things'. So there should be a sense of the system working together and I always believed very strongly that CQC had to be system players, it couldn't just be somebody who stood on the sideline then commented on how everybody was doing. We were in there in the mix with everybody else trying to generate improvements.

So there was a choreography, I can't think of a better word really, around how organisations should work together, but I'm really clear – And then at the other end of the scale, one of the improvements that we put in in my time, no doubt it's all changed again, is that we put more demands around the staff in terms of taking assurances as I was saying to you earlier. So third party assurance as a regulator we describe it so I come and ask you a question and you say 'yes'. What are my expectations, if you were the compliance inspector, to go and look for yourself?

DR KIRKUP: I understand that. It's the relationships between the different parts of the system that I'm pushing at. Let me try and help you then by simplifying it. Is it the case that it was all crystal clear to everybody then and all this now is people trying to shed blame? They're trying to say 'It wasn't me, guv; it was somebody else'.

MS BOWER: Well –

DR KIRKUP: Or was it, as it seems from the descriptions that we've heard, a bit of a mess at the time?

MS BOWER: I think it's – well I hope I don't give the impression that I'm trying to say 'Look everybody else was to blame'.

DR KIRKUP: No, no, that's my interpretation.

MS BOWER: I think the CQC have to take their share of the blame on this. You know, there were critical things that we missed. I think there are reasons why in terms of the maturity of the organisation but, nevertheless, people made mistakes and made bad decisions. That will happen in the most mature organisations, let alone ones that CQC were in, and I'm absolutely clear that

the legislation, the 2008 Act that set up those quality standards for the health service that were legal requirements, despite the fact that I, as the ~~Trust~~ Chief Executive, have to own that the CQC were guardians of that. I couldn't cede that to someone else. I couldn't say 'Well hang on a minute, I'm expecting the SHA – 'SHA's don't even exist anymore – 'I'm expecting the SHA or the PCT' I'm really, really clear that that is CQC's responsibility to take account of those and to make sure that the – you've got an unconditional licence to practice then we have every reason to believe that you are competent to do that. I don't think that that's something that we can just say 'Well hang on a minute, I spoke to Fred Bloggs at the SHA and he told me it was all right so I gave him a tick'.

So we – as the organisation matured, and it has matured even more to this day, we put more demands on the staff in terms of saying 'Tell me how you know. Have you looked? Have you spoken to the patients? Have you spoken to the frontline clinical staff?' So I'm sure it is – you will reflect in your report that this is a complex system of accountability and at the end of the day who is accountable for the quality of care at the Trust? It's the Trust. It's the Trust Board, it's the Chief Executive.

DR KIRKUP: Yes, I agree with that.

MS BOWER: But I don't think – but CQC can't give away it's custodianship of those regulatory standards and it was never, never my intention or desire to do that.

DR KIRKUP: Yes, but do you think that those divisions and those inter-relationships were clear to everybody at the time? Was there a shared view?

MS BOWER: No I doubt it. I think the National Quality Board worked very hard to try and put those into place. But the idea that this worked in some sort of

seamless way in which everybody felt clear about where their responsibilities lay and someone else's began, I think you would have to be over optimistic to believe that.

DR KIRKUP: Yes, okay. The second area is that there was a challenge about the effectiveness of CQC's activity in relation to UHMB in early 2012. This is the whistle blower, aka one of your non executives I think.

MS BOWER: Oh, right –yes, yes, yes.

DR KIRKUP: Can you talk to me about the response to that?

MS BOWER: Well, what I recall of it is this – that I think she wrote an email to me that I passed on to the Chair in about March time. She asked a series of questions about the effectiveness of our regulation of Morecambe Bay.

DR KIRKUP: Yes.

MS BOWER: Now at that time she was asking a – it wasn't just Morecambe Bay she was asking about. She was asking lots and lots of questions into the organisation about how we were being effective in various ways and what we were doing on various things so the Chair had taken a view that she would – because she then discovered, the Chair discovered that in the organisation lots of people were beavering away on answering questions that this non-executive had raised, so the Chair took the view that she would decide on how the non-executive's concerns were going to be dealt with. So when this came in, it was one of – I can't remember that she wrote to me that often but I was conscious that there were a number of issues which she was raising which is why the Chair had taken this view and I passed it to the Chair. As far as I was concerned the Chair was determining how we were going to respond to this.

I can't remember if the Chair and I discussed it but in the April Board we were having a paper about our effectiveness in regulating the NHS because, as I was saying earlier, before I left we put into place some place that Kieran Walsh from Manchester University, who's the sort of country's leading interest in regulation, was going to look at the effectiveness of CQC. So we had a series of Board papers around that, or Board discussions around that, and I believe that Amanda Sherlock was taking a paper to the April Board and UHMB was going to be one of the examples that we used, either in the paper or in a presentation and actually around this time Amanda was interviewed by the HSJ about our problems, the fact that Monitor had published it's look back on its authorisation of UHMB as a foundation trust and Amanda was interviewed and I think she even makes reference in that interview, she admits that we made mistakes in regulating UHMB and she makes reference to the fact that we were going to have this Board report. So this Board report is coming and I think – I can't remember if I discussed it with Jo Williams or not but there was a view that we were going to talk about our regulation of UHMB in the Board meeting and that would give this Board member an opportunity to raise the issues.

Now when we got into the Board meeting, I can't remember knowing any earlier than this, Jo Williams had taken that example out. I don't imagine there was anything sinister in that other than the fact that the presentation was probably too long but anyway, she had changed the presentation and UHMB was no longer one of the examples that we were using but nor did the non-

executive take that as an opportunity to raise it either. But it was unfortunate and I don't know why UHMB wasn't there but it wasn't.

Then in the June time, so a couple of months later then, the non-executive wrote to me again and said 'What happened to my questions?' and I sent an email back saying 'Oh God I completely lost track of that and I'll discuss it with Jo' and I went to Jo and I said we just lost track of this and, as a result of that, she – this was June, as I left in the July, she then said that as part of this work that we were doing to evaluate the impact of ourselves on the NHS and look at lessons to be learned about the regulatory model, she would commission a specific piece of work which was a look back on UHMB and so we agreed that that was the way we would then pick up the concerns of that non-executive.

DR KIRKUP: Did that specific bit of work get done?

MS BOWER: Yes, because that became the Grant Thornton –

DR KIRKUP: Oh I see.

MS BOWER: What happened then was that Louise Guss began writing terms of reference, it was going to be handled through the Audit and Risk Committee which Louise Guss, the head lawyer, serviced and Deirdre who was a clinician, one of our non-executives, was going to have oversight of this as part of this general piece of work that she was having oversight in terms of looking at the evaluation of our work to date. So that was going to become a discrete piece of work as part of that. It was going to feed into that general evaluation.

DR KIRKUP: And when you say it became the Grant Thornton, did it get overtaken by the Grant Thornton report or was that – ?

MS BOWER: Well what happened was I then left as Louise was working on the terms of reference and they were looking for an external clinician I believe at that point to undertake this piece of work that was going to be the specific UHMB look back. So Jo Williams commissioned that, we agreed because we had lost sight of that concern, I left and when David Behan came he decided that he wanted to contract it out to the big accountancy firms and so at that point it then became the Grant Thornton.

DR KIRKUP: Okay, it transmogrified into it. Okay, I understand. Did you think there were opportunities to learn from the feedback from the non-executive short of doing an urgent review like that? It seems, if I can put it like this, it seems that there were no reaction, no reaction, no reaction and then, wow!

MS BOWER: Well, as I say, you have to see it in the context of there was a lot of issues – it wasn't the only issue she had raised.

DR KIRKUP: Yes.

MS BOWER: She had raised a number of issues. I can't – I mean it was Jo –I can't remember – I mean it's probably a good challenge. It was Jo's decision but I think again the other bit of context is that we were doing that broader piece of work about how we evaluated what we were doing and what lessons we could learn from the first couple of years of regulating the NHS and so Jo thought that we could do this as a discrete learning exercise. I mean what she felt was that we'd messed up in not picking up in the first instance on what the non-executive had raised and so she was saying well we need now to take this very seriously, I mean, you know –

DR KIRKUP: I see, okay. Do you want to come back on anything?

PROF MONTGOMERY: There's just one thing I had on my list which I didn't ask directly about because I think you've probably covered most of it but Amanda Sherlock told us about the internal review of regulatory actions that she commissioned in, I think, October 2011, so it was after the stock take –

MS BOWER: Oh this is the ~~[Louise Direly~~ Dineley~~?]~~ review, yes.

PROF MONTGOMERY: And I'm guessing that actually much of its content you've described to us as you've taken us through step by step but I wonder what else that we haven't covered was picked up, or things that you reflected on about regulatory decisions?

MS BOWER: Well, what I – you're right. I mean I was, by October 2011, I was very, very angry about what we'd done about Morecambe Bay. I looked back at the last 18 months and I couldn't believe that we'd given assure – your favourite word Bill! – assurance to other people. You know, we had – I think by this time I'd realised that there was the investigation that we'd never done, I can't remember, but I was just furious that we had so badly got it wrong.

So Amanda and I agreed that she would get Louise to do this look back and then it took six months for her to do it which I was disappointed to say the very least that it took so long. It seemed to me it could have been done much faster than that. When she finally completed it, and I saw it in the March, I felt that – I was disappointed in it because it didn't do what I wanted it to do. I assumed – what it did was it described in general terms, I mean if you just read the report as it stands it's fine but if you look at it from my point of view, I had assumed I would get something that said 'Jonathan Montgomery went to Furness General Hospital on 3 May, he spoke to the Director of Nursing, the

Director of Nursing said 'Everything's fine' so he wrote it down and went away again'.

You know, I'd wanted something that at a very granular level made me understand why we had made those poor decisions which I don't think the report did. What it did it was it talked in general terms about the difficulties we'd had in registration, in getting going, in learning the new legislation, all of which was absolutely true. We had had all those difficulties but I'd been in front of the Public Accounts Committee, the National Audit Office had looked at this, the DH had done a capability review on us, all of that, all of those generalised problems about the start-up of CQC and the difficulties we'd had were in the public domain and had been discussed already. What I was expecting from Louise Dinely was something that said 'On 12 May – 'that looked at individual decision making and said – so I was very disappointed when it came. I felt that it was too generalised, it took far too long, it had been overtaken by events, we'd changed the training for the staff, we'd changed the judgement framework we'd insisted on having as I was saying earlier, topic experts going with you to look at specific areas, we'd insisted on experts by experience, so we'd changed our whole approach to – we'd looked at third party assurances in saying, you know, what guidance we gave to staff around that. We'd moved ~~through~~ Sue McMillan who was the regional director through that critical time, she'd moved to a non-operational job because I felt that a lot of the challenge should have come from her that didn't come is my personal view. So by the time we got it, it seemed to me to have been overtaken by events and it wasn't very specific.

But last but not least, it said at the end, all things considered we took all the right decisions and I couldn't believe it. Of course we hadn't taken the right decisions. It was far too lenient on us. So the report came, in fact I believe that Amanda had told the Board that we were doing that report at the April Board meeting when we were discussing – no it can't have been the April Board meeting but earlier on she had told the Board that we had actually asked for this piece of work to be done, I believe. But when it came I felt that it was far too late, far too generalised, too lenient on us and didn't tell me anything that we didn't already know and wasn't in the public domain. So that was my view of the Louise Dinely report.

PROF MONTGOMERY: And by implication then hasn't told us anything we need to know that we haven't heard already this afternoon?

MS BOWER: Absolutely not.

DR KIRKUP: Stewart?

PROF FORSYTH: No thanks.

DR KIRKUP: Is there anything that you would like to tell us that we haven't covered already?

MS BOWER: No, I think you've given me – I've been grateful, believe it or not. I'm grateful for the opportunity to come and describe some of the challenges that were involved in setting up the organisation and how that led to some of the inadequacies of the decisions that we took around Morecambe Bay. I'm glad I've had the opportunity to say I'm sorry for the role that we played and the role that I played in not uncovering poor care more quickly. As I said, at all times we were trying to do the right thing, prove we could be an effective

regulator. The last thing we wanted to do was brush things under the carpet. We wanted to really demonstrate that the regulator could be a good thing and improve care. And I believe that that's what we ended up doing and I'm sure that that's what's happening to this day but it's still a challenging, challenging thing to have to do.

DR KIRKUP: Yes, sure. Thank you. That's the end of the interview.

MS BOWER: Thank you very much.

[Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15 July 2014

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

Before:

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

JENNIFER BOWNS

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DR KIRKUP: Okay. We'll go again. Hello. Thank you for coming. I'm Bill Kirkup. I'm the Chair of the panel. I'll just ask the other panel members to introduce themselves.

DR WALTERS: Hi, I'm Geraldine Walters, Director of Nursing at King's College.

PROF FORSYTH: Stewart Forsyth, paediatrician from Scotland, from Dundee.

DR KIRKUP: You'll notice that we're recording proceedings and we'll produce a record at the end. You'll also know that we have family members present as observers of the session and others will be able to listen to the recording, if they want to do that. We want what happens in the room to remain within the room until we are ready to put all of the findings in the proper context; hence the removal of telephones, tablets, recording devices and so on, but also please remember that in terms of talking about what happened and any notes that you'd had. Do you have any questions about the process?

MS BOWNS: I understand.

DR KIRKUP: Okay. I'll ask a general question, if I may, just to start things off and then pass you over to Geraldine. Can you tell us when you started in the Hospital Trust and what you've done there?

MS BOWNS: At Morecambe Bay I commenced in early 1991 and that was until September 2012.

DR KIRKUP: Okay. And what have your roles been in the hospital?

MS BOWNS: I was the senior midwife and the supervisor of midwives.

DR KIRKUP: From the start?

MS BOWNS: In 1991, I was ~~assistant~~ A SISTER midwife and then I undertook my supervisor's course within the trust and then did the ALSO Advanced Support in Obstetrics course.

DR KIRKUP: Okay.

MS BOWNS: And then I trained other supervisors as well.

DR KIRKUP: Okay. And did you go on to something else in 2012?

MS BOWNS: I've taken up a post in Plymouth Hospital Trust, so I'm working there –

DR KIRKUP: Right.

MS BOWNS: But I was employed from March 2014.

DR KIRKUP: Okay, thank you. Geraldine.

DR WALTERS: Okay. Just give us a feel of what the Barrow unit was like to work in.

MS BOWNS: Because I've now worked in Plymouth, I can honestly say: old-fashioned, traditional. At the time, I thought we gave very good care as midwives to patients. I certainly have a passion for midwifery and I really felt that the care given by midwives to patients was good at the time. I mean, in the 1990s, women in the area wanted minimum intervention. The large ~~SET[?]~~ NCT (National Childbirth Trust) group didn't want ~~mytrol~~; they didn't want foetal scalp electrodes. And we listened to what they wanted. And as a supervisor I was quite passionate in taking that forward as well, yet it was many ladies that actually wanted very, very specific things within the labour and wanted the outcome to be normal.

DR WALTERS: But you're saying now that you work somewhere else, your view is different.

MS BOWNS: Society has changed dramatically. There's been a paradigm shift and women are getting larger, there's more diabetics. And women that in the past would not have had babies – women with heart problems, other problems, all sorts of medical complications – are having babies. In Plymouth, I obviously see a wider range of people. Predominantly in Barrow there is a white British

public, especially when I came in 1991. And there were a lot of women... I had trained in Glasgow, so I had come from Glasgow with... We had again quite a multicultural [group using?] the facilities. So I was... Yeah, it was very different for me to come to Barrow, after working in Glasgow. What was that original...? Question/Statement

DR WALTERS: Just you were saying that you felt that since you moved to Plymouth, you saw that Barrow –

MS BOWNS: A lot of the Barrow ladies did want what their grandmothers had had and wanted what their mother had had. If anything was suggested to them, they were quite adamant that they didn't want... Now, at that time we wouldn't have been in the habit of documenting that, whereas nowadays if a lady said to me, 'I don't want this,' or, 'I don't want that,' then I would definitely be documenting that.

DR WALTERS: And do you think then the midwives took the view of really, you know, this sort of supporting normality as far as possible? Do you think that was something that was perhaps taken too far at Barrow?

MS BOWNS: I can only say that now in hindsight, because I've got this helicopter view and I have seen outside the box. If I'd carried on working at Barrow... I would say there was a culture that made us feel as if we were doing the right thing at the right time.

DR WALTERS: Do you think that sort of caused a rift between the midwives and the obstetricians?

MS BOWNS: Not a rift. I saw that there were certain midwives that the obstetricians felt were very, very capable and tended then to take a back seat. And that's fine where everything is normal, but if a person hasn't been filtered properly

from the very beginning in an antenatal clinic when they've first been booking and highlighted with risk factors, it's too late by the time they reach the labour ward when they're already in labour, advanced labour. And you're short-staffed. And you're making all these big decisions.

DR WALTERS: Do you think the relationship between midwives and obstetricians was good? Compared to what you see now?

MS BOWNS: It's not so much the relationship that was bad, as the fact that the obstetricians vanished from sight and were more difficult to get hold of. Where I work now, they're there. Or you pick up the phone and they're there within *x* number of minutes. It's a multidisciplinary team approach. And towards the end, before I left, the obstetricians had been told to do certain ~~runs~~ ward rounds at certain times and that still wasn't happening.

DR WALTERS: So did you get involved in team activities as professionals, looking at incidents together or deciding on new policies as a team? Or did it tend to be...?

MS BOWNS: There wasn't as much of that as there should have been, but that was because the staffing levels had been reduced so dramatically that as a labour ward coordinator, I was always on the shop floor rather than attending as many meetings as I had in the past. So in the ~~19...~~ 1990s I would say right up until just before 2010, there were regular meetings – especially those advisory meetings and labour ward coordinator meetings, they would happen regularly, but when staffing levels had been reduced so dramatically, somebody had to look after the labouring patient.

DR WALTERS: So was that after 2010?

MS BOWNS: In my recollection, yes. The change of head of midwifery was in there, or just around that time.

DR WALTERS: So the staffing levels were perceived to have dropped. What justification was there for that?

MS BOWNS: Finance. It was cut, cut, cut, cut costs – all the time. And even the budget for training seemed to reduce dramatically. So again, where I see in Plymouth there's a tremendous emphasis on staff training and review meetings, that had dropped significantly there.

DR WALTERS: So were concerns raised about the staffing levels?

MS BOWNS: Yes.

DR WALTERS: And what was the route for escalating those?

MS BOWNS: They brought in... I can't remember the name of it now, a team that work out the ratio of patients to the number of staff.

DR WALTERS: The birth rate?

MS BOWNS: The birth rate. But again, I have to compare to Plymouth. When you've got a larger volume of women in labour and you've got a larger volume of staff looking after these women, you know, there's one of 10 people that can answer the phone, one of 10 people that can answer the door, one of possibly three that can sort out staffing levels, ~~and then~~ In comparison at Barrow you've got the coordinator looking after the labouring patient. It had become a situation where my role had extended to all these jobs, plus ensuring the patient was fed. On the last shift I worked there, we didn't even have an auxiliary; it was myself and one other midwife, because somebody had just got sick. So there were situations where it left us unacceptably vulnerable.

DR WALTERS: And what did you do in response to those? How did you raise the alarm?

MS BOWNS: We thought it was being dealt with by the senior management team. We had gone, the previous... I've kind of lost the dates and the times, but... The band 7s, we all had to be re-interviewed for a post because within the Trust, we were too many band 7s. But what that actually implied was that there were too many community band 7s, but we all were re-interviewed for a band 7 post, which was an incredibly stressful process to go through. And actually we ended up with not enough band 7 midwives for the labour ward.

DR WALTERS: So did they not increase your 6s? Was it not a strategy to do it so you've got a higher volume of people, but they were lower grades? Higher numbers, but more at a lower grade. Was that the outcome of that, or...?

MS BOWNS: There just seemed to be less staff around.

DR WALTERS: Did some people who interviewed for the band 7 post just leave, if they didn't get them?

MS BOWNS: Hard to remember. I think it was a couple that when they were interviewed, they didn't feel that they were band 7 material. And so they then got a band 7 from Kendal, which is a midwife ~~labour-~~led unit. But that's a quite a big ask to put a band 7 who's ~~mainly-~~been just a midwife for normality and you're suddenly working with the obstetric side of things.

DR WALTERS: So you felt that the numbers had gone down. In terms of the numbers –

MS BOWNS: The skill mix was probably poorer.

DR WALTERS: Yeah. So in terms of how many labouring women might you have had on a shift and how many midwives did you –

MS BOWNS: Well, it varied, like it varies in all units, considerably. You can have two labouring patients or you can have occasionally six labouring patients; you've still got the same number of staff. And if you're lucky, you can phone ~~London~~ around and ask somebody to come in from home. That would have really been the matron's job to do that.

DR WALTERS: Yeah. So how many staff would have been on during the day?

MS BOWNS: There's two on the labour ward and two on the maternity ward. And in the morning, especially if there's a caesarean section, there would be three midwives on the ward. So there's supposed to be five midwives at all times, but frequently towards the end, there was two – sorry, there were four.

DR WALTERS: And were people sort of filling in incident forms or anything like that, if you felt there weren't enough people to give the right level of care?

MS BOWNS: There were incident forms.

DR KIRKUP: Related to staffing levels, or related to particular episodes?

MS BOWNS: I can't.... All I can say is [inaudible] from the meeting to staff. I think some staff did, but just... Later, there were more incident forms. There wasn't an encouragement to do it. Again, that's a thing that actually has developed and it does happen. You need time to write incident forms as well, and time was very precious. We weren't getting breaks and we weren't... getting off duty in time

DR WALTERS: Who were the senior management who you felt should be dealing with it? Who was kind of responsible, do you feel?

MS BOWNS: Well, I felt I was responsible for the team members that were on with me. And I did my best to relieve them, so that they would get a break and so that they would be looked after and so that their patients got good care. I just

feel that in doing that, ~~it~~ I got left very vulnerable. It would have been the next step above me to make sure, you know, The Matron or the head of midwifery, that would be looking after...me

DR WALTERS: And was there much communication between yourselves and the matron and the head of midwifery, so that it would be sort of understood what the plan was and where you were heading, in a sense?

MS BOWNS: Not enough. I can remember on one occasion wanting to speak to the head of midwifery and we'd only sat down when she got called off, and that was her. That was difficult, because she was on three different sites. I was based at Furness General and I wasn't full time, so the actual logistics of being in the same place at the same time, I would've had to make a special appointment before to see her. But again, as I say, it's all in hindsight, looking back, that you can see lessons and learnings, and there are different ways of working. I think we were...

DR WALTERS: So I think there are some problems that were recognized from about 2008, weren't there, in terms of there being some serious incidents. What was the response in the unit to those? Do you think people thought, 'Gosh, we've got a problem,' or was it a case of, 'We've had some unfortunate episodes which just happened to have happened around about the same time'? I'm talking about what led to the Fielding report.

MS BOWNS: Yes, I think it would be fair to say we've had unfortunate incidents, rather than there being a problem at that point.

DR WALTERS: Right. So the feeling of the unit was, 'Actually, everything's all right but we've had a blip of unfortunate cases.' Do you think that...?

MS BOWNS: Yes.

DR WALTERS: So when the Fielding report came out, what was the unit's response to it? Did people think it was a good sort of summary of the situation, or fair, or over the top, not strong enough, or...?

MS BOWNS: I cannot honestly remember having a conversation with anybody about the Fielding report.

DR WALTERS: Did you read it yourself?

MS BOWNS: No.

DR WALTERS: So from your point of view in the unit, nothing much happened in response. Why do you think that was?

MS BOWNS: I think there's such a big gap in my memory for that period of time that... I think a lot of it is to do with communication, isn't it, from the top down. And if you're not in the right place at the right time, where these issues are being discussed, you can be missed.

DR WALTERS: So did you, from just a practicing midwife point of view, see any improvements put in place in the couple of years, or year or so, after the Fielding report?

MS BOWNS: I thought we even got worse.

DR WALTERS: Right. What happened?

MS BOWNS: Well... In the northwest, as you know, there was a huge amount of damage. Nearly every day – not every day, but on a lot of occasions, travelling to work there would be ~~[billables?]~~ bill boards to read. And then you'd arrive on the scene and there would be members of staff that would be upset and you need some time to talk and communicate. More staff would be off sick. When I first went to the unit, there was hardly any staff sickness at all, but the staff had started to become very, very stressed at work and...

DR WALTERS: You kind of alluded to this before: do you think the risk profile in the unit changed over the time that you were there, in terms of the sorts of clients that you were seeing?

MS BOWNS: Definitely.

DR WALTERS: And was the unit able to respond to that?

MS BOWNS: No.

DR WALTERS: Did any of the senior management come and speak to your unit around this time, 2008/2009?

MS BOWNS: No recollection of that.

DR WALTERS: Thinking in terms of incidents and risks and things that happen on all units, how were they dealt with? If something has happened and the outcome wasn't good, what was the general response to that by yourselves as midwives and the obstetricians?

MS BOWNS: It must have been done [fairly higher up, because I can only think?] – again, comparing it to Plymouth – if there's an incident, everybody has to write a response to it, with regard to a review, there's lessons learned from it, and there's taking the case forward. It's a very honest and open policy.

DR WALTERS: So you're saying that didn't happen?

MS BOWNS: I'm not saying it didn't happen; it's just whether... I wasn't relieved to go to a meeting like that. Where other people – I mean, I can't answer for everybody. I just haven't an awareness of sitting in a room with everybody discussing it. I am aware that, you know, the risk team, the head of midwifery and clinical governance, they were meeting but it just didn't seem to involve ~~RNL~~Registered Midwives.

DR WALTERS: So even if midwives were involved in an incident, they wouldn't take part in that?

MS BOWNS: There would have been discussions with the midwife and there would have been discussions with obstetricians, but whether it was all done together, I can't answer. I don't know.

DR WALTERS: Were you aware of things you saw happen that could have been avoided?

MS BOWNS: Do you mean big things like [inaudible] or...?

DR WALTERS: Just little things. Incidents are on a sort of spectrum, aren't they? Some of them are fairly minor and some are a bit more major. I'm just wondering if you had an impression of, well, actually that could have been avoided had *x*, *y* and *z* been in place, for example, or if somebody had made a different decision to the one they made?

MS BOWNS: Yes.

DR WALTERS: And was there any sort of closure of the loop, saying 'We were able to make decisions around this and this is how we could prevent this happening again as a team'?

MS BOWNS: It certainly hadn't happened before I left.

DR WALTERS: Okay, that's it for the moment. Bill?

DR KIRKUP: Okay, I'll pass you on to Stewart.

PROF FORSYTH: Was there resistance to change in the unit?

MS BOWNS: Yes.

PROF FORSYTH: Where did the resistance come from?

MS BOWNS: That's hard to say. I mean, coming in from Glasgow and working in Furness General at first, [I frequently heard?], 'Oh, we don't do it that way.' And after a while, you start to fit that.

PROF FORSYTH: You must have had some new midwives come in during the time you were there. Did they try and introduce or want to introduce changes? Was that prevented?

MS BOWNS: I can't think of any specific...

PROF FORSYTH: To put it another way, did the resistance come from midwives not wanting change?

MS BOWNS: In some cases. But as I said previously, in some cases it was the women wanting it the same way as their mothers and their grandmothers. They wanted their waters broken. They wanted, in some cases, you know, they did not want an epidural; they were quite adamant about what they did and what they didn't want. They didn't want a baby monitor. They didn't want any ~~[of the amenities?]~~interference. It was a very, very vocal group. And I think when you get a lot... Furness General is very much in a cul-de-sac and when you get people that live in the area and work in the area... Taking it not just a work level but a social level, the midwives had their families already, so as an incomer, for me to find friends and make acquaintances, I then tended to, you know, meet with newcomers. That's it. It took a long number of years to actually fit in.

PROF FORSYTH: So are you saying that you modified your practice to fit in with colleagues that were already there, plus also the views of your –

MS BOWNS: You learn. You do learn to work with what you've got, which I'm not saying is a good thing, but...

PROF FORSYTH: What about the relationship – you touched upon this earlier with obstetricians but also, for example, with paediatricians? Did they not want to try and do things differently?

MS BOWNS: Paediatricians?

PROF FORSYTH: Yes, and obstetricians as well. Did they not want to alter the practice to the other kind of activities that you're now experiencing in Plymouth?

MS BOWNS: They wanted to do less. As an ALSO instructor – Advanced Life Support in Obstetrics – it was part of our role. We were trained – because I had, obviously, been up and down the country – to involve the obstetricians as well as the midwives in training sessions. And we tried and we better tried to get the obstetricians to come to those sessions, and they always had excuses, apart from the new obstetricians. The ones that actually lived in the area and had been [inaudible] and working within it had their own agenda completely. And again, down in Plymouth, where we do mandatory trauma training, we actually go onto the labour ward, we do the scenarios, we go in and we re-enact the situation, and what we've been doing as midwives teaching, it was as if the obstetricians thought, because the midwives were teaching it, that they didn't need to know, even though they did know that we had been on a specific course and it was Advanced Life Support in Obstetrics, and we were doing it for the benefit of the patient wanting a multidisciplinary approach.

PROF FORSYTH: So, what about the paediatricians? What was the relationship between midwives and paediatricians?

MS BOWNS: It was very poor at that time.

PROF FORSYTH: Why was it poor?

MS BOWNS: Could I give an example?

PROF FORSYTH: Pardon?

MS BOWNS: Could I give an example?

PROF FORSYTH: Yes.

MS BOWNS: I had been on a full shift and I had gone home at the end of the day. I was called back in to the unit as the supervisor of midwives. It was three o'clock in the morning and there was a patient that had come in for an emergency caesarean section because it was an undiagnosed breach. I spoke to the paediatrician and said, 'Just to let you know, we're going to theatre. We've got an undiagnosed breach and she's having a caesarean section', and he turned round and said, 'I don't need to go.' I thought... he hasn't understood me properly ~~[inaudible]~~ I just said, 'It's an undiagnosed breach and she's going for an emergency section, so we're leaving labour ward and, if you want, I'll call when I arrive.' So, when we arrived in theatre, I phoned to say we had arrived in theatre, and he said, 'I've spoken to Special Care staff and I don't need to come.'

Now, you've got to remember that I had already done a shift. I've only been home in my bed a short time. It was three o'clock in the morning. The patient was very, very anxious, because she didn't expect a caesarean section for a breach. She's saying, 'Please, please don't leave me.' I spoke then to the obstetrician and I said, 'We do want a paediatrician here ~~[inaudible]~~ he is saying he doesn't need to be here for this delivery', and she said, 'Yes, of course we do.' So, I went back to the phone and I bleeped and said it was ~~[inaudible]~~the request of the obstetrician, 'We'd like your attendance, please.' When I went back into theatre, I was compromised because the baby was nearly born so, instead of the usual scrubbing up, I had to put on gloves very, very quickly to

receive the baby, and I watched as that... It was a difficult delivery. It took quite a while to deliver the head. You've got to imagine: here I am. I'm the one that's receiving this baby to take to the Resuscitaire, okay, and it's the middle of the night. I took baby to the Resuscitaire.

The paediatrician sauntered into the room. He looked around as if, 'Where are the gloves?' and because I said to him – which was unfortunate – I said, because I was tired and anxious, 'You're a disgrace to the profession', he then sent a letter of complaint to all the obstetricians, paediatricians, head of midwifery, and I was made to apologise to that paediatrician. So, instead of somebody saying to the paediatrician, 'This is your role and you should have been at that caesarean section', instead I was ~~[inaudible]~~reprimanded. So, that made it then... that made it very difficult to then...

PROF FORSYTH: So, when was that? How soon or how long ago was that?

MS BOWNS: Around about the time of all the troubles with ~~[inaudible]~~the Trust paediatricians ~~[inaudible]~~stated they had other jobs to do and couldn't just stand around waiting for babies to be born.

PROF FORSYTH: What about... were they involved in training yourselves [inaudible] care of the newborn infant?

MS BOWNS: Not on the labour ward. They may have done some training on the postnatal ward.

PROF FORSYTH: Were you only involved in the labour suite or did you do antenatal and postnatal as well?

MS BOWNS: I was a labour-ward coordinator.

PROF FORSYTH: So, it was primarily in the labour ward.

MS BOWNS: Yes. Initially ~~[inaudible]~~in 1991 I did a rotation so that I was aware of ~~[inaudible]~~The Maternity Unit as a whole.

PROF FORSYTH: In terms of resuscitation, did you get regular training on resuscitation?

MS BOWNS: I did, because I was teaching the Advanced Life Support so I was in other units as the trainer, and then taking that training. There was a specialist trainer as well within the unit, so we did that with the staff-training days, but it wasn't the paediatricians themselves doing that.

PROF FORSYTH: So, on the labour suite, midwives had to have the Advanced Life Support, did they?

MS BOWNS: All the coordinators, yes, but I was a teacher on the ~~labour~~ALSO course... They had been on the course but...were not teachers.

PROF FORSYTH: Yes. In terms of, again, the [inaudible] any issues of practice that you felt that staff could have prevented incidents? We've touched upon that but are there other aspects of training or supervision that might have helped them to perform better?

MS BOWNS: Communication skills, but that's where, if you practise in a multidisciplinary-practice setting, then you're used to interacting with each other. If you've got missing obstetricians and you're just teaching the midwives, the midwives get used to being with midwives. I was actually asked to do a training session with the obstetricians, and the session I was asked to do was cord prolapse. Because there were no medical students or GP trainees at the time – it was just the senior obstetrician and the staff grade – they showed absolutely no interest. I had given up... it was my own day off [inaudible] day

off and I think they were rude. I think they behaved like schoolboys. I was appalled.

PROF FORSYTH: Did you have much contact with the clinical director for obstetrics and gynaecology? Presumably, there was a clinical director for obstetrics and gynaecology? Did that individual communicate well with the midwives and listen to what your concerns were?

MS BOWNS: I don't think there was an emphasis raised on the fact that we were seriously concerned. And I think, again, that's... I can only say that in hindsight.

DR KIRKUP: I just want to pick up some points that have come out of answers that you've given to my colleague. I'll start with the [inaudible] you've spoken about a couple of times, which is that you felt that women in Barrow wanted a particular form of maternity care that tended to be a bit more old-fashioned and a bit more 'minimised', I think was the word that you used. Did that cause you to alter your practice as a midwife?

MS BOWNS: Yes, but when you're involved with looking after patients that require normality and were on the normal midwife-led pathway, that's absolutely fine – it's absolutely acceptable. Where you can, you have to be very, very aware of who follows that pattern and who really should be on a higher-risk obstetric pathway.

DR KIRKUP: When you say 'should be on a higher-risk obstetric pathway', does that mean to imply that, sometimes, people who should have been weren't on a higher-risk obstetric pathway?

MS BOWNS: Yes, I feel, honestly, I have to say that is the truth, yes.

DR KIRKUP: Can you tell me why you think that situation arose?

MS BOWNS: I think every healthcare professional who meets an obstetric woman should be actually making that risk assessment at each point of contact. So, if the person has started off with midwifery-led care, and then there's a shift, it should be highlighted. Quite often, we said that person was then under the umbrella of the obstetrician.

DR KIRKUP: If there was a situation where you were looking after somebody on the... let's call it the minimal pathway, just for the sake of brevity, that you thought was misplaced and should have been on the higher-risk obstetric pathway, isn't there a professional-midwifery duty to raise that – to say, 'Come on, I think they're not giving the right form of care for this woman?'

MS BOWNS: Yes.

DR KIRKUP: And were there instances when that didn't happen? It seemed to be implicit in what you said earlier.

MS BOWNS: Well, the answer to that is 'yes', but the way the question is answered, that then falls to the blame all the time of the midwives, whereas I didn't believe it was always the fault of the midwives.

DR KIRKUP: And I didn't suggest that. I'm asking specifically about whether, under those circumstances, there is a duty that falls to the midwife; not necessarily the only duty but a duty that falls to the midwife, and I think you said the answer to that is 'yes'.

Okay. Let's move on to something else. You mentioned the damage that you thought the newspapers – the *North West Evening Mail* – had done to staff morale and stress and sickness absence and so on. I just wondered whether you had reflected that maybe there was a reason for that happening in the way

it did. You were quite clear that you blamed the newspaper for that, but was there a reason – an underlying cause – for that?

MS BOWNS: I do feel that, up and down the country, there are losses to both mothers and babies [inaudible]. Nobody within the profession would want that to happen, but sometimes it does occur and it... I think if the Trust had a very open and honest policy, and parents realised that it's being investigated by the Trust investigation process, then probably the newspapers then do not get involved. But I am aware that ~~[inaudible]~~when the newspapers do get involved ~~[inaudible]~~they print sensationalist stories, but I can give you an example. I was looking after a young lady [redacted] who had delivered the baby. I hadn't delivered the placenta. I was in there. I was being completely respectful of her condition and she was on her mobile phone and she was speaking to her nan on the phone and she said, 'Yes, nan, the press are outside. I know they're investigating the hospital and the midwives. I'm in the process of delivery now.' [Inaudible] that she's not actually... [inaudible].

DR KIRKUP: You described situations where things had gone wrong and were dealt with by investigating, by following the duty [inaudible] affected by it, exactly what happened. Are you saying that that was going on in Barrow in those years, before the *North West Evening Mail* [inaudible]?

MS BOWNS: Well, no. I trusted the process. I trusted the fact that I believed that the senior management team and the risk team [inaudible] I believed that that was all under their care.

DR KIRKUP: You mentioned a process around investigating and discussing incidents that had happened, and you said you couldn't account for who was present when those discussions were happening, whether midwives,

obstetricians and paediatricians [inaudible] were there. Were you involved in any of those discussions yourself?

MS BOWNS: There were private interviews where I was asked to give an account of the events, but not... there were no obstetricians or paediatricians, or any multidisciplinary approach.

DR KIRKUP: I just want to be clear about that. What that means, then, is that there weren't joint discussions. Discussions were held individually with different [inaudible].

MS BOWNS: I can only give an account of everything that I was involved in [inaudible] I don't know.

DR KIRKUP: Yes, but if there had been joint meetings, you would have been involved in them.

MS BOWNS: Yes.

DR KIRKUP: We want to ask you some questions about individual cases and, therefore, patient confidentiality applies, so there'll be a brief pause while we ask the observers to [inaudible].

THE MORECAMBE BAY INVESTIGATION

Monday, 15 December 2014

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

Before:

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

ANGELA BROWN

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(At 3.50 p.m.)

DR KIRKUP: Hello, take a seat. We'll just have a short pause while we make sure the equipment's working. [*Sotto voce conversation*] We're okay. Okay, there's a glass of water there if you'd like one.

MS BROWN: Thank you.

DR KIRKUP: My name's Bill Kirkup, DR KIRKUP of the investigation. Thank you for coming. I'll ask my colleagues to introduce themselves to you.

DR WALTERS: Geraldine Waters, Director of Nursing and Midwifery at King's College Hospital

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

PROF MONTGOMERY: Jonathan Montgomery, I'm Professor of Healthcare Law at University College London and Chair of the Health Research Authority. In the past I've chaired PCTs and SHAs and provider Trusts.

DR KIRKUP: You'll see that we're recording proceedings. We'll make an agreed record. You may know that we've invited family members to be present as observers. As it happens we don't have any here this afternoon, but they may listen to the recording subsequently.

MS BROWN: Yeah, that's fine.

DR KIRKUP: You also know that we've asked you to hand in any mobile telephones or –

MS BROWN: It's gone.

DR KIRKUP: ...laptops or recording devices just to emphasise that we don't want anything to go outside of the room until we can produce a report with everything in context. Do you have any questions for me about the process?

MS BROWN: [*indicates negatively*]

DR KIRKUP: Okay, I'll start out with a general question, which is, can you tell me when you started in the relevant post? I think it was in the SHA, but perhaps you could confirm that.

MS BROWN: The SHA, yes, NHS North West. I transferred into that post – it would be in 2006, as the SHA started.

DR KIRKUP: Okay. Where did you come from?

MS BROWN: I was working in Cumbria and Lancashire at the SHA there, and I

transferred as part of the process.

DR KIRKUP: Okay, where would you have started at Cumbria and Lancashire?

MS BROWN: I started there in 2002. I was working at the North West regional office before, in the Department of Nursing, and I joined that substantively in 2001 but I went there on secondment in 1997.

DR KIRKUP: Okay. So, you've been acquainted with the Trust in one form or another since 1997.

MS BROWN: In one form or another.

DR KIRKUP: In one form or another – it wasn't a joint trust in 1997, I think.

MS BROWN: No, it wasn't. I was aware of it – actually, I think it merged around 1998, because there was a lot of discussion around that at the time. This was a merger with a huge geographic distance.

DR KIRKUP: Yes, indeed. And you continued in the SHA until it got wound up.

MS BROWN: Until it was disestablished. What I did was I saw the nursing and quality team through until the end, and then I took the job of Deputy Director Patient Experience, working with Gill Harris. The plan was that that was going to be part time, because I was reaching retirement and I'd sort of planned it as a staged change, so I pointed the Patient Experience Team, but I recognised quite quickly there was no way that was going to be part-time post.

It wasn't fair to the team, so I said, 'Well, I'm looking to go,' and so we appointed the team, pulled everything together, saw one or two possible successors and was ready to hand over, but also there were personal reasons as well. [redacted]

DR KIRKUP: Sorry.

MS BROWN: So, I wanted to spend that time, which I'm really glad I did, because it's time you don't get back.

DR KIRKUP: Absolutely.

MS BROWN: And you put so much on hold when you do these jobs that that was the reason, so...

DR KIRKUP: So, are you now formally retired?

MS BROWN: I'm formally retired; I retired a year ago. Sort of probably now reaching the point where I think, 'Hmm, would I perhaps like to do something on a sort

of part-time basis?' but I made my mind up that I wasn't going to do anything whilst I was looking after my mum.

DR KIRKUP: Yeah, sure thing. Thank you. That's very helpful. John?

PROF MONTGOMERY: I've just one more bit about background. Your professional qualifications and...?

MS BROWN: I'm a Registered General Nurse. I trained at Edinburgh University. I did the integrated degree course, started there in 1970, which also gave me a district-nursing course. I subsequently went on to do the health visiting training, which is when I came down to Burnley.

I went on to do a Master's at Manchester University, got an MSc with that. And I'm a sort of fieldwork teacher for health visiting, so it's a public-health community background, which is... I went up then through community management and went into the regional office, and that was for primary care.

PROF MONTGOMERY: Thank you. Can you take us through the main responsibilities of the Assistant Director for Quality and...? I don't know if it always had that name, but I've got something in front of me that has that name. But just take us through the job at the SHA.

MS BROWN: Yeah, it was Associate Director. I was responsible for patient safety and quality, but also responsibilities around nursing and the link with the LSA. The patient safety and quality – I had a team that I led for that, that picked up the different responsibilities around patient safety. And we developed a team to deliver that function. The nursing particularly was around nurse leadership and managing the nursing network.

PROF MONTGOMERY: So the safety was an overall brief, then.

MS BROWN: Safety and clinical quality, yes. So, subsequently we set up the patient safety action team that worked with that. Clinical quality developed into picking up the measuring of quality experience, the quality board, CQUIN, that area of work. The nursing – and that was very much in support of Jane Cummings, who had the nursing leadership, the 'Energise for Excellence' response to Francis – that area of work.

With the patient safety it was about the ~~incidence~~ incidents and the inquiries, but we also had within that picked up the Section 12 doctors' professional performance the issue of alert notices, so it was like many of

those teams, in that additional responsibilities join it. So, it was a combination of me leading, developing and establishing that team, because it took some time to build up. People aren't ready-made for these jobs; you have to work on those.

And then there were specific responsibilities that I undertook, deputising for Jane. Jane joined us in 2007, but there were other major projects that I did, and some of them are quite relevant in terms of my development as well, in that one of the first jobs I had to do was very much around MRSA. There was a great push on actually reducing the incidence and the work towards that, and that was very much in 2007/2008.

SHA assurance came in 2009, the September. Up until the October/November that was a detailed piece of work.

PROF MONTGOMERY: So, were you responsible for preparing the whole of the support for the SHA for the assurance?

MS BROWN: No, no – the quality section. After that it was very much the measuring for quality, improvement and pulling the indicators together. That was a piece that fed in nationally. In 2010, from March-July, there was quite a big inquiry around a particular organisation, and we had to review the PCT. And then in –

PROF MONTGOMERY: Was that one of ours in this patch or was it...?

MS BROWN: It was indeed.

PROF MONTGOMERY: We'll want to know about that.

MS BROWN: It was Tameside, and that was done –

PROF MONTGOMERY: That's fine, that's not in our patch then. That's okay.

MS BROWN: Right, sorry. I was just wondering what the patch was.

PROF MONTGOMERY: Yeah, Cumbria and [cross-talk].

MS BROWN: So, that was in 2010 and in 2011 there was another major incident that we were working with in Manchester, and again that was how you implement the major incident process. So, I had particular responsibilities and then I lead the team.

PROF MONTGOMERY: So, some of that's proactive in the sense of monitoring and surveillance of systems; some of it's reactive in relation to particular projects or issues that come up.

MS BROWN: Yeah, some of it was monitoring. Some of it was very much that kind

of project work. A lot of the work we also did that was within the team was around capability- and capacity-building, so we also did a lot of improvement work around patient-safety improvements, Safety Express, Patient Safety First – that kind of project work.

And then some of it was intervention, which was obviously what we did with major incidents.

PROF MONTGOMERY: Thank you. So, if I can ask you to focus on the bits of that work that related to our terms of reference, which were about University Hospitals of Morecambe Bay Trust, can I ask you first of all to talk through the monitoring aspect of that? So, you obviously knew of the Trust when you went to NHS North West, but I think it'd be really helpful lot understand how, if at all, University Hospitals of Morecambe Bay featured on the radar from the overall surveillance and monitoring process.

MS BROWN: Right. It featured, I think, initially in terms of incidents that were reported to the SHA. And when we first went into the SHA – because I think this is relevant as well – we had a really very small team, so it was really picking up the incident that actually seemed to attract particular concerns.

And so, clearly, when the Joshua Titcombe incident was reported, that was something that was flagged up initially.

PROF MONTGOMERY: And when was that flagged up to you? When did you become aware of that?

MS BROWN: That was in 2008. My –

PROF MONTGOMERY: Just to confirm, we know that's when it happened. That's when you became aware of it as well.

MS BROWN: Yes, it was reported, and my Assistant Director at that time, Linda Ward, came through and said, 'We've had a really serious incident at Morecambe Bay,' described what had happened, that the baby had been transferred – Joshua had been transferred to Newcastle.

He had developed an infection that hadn't been recognised. It had been completely missed. The chief executive had phoned to say they'd really let the family down, and was going to get an independent investigation underway. And potentially he was going to look – sort of looking at the clinical governance systems as well.

Certainly, from the first understanding of that, he was taking it very

seriously. We talked through what else could possibly be done, because he was in contact with the family, which is what we would expect, but he was having it investigated and felt that the Trust had responded appropriately with that, and we would see what happened subsequently with that.

I was also aware that there had been other incidents, maternal deaths, of which some work was being done with John Ashton in Cumbria, who was looking at the maternal deaths. Linda Ward was our Assistant Director for Patient Safety at that point, because the team got larger once we built up the patient safety action team, but she was also working with the children's team, with Anne Hoskins, so was very conversant with ~~[CMATS?]~~ CEMACH work. And she was in contact and had contacted [Marian Drazek?], who was the lead for the LSA. And they were making contact with John about what was happening around the maternal review, so there was work that was happening.

Some of the other things that we did also were I was in regular contact with the Healthcare Commission, seeing that as a priority when I first went. Steve Bennett was with the Healthcare Commission and we made a point of meeting every six weeks, every month, just to go through our main concerns. And so would share information around Morecambe Bay and there was that general dialogue.

PROF MONTGOMERY: So, Morecambe Bay featured in those sessions.

MS BROWN: It did, yeah.

PROF MONTGOMERY: And what was your impression of Steve Bennett's assessment of how significant those Morecambe Bay issues were?

MS BROWN: I think it was shared that this was an organisation to watch what was happening in – and making sure that they were following up on the incidents and that the right things were happening that would resolve the patient concerns, any failures that had been there – but they were becoming a learning organisation. It was that kind of conversation.

PROF MONTGOMERY: Would you have expected Steve Bennett to have that sufficiently high on his radar to have specifically handed on to his successor?

MS BROWN: I would think so. It was known by – it was certainly known by the Healthcare Commission, and subsequently at some of the collaborative risk reviews that we had, Morecambe Bay was included in those of concerns that

each organisation was aware of – and we would share that information.

PROF MONTGOMERY: And that's within the Healthcare Commission days.

MS BROWN: In the Healthcare Commission days, yes.

PROF MONTGOMERY: So, it would be surprising to hear that it wasn't flagged up in the handover to the CQC that Morecambe Bay was one of the organisations to watch.

MS BROWN: It would be surprising, yes. I would have expected that to follow through. I think it is always the case, when organisations transfer, that you do lose information. I mean, we know that; that's what happened. But we were having conversations about Morecambe Bay, yes. And I think the Healthcare Commission were dealing with a whistleblower incident that they were following through at the time.

The other thing that we were doing with Morecambe Bay – and in fact with all organisations that weren't Foundation Trusts – is that, as an SHA, we used to contribute to the healthcare standards declaration, so we would look to see which organisations had outstanding actions plans. And I've not been able to track – I've sort of had a fortnight to reacquaint myself with Morecambe Bay, so my head's full of detail and some of it isn't there.

But my memory is that in Morecambe Bay there was a technical standard that it wasn't compliant with, and there was an action plan around that, but a lot of these – this was the time of self-assurance, and it was kind of a hole that sometimes things disappeared into, but we were looking at it from both those perspectives.

But it was the incidents that flagged it up first for us, so that's when it came onto the radar, but we actually felt that the Trust response was quite a robust one that was, 'We've got this wrong. We've got a problem and we need to put it right.' And, certainly, Tony then followed that up with the clinical governance review that Charles Flynn undertook later and also the LSA was involved, because of the midwives, and needed to pick up the supervisory investigations to look at what had happened.

PROF MONTGOMERY: We'll come back, perhaps, to that in a minute. You described the two things, the John Ashton work around the other incidents and the Joshua Titcombe death coming to our notice. How did those two things connect together?

MS BROWN: They connected, because there appeared to be a cluster of incidents that had all happened in that sort of 2008 period. They were all different, but they'd all come together. And, having had the two maternal deaths, one was quite late in being ~~recorded~~ reported, because it had happened in the community. What John's concern was, 'Was that more than you would anticipate? And was there a problem?' and he was wanting to look at that.

PROF MONTGOMERY: And what did he conclude?

MS BROWN: I've never seen the results of that. I know we discussed it later when we had a meeting when we were handing over the management of serious untoward incidents with the PCT, and that happened in the June. It was discussed about whether this was an unusual number, and part of the issue they were looking at was the ~~CMATS~~ CEMACH information. And Morecambe Bay was not seen as an outlier, but that information was not broken down into unit level; it came at Trust level. It wasn't seen as the outlier, but you get into small numbers.

PROF MONTGOMERY: That ~~CMATS~~ CEMACH data – was that related to 2008? Was that available by June 2009 or was it earlier?

MS BROWN: I'm trying to remember the discussion. In the 2009, we were waiting for that information to come out, so some of it had been early information that was indicating they weren't an outlier, but they were looking for more detail and I think John wanted to do some more detailed work around it.

PROF MONTGOMERY: So, that's the statistical outlier question, but there's a second question, which is, are there any common themes to this cluster? Have you discussed them?

MS BROWN: Some of that came up when we were moving into the Foundation Trust early work, which is when I was asked by the team to look at these incidents. I wasn't an integral part of the Foundation Trust process, but I was asked by the team to look at them. And Tony gave me all the information and the reports and sort of laid them out and matched them to see what was here, really.

And from that perspective, when I looked at them, there was what happened to Joshua, which was neonatal sepsis which had not been recognised – and that was very much round systems failure. There were some individual errors in that, but a lot of that was systems failure.

Another was the stillbirth, which was Alex Brady. Some of these I didn't know the names of; I've come to known them later. When that was failure to monitor and prolapsed cord, and it had been a difficult birth, a dystocia, and that was very much about an individual midwife.

The further one was the amniotic embolism, which my understanding of that – and I'm not a midwife, but my understanding of that is actually that was difficult to predict. It was a devastating event, and then the other one was the lady who had died in the community and there was possible cardiomyopathy underlying condition, which seemed different at that stage.

So, they'd happened in the same area, but they seemed to be from different causes, but it was sort of the clinical team. So, could those have been related? They might have been, but it wasn't immediately obvious.

DR KIRKUP: Can I just clarify when that ~~look~~ telephone call with Tony Halsall took place? When would that have been?

MS BROWN: That was probably around April.

DR KIRKUP: Of?

MS BROWN: 2009, because that was when I was approached by the team, the Foundation Trust team, to go through with Monitor what we thought these incidents were and what was happening. I was very much on the patient safety track. 'Have they investigated them? Have they looked as to what the issues were? Have they got action plans in place? And is it being monitored?' But at that stage it was, 'These are what the particular incidents are.'

DR KIRKUP: Okay, sorry, I need to be absolutely crystal clear about this, because this is an important part of the time sequence of events. In April 2009, who was it exactly who approached you and said, 'Have a look at these incidents?'

MS BROWN: It was the Foundation Trust team that approached me.

DR KIRKUP: Who's the Foundation Trust team?

MS BROWN: The SHA.

DR KIRKUP: The SHAs, right, okay, got you.

MS BROWN: Sorry.

DR KIRKUP: No, no, I didn't know you had a Foundation Trust team, but that makes perfect sense now.

MS BROWN: There was a team within the SHA that were act managing the Foundation Trust programme.

DR KIRKUP: Okay. And in April 2009 they said, 'Cluster of incidents...' Did they say where they'd heard about them from?

MS BROWN: It was Monitor, who'd contacted Mark Ogden at the SHA and said, 'We're looking at Morecambe Bay's progress towards becoming a Foundation Trust. There appear to be incidents. Please could you look at them and give us some information about them? And then if you could contact Miranda Carter...'

DR KIRKUP: Okay. What information did you have when you looked at the incidents? You said that you were there and Tony Halsall was there, but was anybody else there?

MS BROWN: Sorry, no, we did this by phone. How this happened was they came through to me. There's a time constraint. I pulled the information. I asked my Assistant Director, 'Can you get me the information on the incidents?' so I had the STEIS reports in front of me. I rang Miranda at that point and said, 'These are what we have. These are the incidents,' and explained the process whereby we would be performance-monitoring them.

And she was asking me two quite specific questions. And one was, 'Were there more incidents than we would expect? And were they connected?' And from the information I had in front of me, I gave her what I could at that point, but they I said, 'I need to ring you back. I need to go back to the Trust.' I then rang the Trust and Tony sent me the information in terms of the investigation reports. At that –

PROF MONTGOMERY: Can you remember which they were? This is a crucial place in our timeline to understand.

MS BROWN: I realise that, and I'm desperately trying... There was certainly the independent investigation and the review from Joshua Titcombe.

MR BROOKES: So, you didn't receive the root-cause analysis.

MS BROWN: That I saw was the chronology, and then there was – part of that also included the questions they asked. And so it was set up in a root-cause analysis format, in that it identified what were the issues that had come out of that.

DR KIRKUP: And this is the external review of the Joshua Titcombe case.

MS BROWN: No, it was... I got the external review as well. That was done by –

DR KIRKUP: Chandler and Hopps.

MS BROWN: Yes.

DR KIRKUP: Okay.

MS BROWN: So, I've got that as well.

DR KIRKUP: So, what was the other thing that you had for Joshua Titcombe, the chronology? That was the internal document.

MS BROWN: Well, it was the internal report. There was a chronology and then underneath it – it certainly gave the impression of root-cause analysis, and that was actually some of the standard we were getting from organisations at the time, because the abilities around root-cause analysis right across the patch increased over the years. This was a skill... For clarity I had the Trust's internal Investigation and the Chandler & Hopps report for JT.

DR KIRKUP: Yes, I understand that. But what –

MS BROWN: But that's how it was at the time. Pardon?

DR KIRKUP: Can you remember what documentation you had for the other cases?

MS BROWN: This is difficult, because I got some of them later when we were into some of the complaints and the analysis. Can I be 100% specific? Because later I did get both the Alex Brady and then the Hendrickson root-cause analysis as well. I got those later, particularly when we were looking at the complaints.

MR BROOKES: How much later was that?

MS BROWN: That would be – let me concentrate. It would be in 2011, because that's when the complaints came in from the family. I can see emails coming from Tony saying, 'And I'm sending you this, and I'm sending you that,' so it may well have been that I got the root-cause analysis, both for Alex Brady FA I did not have the Alex Brady RCA in April 2009 AB was not discussed with PCT in June 2009. and for the Hendrickson case, at that time, because I think they were done, because I think we had a discussion about them at the meeting with the PCT.

But I then looked at what was there and mapped out what seemed to exist in the root-cause analysis – had that moved on into action plans?

MR BROOKES: Sorry, I just want to be clear in my head. So, I know what you had for some, but in terms of Brady and Hendrickson, what did you actually have

at that initial stage?

MS BROWN: And that's what I'm struggling to remember. When I got them...

DR WALTERS: Not wanting to throw you off, but in April 2009 had they already been reported to STEIS?

MS BROWN: Yes. The StEis records I have located indicate that they were reported. Each document has an audit trail

DR WALTERS: So, you already had them on your system.

MR BROOKES: Well, they had the initial STEIS, because there are different levels.

DR WALTERS: There's an amount of detail that actually goes on STEIS, isn't there?

MS BROWN: There is.

DR WALTERS: So, they had already reported them to you at that point. FA. They had been reported to the SHA

MS BROWN: They had already... Yes, they had.

DR WALTERS: Right, before Monitor said, 'Have you seen it?'

MS BROWN: Yes, because that would have happened in 2008. FA. No I had been advised I had not seen the StEIS report.

DR WALTERS: Right.

MS BROWN: And it was when we were reviewing them for the...

DR KIRKUP: There's a different version of when they appeared on STEIS.

MS BROWN: Right, okay.

DR KIRKUP: You just need to be aware of that. Actually, some of them were STEIS'd later in the process. FA 1 maternal death was reported late.

MS BROWN: Okay, right.

DR KIRKUP: And you don't recall that.

MS BROWN: I... It was the team that – and I'm sorry. I'm really trying to remember.

DR KIRKUP: Yeah, I appreciate that.

MS BROWN: Some of them you look back and you can't remember when you actually got the information.

DR KIRKUP: Sure.

MS BROWN: I certainly remember the conversation with Tony about what were the incidents. I also remember that when I spoke to Miranda the incidents that I have knowledge of were going to have been the Brady case not correct I heard about this in July, the Hendrickson case, the Titcombe case, the lady who had died in the community – and the fifth one that I had was another

neonatal sepsis that was later removed, but it was put on the STEIS because they thought there might have been transmission.

So, I had the conversation certainly with Tony about, 'These are the cases.' There were inquests happening. What I'm really struggling to remember, unless I could get into my emails to say exactly which ones came in then, but I had that level of detail to know that there were perhaps distinctions between them, as I've described to you, as to what I understood as to possible connections. And then I had the conversation later with Linda and understood where we were with the CMATS data that would say were they more than expected.

I think the other thing to say, also, about being able to answer that question is that we knew that not all incidents were reported on STEIS – there were a lot of unreported incidents – and not all organisations were reporting on STEIS, so you only ever know what sits in front of you. And, actually, reporting is good because then you can see it and you know what has happened and you can start to put that right.

But certainly, because I know I did briefings around it and what my was – that was clearly described in a briefing I sent to CQC as well as one that I did for the DH as to what I understood. We did have a joint meeting with the PCT, and you've probably got those minutes anyway, at which we went through the incidents, what was known, and there were clearly some inquests.

The one we were clearest about, I think, would be Joshua Titcombe.

PROF MONTGOMERY: I can see –

DR KIRKUP: I want to come back some specifics, because we're talking about generalities now.

PROF MONTGOMERY: I can see from those minutes a very clear tracing-through of the numbers question, and I can see a clear tracing-through case-by-case. What I can't see is the question, were they linked or not? Was that asked again at that stage? Did you ever go back to that question? You formed a view in April on the information you held.

MS BROWN: I formed a view that I couldn't see they were linked, but, you know, information keeps getting added. We then began to – what you might see in those minutes, certainly from my recollection, is that there was a

consideration that in fact the women had come from Asian backgrounds. And I remember Sue Page asking, was there some public-health work that needed to be done around that? And I think the other issue that seemed to be a common feature was very much around the diabetic care, so that came up.

So, I think the only time that we – that was the one I had with Miranda, when it was, are they linked or not? And my initial view was, well, they seem to be different. I'm not clear that we came back to that. I think it was more, 'Let's understand more about the incidents. What is the background to that? What else might we be missing?'

PROF MONTGOMERY: That's quite important, because we haven't found any other point at which that question has been asked in the SHA, so if you do, as we go on in the conversation, think of another point where you might have come back to it, it would be really helpful to flag that up, because it gets repeated a number of times in briefings that the question's been asked whether they're linked or not and the SHA view is that they're not.

And the only person who's been identified by anybody we've spoken to who's actually asked that question is yourself at this point, so it's really helpful for us to understand how that happened.

MS BROWN: Yeah. And, I mean, I can understand that. yeah memory is the first time we discussed that was with Miranda and she raised the question, and I think we got into, are they linked and what might the links be and what do we need to do about it? So, that was a conversation that happened there, and then obviously it's laid there and has kept –

PROF MONTGOMERY: I understand that. It does keep being repeated, but we're just trying to check whether anybody else other than you had been able to ask that question or whether anybody had asked you to just confirm whether, in the light of any additional information, you still had that view. This is correct. I was unaware until the interview that the view that "the SHA said the incidents were not linked" existed and was being repeated.

MS BROWN: Well, curiously enough, nobody came back and said, 'Do you think they're linked or not linked?' because, actually, with all patient safety, you just keep finding out more and more and more – and it develops. And that's what it did continually with these cases.

I think another point that has struck me since – because we changed this later in the SHA – is that at that time we worked in parallel and we had conversations that went through, whereas in later years, when the quality was much more central to the process, is that it became integral.

And the point where I really felt, 'We've got this right,' was much later when I joined the board that actually reviewed the Foundation Trust, because you then have a rounded conversation and everybody carries information in their head and then they share it. And you think, 'Well, if I understood that, I would have asked that.'

PROF MONTGOMERY: When did that happen? When did that board get created?

MS BROWN: The process started to take shape, I would think, in late 2010, because then the Department of Health were wanting more of a quality input, so our team – together, we devised a process whereby we met the Trusts; [redacted] we went through that. And it sort of probably took six months.

We did a visit to the Trust, and that supported Mike Cheshire, who then needed to go to Sir Bruce Keogh, but then also answer the DH questions. And then we took another leap, which would be in 2012, which is when I joined the main group, and then we had the proper conversations about it.

PROF MONTGOMERY: Okay. This is quite important in our timeline, but you may not be able to pin it down. Do you remember when in 2010 that first stage of bringing stuff together to brief Mike Cheshire to take to Bruce Keogh's group – do you remember when that emerged?

MS BROWN: Well, it was certainly taking place in 2011. By the end of 2010, Mark Thorne, who was the person I'd tended to work with, in the Foundation Trust team, said, 'Actually, we want much more from quality,' so we started getting heads together to figure out what that should be. And that was well underway by 2011, because suddenly there was a long list of trusts that we needed to visit, and it was very detailed work, was that.

PROF MONTGOMERY: And were you asked for information in the earlier part of 2009? Because in February 2009, the SHA's had to brief the Department of Health and it's had to recommend to the Secretary of State that the organisation goes into the FT formal application process.

MS BROWN: The first contact I'd really had about that was April 2009, and it was

very specific to Morecambe Bay, which was the case of, 'What's happening with these incidents? Can you tell us?'

PROF MONTGOMERY: So, if those incidents had been reported on STEIS promptly, they would have been in the system by February? Might anybody else have accessed those or would it only have come through you?

MS BROWN: STEIS was managed by our team, and they would have come through, but at that stage there was one person who was looking at STEIS and we inherited 1,400. And there were large numbers, so this was just picking up what came. FA. 4 people had access to STEIS 3 Assistant Directors 1 Admin Assistant

PROF MONTGOMERY: Okay, I don't want to put words into your mouth, but do you think you would have known if someone had been trying to find out what was held on STEIS about this trust in order to brief the Department on what to say in that process in February, would you have know that that question had been asked or could it just have been asked without coming through you?

MS BROWN: Well, we had it password-protected, so only certain people could actually go on. It might not necessarily have come directly to me. It might have gone to Linda. What you can track with STEIS is –

PROF MONTGOMERY: ...who's accessed it.

MS BROWN: '...there's an audit trail behind it. What you may also know is that STEIS was a very difficult beast.

PROF MONTGOMERY: I know. We do know that, so we're not –

MS BROWN: And you will have heard that.

DR KIRKUP: I don't know. *[Sotto voce conversation]* I wouldn't say that.

MS BROWN: Sorry? I mean, it's wonderful in that it's a real-time reporting system, but making sense of the data...

PROF MONTGOMERY: So, in February 2009 you've no knowledge of being asked that question. In April 2009, you know it's being asked, prompted by Monitor, and then you've pulled together the information you hold within the SHA, you've been supported by Tony Halsall by providing further information for you to have a look at that.

MS BROWN: Yes.

PROF MONTGOMERY: You've formed a preliminary view, shall we say, on the basis of what you knew at the time, that both the answers to Miranda Carter's

two questions are, as far as you can tell, this isn't a bigger number than you'd expect.

MS BROWN: Yeah, I said, '~~CMATS~~ CEMACH is not suggesting it's an outlier.'

PROF MONTGOMERY: Yes, yes. And as far as you can tell there aren't obvious connections, but you follow that up in June at the handover of the SUIs to the PCT, and at that point the possible connections are an ethnicity connection and a diabetes-care connection.

MS BROWN: Yeah.

PROF MONTGOMERY: Okay. Can I ask a bit more about that SUI transfer process? Because you didn't have to transfer the SUIs at that point to the PCTs. You had to form an assessment of whether they were ready to pick it up, so...

MS BROWN: Yeah. When we sort of first went into the SHA and we saw the size of the incidents, we knew that at this distance there was no way an SHA could have good oversight of every single incident that was reported within the Trust. And in Cumbria and Lancs we'd had 24 organisations and we now went up to having 60.

And, actually, for good SUI management it needs to be local scrutiny. It doesn't work at a distance. You need to understand how that organisation's working. We'd sort of looked at the resources and it was very clear that this was going to be a strategic job, that there weren't additional resources until we got the [PSAT?], so it was very much, 'How do we do this?'

And I think what's also recognised with patient safety is that knowing what incidents provide will only take you so far. It won't bring you the step change into patient safety. You've got to go into the improvement global trigger tool – and improvement like the safety programmes.

So, there had been a previous piece of work in the former SHAs. It went under the name of ~~[RITZ?]~~ RIITS. Don't ask me what it stands for, but it was around re-developing STEIS so it was a much more flexible system and that would be based around the commissioners, because that was going to give them the local oversight and recognise that Foundation Trusts weren't accountable to SHAs, so we had to get those accountabilities right.

So, it was clear that a priority was moving towards the delegation of serious untoward incidents or, certainly, bringing serious untoward incidents into the management system of commissioners. That had to be our priority.

So, in order to do that we set up a series of workshops to explain how that would work, the policies, the protocols, and we put some time and effort into working with the contracts team and we went into the contracts FA SUI REPORTING & the StEIS PROTOCOL WENT INTO THE CONTRACTS, so it all sort of came together.

We went out for early implementers who would be interested in joining us, and Cumbria was an early implementer. North Lancs came later. We'd also tried to devise this system around what was then the Lead Commissioner, so for local scrutiny you need to see all the incidents so you've got the picture and the pattern.

PROF MONTGOMERY: Who was the Lead Commissioner at this point?

MS BROWN: Well, it was different, because it was –

PROF MONTGOMERY: I'm slightly glad you said that, because we're struggling.

MS BROWN: It was – Lancashire and Cumbria were both equal commissioners, which was going to be problematic and –

PROF MONTGOMERY: But only Cumbria was picking up the SUIs at this stage.

MS BROWN: Yeah, North Lancs came on, probably – and I can't remember exactly – maybe a year later, but Cumbria was keen to take that over. Certainly, a lot of the push came from John, keen to have oversight of those incidents, but it really made sense, because Cumbria was a long way away and you were getting the oversight in early.

We used to have these – we ran a series of workshops and then we ~~sent~~ SET some criteria that would enable us to have some confidence, and we looked at those. There were executives that had responsibility. There were operational people managing STEIS. They'd been through the workshops; we'd talk them through the process, the policies in place.

So, with those three, Cumbria met those criteria, were keen to take those over, so we proceeded with that – and that then led to the handover arrangement that we had with that meeting. You will have seen in the minutes saying, 'You've got another commissioner here. You need to work closely with them on the SUIs.' I know Linda Ward, who was leading this project for us, ran a joint workshop. She got them both together and said, 'You do need to have some joined-up arrangements, so that you can see what is happening.

And sometime later – I think it was in 2010 – is when Linda had left and Sue Bothwell became the Assistant Director that worked with Cumbria and Lancashire. She did further workshops with both commissioners and the Trust to try and get some commonality about how incidents were reported, because they had different expectations.

And I think the Trust had said to us that they found it quite difficult going in two waves. They had different expectations and later felt as well that the commissioners would have wanted potentially different solutions for the Trust, in that Lancashire would have had a wish to pull Lancaster out, whereas Cumbria wanted to keep it together, and I think that brought in a tension which sowed itself right in the management of the SUIs but also in the whole management of the Trust.

But what we did was that work in trying to have those workshops to go through common agreement of how that process might work.

PROF MONTGOMERY: Thank you.

MR BROOKES: Sorry, can I just ask on? Did the SHA retain STEIS and an oversight of STEIS across the patch or was it over time completely devolved to the PCT?

MS BROWN: Certainly when we got the PSAT in place and we were doing the delegation, a member of the team would review each incident. And we had a protocol as to what would stay with the SHA. For example, we did [an accountability around mental health once, so?] they always stayed with us. But they would look at them and make a determination as to whether that would go to PCT, whether it would stay with SHA. If it then went to PCT, it went out to the PCT and, latterly, what the team did was review those incidents, talk them through with the PCT, and agree closure.

I think the long-term view was we'd looked at it as having this delegation process, and then we might reach a time when in fact all of them went out to the PCTs and the PCTs would be flagging up to us, 'Actually, SHA, this is one we've got a concern about.' We never quite reached that point; it was always the delegation.

The other thing which was hugely problematic was STEIS itself, not only in its quality of information but the fact that in trying to arrange the delegation you had to do it one at a time, because if you tried to give blanket

delegation it was all the PCTs could see everything and you had breached the sort of need to know – and that one tied us up quite considerably. And I think we'd always hoped that if we got ~~RITZ~~ RIITS or any sort of later iterations we would have been able to move that forward,.

But in answer to your question, we had oversight of each of them in terms of reviewing that incident. What we got better at later when we had the full team and support staff to that team was to be able to meet the different organisations and go through them, because we began to pick up problems of incidents clearly not being closed and open for a long time. And what was the reason for that? I think it's multifarious.

MR BROOKES: And I can understand the management of the process there. Was there any work being done at the SHA in terms of looking for patterns around particular incidents, both within an organisation and across the piece as well?

MS BROWN: Probably – and, again, I'm trying to remember some of the sequence of that. In around 2010, we'd appointed by then somebody who was a patient safety manager, who was helping us with the technicalities of STEIS. And we had made contact with other SHAs, because one of the things we did fairly early on was resurrect the SHA clinical governance leads. I used to chair that group. We came to an arrangement with the patient safety team in the Department of Health and had then a good link with the NPSA and they used to run study days for us, and we had a good discussion about STEIS, about how you could download information from that.

And, on the basis of that, we then were able to look at how we began to download. And in 2010 we began to pull information down. It was – STEIS was always changing, so it was really difficult to get accurate information, but we began to be able to look at different patterns of reporting and timeliness against numbers. We did it on admissions.

So, we could compare NPSA data and we could compare STEIS data for specific areas. We could manage that by 2010. What we struggled with was actually particular types of incident, because they were reported differently. And the category of 'other' was always quite large. We sort of had to unpick all of that.

So, we were beginning to do that by 2010, and we did look at Morecambe Bay as part of that. And they were middle of the pack. They

were a good reporter by 2010. They were coming up as timely reporters, good reporters and they weren't outliers for – because we still had some organisations that weren't reporting at all by STEIS, so they were giving us a pattern, in 2010, of improvement. And that was good, but we struggled to get reasonable data about types of incidents.

MR BROOKES: Yes, thank you.

PROF MONTGOMERY: Can I just ask you about the Fielding report?

MS BROWN: You can.

PROF MONTGOMERY: So, you've had a discussion in the April with Tony Halsall and he's also been involved in those June discussions. And I think our understanding is at that point, when he was thinking of commissioning the Fielding report, he'd had a conversation with you about who might be a good person to approach. Is that your memory?

MS BROWN: Yeah, that's true. It happened in a discussion as part of this sort of information-gathering process around STEIS and all of the – sorry, around the Foundation Trust process of the incidents.

I had met with Jackie Holt and Angela –

PROF MONTGOMERY: Oxley.

MS BROWN: Thank you. And they were at a nursing network, and I'd explained that Monitor were asking us to look closely at these incidents. Angela at that point was telling me – she said, 'You know, so much has changed. We've changed the way the supervision interviews are done and we've got a protocol around babies with sepsis and we've tested it and it worked.'

And I said, 'There's a thing about the different reports that you've got that's a potential hole in the middle, in that you've had the independent investigation that's looked' – and it had been a case note review; that was clear by that point – 'and it's identified that you've got some major issues in terms of knowledge around neonatal sepsis and [inaudible] and all the systems part. You're having a clinical governance review done and that's telling you progress is being made, but you've still got some gaps. The LSA is over here. What you need potentially, what might be useful' – so, it was advisory – 'is you've got a gap in the centre.'

PROF MONTGOMERY: And this was mid-2009 you had this conversation.

MS BROWN: Yes. And I said, 'I just feel that for further assurance you need to look

more deeply at this.'

MR BROOKES: Can I just be clear, for my own head, what you mean by 'the gap'? What was the gap you identified?

MS BROWN: When you've had three reports that come from a different perspective, you may well have covered everything – but you might not have done. But some of it you don't know, sometimes – you don't know. And asking further –

DR WALTERS: So, that's the LSA, the individual clinical reports.

MS BROWN: There were the individual clinical reports, but what I was looking at was the additional reports that had been done to the initial root-cause analysis.

MR BROOKES: So, this is the Chandler/Hopps report and also the Flynn report.

MS BROWN: The Flynn report – and what was happening with the LSA report.

MR BROOKES: Okay. So, the potential gap could be, 'There are some systemic issues underneath.'

MS BROWN: That they haven't gone far enough to pick up what those systemic issues might be.

DR KIRKUP: Just to be clear, this is a gap in our understanding of the past as opposed to the present. I think there are three things that might be going on. One is, 'We've looked at these things that have happened and we might not have seen anything.' So, that's one gap. There's one, 'We have some action plans in place. Do they address all the things that have come out of those reports?' And then there's, 'Have those action plans worked?' which would be more future looking.

MS BROWN: Yeah, 'Have the action plans worked?' would have been much further in the future. I think certainly in 2009 it was, 'We have action plans in place.' What we don't have then is the impact and outcome question. 'Will they address everything? Will we know they have worked?' That comes further. This was around, 'Have you understood everything that has happened that is important? Are you certain of that?'

Some of my experience has obviously been with the large mental-health investigation work that we had. The standard practice then was there might be an internal one, and then you have a big one that covers everything, like the work that HASCAS did, that you absolutely know. And some of this was instinctive, that I just felt, 'This doesn't feel as though we've

covered everything; it's really important that we do for further assurance.'

MR BROOKES: So, would you have expected that piece of work you're describing – I just want to be clear on this – to have looked at whether there was an interrelationship between those cases?

MS BROWN: Yeah.

MR BROOKES: ...and whether there were some underlying issues, which may have manifested in different ways in those different cases but was there?

MS BROWN: Well, I think at that point in time we were talking about the Titcombe case, because that specifically was the one that had been systems failure. And it was just having that extra assurance underneath it. They came back to me – because I'd worked with Pauline before on another one, and I knew she understood clinical governance.

She's worked for CHAI before and she'd had that background, because they said, 'Do you know someone?' and she was the name that came to mind as a possibility. I wasn't saying that she was the one who needed to do it, but it was somebody who would be able to help her, but I said, 'You need to discuss that with the Trust.'

DR WALTERS: So, just to be sure, the Fielding report – did it originate from you talking to Angela and Jackie or were they asking you for ideas on who might do something? Was it their suggestion?

MS BROWN: No, it was my suggestion.

DR WALTERS: Okay.

MS BROWN: And that was really as an SHA giving feedback and advice on what you've got, because on the initial sort of sight of this it was, 'This has been really well investigated. It's all got the different reports,' but there's a risk with different reports unless somebody actually brings them together.

MR BROOKES: And then maybe commentates, which individual reports don't.

MS BROWN: Well, I was originally looking particularly at what had happened to Joshua, but when they came back and said, 'This is something that's really important,' and it was the Trust who then said, 'Actually, we're going to ask Pauline to look at something different, looking at the issues from all the serious untoward incidents,' and I thought, 'Actually, that makes sense.' And it was what was of value to them.

PROF MONTGOMERY: So, your understanding of what they were commissioning

was a report to investigate that group of potentially connected but possibly not connected incidents.

MS BROWN: Yes, it was – they said two things to me. One, that they wanted to pick up all the other incidents but also have a piece of work that would enable them to move forward, and that actually made sense as going to another stage to give them additional assurance, which seemed to add to that.

PROF MONTGOMERY: And did they seek any advice from you on the terms of reference?

MS BROWN: No.

PROF MONTGOMERY: Did you ever see the terms of reference?

MS BROWN: No, not – only later, after the piece of work had been done. I'd seen this as the Trust's piece of work. They came back and said, 'Would you know of a midwife?' I went to Mary Bell, who was our consultant midwife within the SHA, and asked around her network. And we identified some possible, but it was really sourcing individuals rather than saying, 'This is the person you should have.' I'd seen this very much as a Trust-led piece of work that they were going to add to their governance.

MR BROOKES: So, once you'd helped them find the individuals, what was the next thing you heard about the Fielding report?

MS BROWN: We'd handed over the SUIs to the PCTs, but I'd made a practice of keeping in touch with Jackie Holt about the progress, because they had pulled the action plans together and I know I gave some feedback about those action plans, because initially they were okay for an initial response, but you needed something that was long-term and sustainable. And some of the gap I potentially saw underneath it is that you need smart objectives; you need a good audit programme underneath it to know that it's being managed.

So, I sent her that comment and feedback and made a point that Jackie and I would keep in contact. And she just said – she told me that they were making progress and that they were actually having assurance undertaken by the board to make sure that they made the required progress. And they seemed to be doing well with it.

DR KIRKUP: When did you see the action plan?

MS BROWN: The action plans came with those initial incidents.

DR KIRKUP: No, I mean – sorry, I'm probably jumping ahead of myself.

MS BROWN: Yeah, I'm kind of doing it in a sequence.

DR KIRKUP: Yeah, I shouldn't have interrupted. You carry on, Jonathan.

MS BROWN: So, I was keeping in contact with that, and I would ask how it was going with Pauline's work. And I'd also spoken to Pauline before she made contact with the Trust to see if she was okay with it and said, 'It would be good if you could link in the LSA work as well,' but then it was the Trust to take it forward.

So, I was understanding that it made progress, but I think they had difficulty actually identifying key people for it. So, it must have started December/January time. So, I knew it was being completed.

She said they had got it; it was giving them good detail. There was some discussion they were having about the workforce element.

PROF MONTGOMERY: Do you remember when this is, this conversation?

MS BROWN: We're probably talking about – I'm thinking 2010 we would have had that conversation, maybe February/March. But it came to the fore again when we went into the second Foundation Trust discussion. And I was approached again by the time, as to, would we contribute to that process and where were they with it?' and I said, 'I know there's been good progress made on the action plan, because I'd seen the emails that it was going off to the Trust; it was going off to CQC.' And I had Jackie's feedback, but I said, 'But the one thing we haven't had is the Pauline Fielding report, and I think we should get it.'

Right, so, kept asking the question, 'Have we got it yet?' I said, 'No. They're looking to make sure of the detail of that and we're going to take it to board.' So, there was coming up a time constraint and I felt this sort of time constraint. And this was obviously going to create a problem, so I said, 'Well, maybe if I speak to the Trust and see if we can find an option, a way through this, in that they give us headlines and... So, that might be enough so that we can kick-start the process, but I think we do need the ~~reporting.'~~ report.

MR BROOKES: Can I just be clear when this was?

MS BROWN: This was – wait a minute. It probably would be June 2010 that I had that conversation with Jackie, but what I also had had – when we'd been working through the LSA investigation and we'd had the first report back from Yvonne Bronsky, I'd been out to see Tony to talk about the findings and, 'Is

there anything additional that we needed to do with that?' And that would be in the May.

And he'd mentioned the Pauline Fielding report then and he said what they wanted was a report that would move them forward, and his priority was very much about getting the maternity unit functioning well and providing a good service. So, I knew it was in train.

What Jackie also told me was, 'It hasn't really told us anything that we didn't know and we weren't working on. This is work is progress, but it is about taking us forward.' So, she sent to me a document that had some of the key recommendations or what I thought were the key recommendations, as well as what was the – she'd put on that as well the terms of reference, which was the first time I'd seen the terms of reference. And on the bottom of that was also confirmation that CQC had done a visit into the unit and that everything had gone well.

And I made some assumptions from that that CQC were sighted and this was a very joined-up piece of work, so I was getting... I felt reassurance, assurance – I think it's reassurance, really, that this was a managed process and things were going well.

PROF MONTGOMERY: Two things. You saw the terms of reference for the first time. You described earlier what you thought they were commissioning. Did the terms of reference look as though they'd commissioned what you'd expected?

MS BROWN: I saw what they had commissioned and what they commissioned seemed to make sense to me that this was around looking at their systems to take them forward. It was about developing their clinical governance and it had got into the clinical governance,

PROF MONTGOMERY: But it specifically doesn't cover the gaps question, the whole question that you'd picked up earlier on. She wasn't asked to review the incidents, for example.

MS BROWN: No, she wasn't asked to review the incidents. It was more the issues that had come out of the incidents, and they had thought that might be a more useful piece of work. Now, I made some assumptions around that, because I've never discussed it with Pauline since, that, actually, within that kind of investigation, you would have looked at the incidents to see what had

come out of them and then follow that on, but that was my assumption.

PROF MONTGOMERY: But she was specifically told she didn't need to do that, because it had already been identified that there were no connections between them.

MS BROWN: I didn't know that.

PROF MONTGOMERY: Okay, that's helpful. Other thing up to this point – and we're going to let you carry on with the story – is that the CQC has registered the Trust without conditions in April 2010 and, as part of that, they say they've had assurance from the SHA that the SHA doesn't have any quality concerns. Were you involved at all in that process? Is that a question they asked of you? FA I remember a meeting in Preston in 2010. I remembered it as a risk collaborative. January when I reported the Pauline Fielding was working for the Trust.

MS BROWN: I don't think so, no. I'm not sure that we were involved in that registration without conditions. I'm really trying to remember hard. We didn't have a process around it, and I don't think the question ever came up.

PROF MONTGOMERY: Okay, thank you. So, you've now seen the terms of reference and a summary of the emerging recommendations in June 2010.

MS BROWN: Yeah.

DR WALTERS: Can I just be clear? Would you have expected her to have looked at the five incidents again and see if they were connected? Was that your understanding of what should have been part of the remit of that report?

MS BROWN: My – gosh. My understanding, if I just rehearse it again so that it is clear, is that my first understanding was very much about what would be helpful with the Joshua Titcombe case. 'You can have three things and a gap in the middle. Let's be sure there's nothing in it or you have picked it up.'

The next thing I heard was that it was about picking up the issues from the incident, and I thought, 'That sounds even better, because it's looking at all of them. That's sounds a good piece of work.' And I assumed that that was going on.

DR KIRKUP: But did you assume that she'd looked at the incidents, Dame Pauline Fielding?

MS BROWN: Yes, I did.

DR WALTERS: But not to re-investigate them? Because, you see, there's two ways

of looking at this, aren't there? There's either, 'Are there systemic issues in this unit which could account for why they've suddenly had five incidents, i.e. got something seriously...?' You know, poor competence, whatever. Or are you going back to say, 'Were those individual issues? Did each individual one show signs of similar levels of poor clinical standards?' which might not be about, 'Was it all the same operator? Were they all ethnic women? Were they all diabetic?'

Did you think they might have a serious issue in that maternity unit and the Pauline Fielding report would give you the answer to that?

MS BROWN: I didn't know whether there was a serious issue. My suggestion about Pauline, taking – certainly when it came back that she was going to have a wider brief, I thought, 'That is good, because she will then see if there is anything.'

I wasn't involved in any way in what it might look like. I'd seen that very much as a Trust responsibility. I'd seen this as something in addition. So, from the conversation I had, I thought, 'They're taking a wider brief. That is going to be ever better as to what is there.' But I had assumed in order to pick up issues from the incidents you would have had to have looked at the incidents. That would have been...

But was I sighted? Did I have that conversation? No, I didn't. I had left it with the Trust.

DR KIRKUP: So, we've got to the stage where you've got the terms of references and headline recommendations. When did you actually see the report?

MS BROWN: I called it in as part of the work that we were doing on the LSA, the Joshua Titcombe, when I'd gone back to the NMC to see if there was additional work, because I knew that Pauline had looked at the LSA.

We'd had – Jackie said that she would let us have that report as soon as they could, and it didn't come in and it didn't come in. And we went through the Trust process for – confirmation for them as a Foundation Trust, and I heard that they had achieved their Foundation Trust status.

And I can't remember asking the Foundation Trust team, Mark Thorne. I said, 'It went through alright; they didn't want anything further on the quality,' and he said, 'No, that was absolutely fine.' Actually, they had done extremely well at Monitor. It had been a good performance and they were very pleased

about it.

So, I thought, 'Right, we've sort of made progress.' And that was going to be at the end of September they got their authorisation.

PROF MONTGOMERY: Yes, that's what...

MS BROWN: And we still hadn't got it then. In the September I was –

PROF MONTGOMERY: Did your FT team in the SHA know that the Fielding report had been commissioned? You clearly knew, but anybody else?

MS BROWN: Yeah, I told them, because I said... That was the whole conversation we'd had. And I said, 'We haven't got it in yet and I think we should wait.' And then it was, 'Were running out of time,' so we came up with that compromise, and that came in and looked at it. And what the recommendations – I looked at it and thought, 'These are recommendations that are about strengthening clinical governance. They will take them to the next step.'

I'd already got – we had looked at some of the clinical indicators that were telling us this Trust was on an improvement process and this seemed to fit. But, as I say, the report just didn't come in and the next thing I knew they had gone to Foundation Trust status.

So, that was going to be at the end of September. And during September I had visited the Trust. Sue Bothwell was helping us do the further review onto the LSA process and I went to visit Angela Oxley and Jeanette Parkinson. And we had talked through the incident with them and we wanted evidence from their minutes and to pull that in.

And I said, 'By the way, I've not had the Fielding report yet.' I said, 'It'd be really useful to have it so that I can cross-check the LSA work.' And I can't actually tell you when it did come in, because it didn't come in on my emails. It came in hard copy. And I think it must have come in, hard copy to me, by mid/end of October.

DR KIRKUP: 2010?

MS BROWN: Yeah. It came in to me then, because I had done all the analysis work, actually, and we'd got a very clear picture about what was and wasn't working. So, it just appeared on my desk when I'd completed all of this, and I opened it and thought, 'This has arrived at last.' I was heading to a different meeting, put it in a drawer and came back to it. And I read it as evidence for my report.

I read the first bit and saw the words 'improvement' and 'making

progress. And I think that view of the organisation that I had about, 'This is an organisation with challenges, but we're addressing them through improvement,' went probably from 2009 right through to the end of 2010. And it was at that point things happened and you think, 'Has it stalled?'

I came to a point when the families had written in to us, asking for further information, and I was looking through all that information again. And the end of February Laura sent through a piece of email that had come from James about all the things that he was finding difficult that hadn't been explored yet, and we were sorting of looking at, 'Would an LSA further investigation help or is it wider?'

And there was right at the end of it a comment about a secret report, and I thought, 'What's that? I don't know about a secret report,' and I sort of pondered that and then I thought, 'I wonder if that's Fielding,' so I rang Jackie and I said, 'You did share the Fielding report, didn't you, with CQC?' and she said, 'I'm sure we did,' but I said, 'You really need to check. It was the Trust's responsibility to share it.'

So, she said she would check, but I said, 'You have done the work,' because she told me that the recommendations were work in progress, they were doing it and they were all rolled into the one action plan.

DR KIRKUP: The recommendations from Fielding, that arose from Fielding...

MS BROWN: ...were going to be rolled in. And that work was in progress. And in fact the board wanted some independent insurance that this had all been done and it was in process. And by that time I was reading the report with a very different eye, because –

PROF MONTGOMERY: Just to be clear, how did Jackie respond to that question? Because the Fielding report hadn't been to the board at this point.

MS BROWN: In 2010 – 2011?

MR BROOKES: Not as far as we can tell.

DR KIRKUP: It's April 2011.

PROF MONTGOMERY: And the report, Pauline had never presented to the board?

MS BROWN: I was - Jacky emailed me and said the report had gone to board in 2010. It went to Part 2 and that she felt Monitor would have a copy. FA This is incorrect the email was 2011. At some point I gained the impression that the report went to Board in August 2010 and it went to part 2. But I can find

progress'. The SUIs were a legal process and have been completed, but I then assumed that Pauline had looked at them and she said that the incident process seemed to be working well and there was risk management in place, so I thought that they had made progress against their action plan.

So, I looked at that and I read the beginning and then I cherry-picked what I read. So, I went to the incident stuff; I went to the LSA stuff. And I thought, 'That seems to marry with what I've got, so that's good,' and then I looked at some of the clinical governance stuff. And I thought, 'That's got to the basis of this; this is really going to move them forward.'

And then I went through in my mind what else I knew, because I knew CQC had been in done a visit in 2009, because after the work in 2009 the Trust were dropped until CQC did that further work. And they had gone in and tested their assurance and decided not to investigate the incidents, but were concerned about the clinical governance. And that was passed on.

And then they had been in the Trust and had given the unit the okay. And I thought, 'CQC have got the clinical governance covered. Good work by Monitor, because they must know about the governance, so this is on track and she's identified some risks.' I was, by that point, involved with some other trusts, doing detailed work, and a lot of the stuff you lose some detail to do others – but it sat there.

And we went then into a phase when I was also then in regular contact with Sue McMillan, who I felt was actually looking at the – was onto the Trust, really, and was beginning to see that...

PROF MONTGOMERY: And did you understand that she also knew about the Fielding report?

MS BROWN: No, I didn't at that point. FA I believed that CQC knew about the issues & PF's work and it was part of the review process in the summer. Sue & I didn't discuss it until Feb/March 2011. I'd assumed it was work done and that's where my head was at that point. But it sat there. And what Sue did that in some respects I was doing as well is that we saw the incidents of 2008 over here and we saw the present-day safety of the organisation.

And I certainly had a view that the Trust was in improvement mode and Sue was coming back saying things like, 'We feel it's a strong Trust, but it's showing up these kinds of indicators as well.' But we felt it was sort of making

no evidence of the conversation

DR KIRKUP: Okay, we've managed to track that.

MR BROOKES: Certainly there's no evidence that that's what happened.

MS BROWN: Sorry?

MR BROOKES: We've certainly got no evidence that that's what happened.

DR KIRKUP: There's certainly a presentation in 2011, which looks as if it's the first time it's been to them.

MS BROWN: I have the email.

DR KIRKUP: Okay.

MS BROWN: So, I had some reassurance around that and I said what about theatres, have you done the work on the theatres; because my eye, the first time it had gone over that, and you know, it had hit me in the face, and I thought 'Oh' and she said, "Well, Peter Dyer can give you assurance about that, and I'll get him to ring you" because – and I said, "Well, that would be helpful."

And then, very shortly after that Sue McMillan came to the meeting with the ~~SHF~~ SHA and we had that meeting, which is when I was going to raise it with her, of which she said, "We've had some new information that's come to us that's causing us concern" and she mentioned it was the Fielding Report and that if they'd shared it with me", and I'd asked Jackie to make sure it was, and she said it had come together and "If we'd had that we would have redesigned our process" and at that point I thought, 'Oh that's –'

PROF MONTGOMERY: Can I just be clear about what you mean by "redesign the process"? Clarification planned it differently

MS BROWN: I mean – and again, it's how we understand what one another had done in that they would review against their standards, and they were looking at the impact. And that they looked at certain aspects of the care, and the care had been included, the care, staffing and something else had been included.

And I know when I'd seen that I thought 'Well, if they've looked at the care, they've walked the floor. They have been in the building. Some of those things will have been seen'; and I made assumptions of that. But it was clear they might have looked at other things if they'd had the information. And it's

also how you pick up questions on things happening, other meetings, when I had been in another meeting with the CQC CQC had said and I said, "No, we don't performance manage the action plans anymore, we just get the information". But what Sue was saying is we'd have looked at different things.

PROF MONTGOMERY: Can I just tease out whether you think that's a good reading of the Fielding Report? I'm trying to understand what the Fielding Report says that is not in the Flynn Report, about the culture and the leadership?

MS BROWN: Well that's –

PROF MONTGOMERY: Because there's something about seeing the document and there's also something about being aware of the issues it addresses?

MS BROWN: Well I had sort of read this as part of what I'm looking for that's going to help me with the LSA stuff. There was a lot that resonated, that was already known, the culture was already known. What I thought Pauline had done was say it in a very specific way that if you were wanting a report to be a catalyst for change within the organisation that's the kind of things that you would say. And having worked with Pauline before, I know shew would work on presentation but she wouldn't move from substance, if she felt; certainly that was my experience of working – but I would never ask anybody to change on substance anyway.

But, she was saying there were things around the culture, there were things around the clinical governance; what she'd done was specified and there is something in the terms of reference that says about giving expert advice. I thought she – that clinical governance system had been reorganised and it actually needed to take shape, so it was delivering as it should.

So, there were those common things in Fielding that resonated actually with what was there; she just made it more specific and picked that up. But that's what Sue had said, is that we would have designed the process differently and we should maybe have investigated at the time.

She then said, you know, they were looking to do an unannounced visit, probably the NMC, well how could we help with that, because my concern then was well, do we know they're safe? That was my overriding – I think that's when the churn started, and this could be difficult. I then said, we

would attend and I would bring Lisa Bacon, who was our LSA, and then that's when I said to Jane "This report has not been shown".

MR BROOKES: And when was that exactly?

MS BROWN: It was after – I'm sure it was after the meeting I had with Sue. And I had can't tell you the date; I'm sorry about this, but I think it would be May 2011.

MR BROOKES: May 2011, thank you.

MS BROWN: It would be then that we than sort of – I think that was the time that I recognised that the assurance that an improvement that I thought was going on, that I'd seen that was the indication to me that –

MR BROOKES: Began to question.

MS BROWN: It wasn't, and I had then a conversation – Peter Dyer rang me and I wanted to check out the theatres, yes he said, theatres have – "we've sorted out the on-call work. But yes, we've got on top of that." He said, "The refurbishment we have looked at" I said, "You've risk assessed it?" "Yes, it's on the risk register. We're looking for the finance of that".

I asked him about what about the staffing, the culture in there, the midwives and the doctors and he described the problem with the very experienced midwives but doctors, who are inexperienced and needing to move towards the Westminster model. He described us bringing in consultants that would have that expertise and overview; he explained that to me. He said they had had another incident; they'd reported it to the PCT. It was with a doctor, so I said, "Have you got ~~NPSA~~ NCAS involved?" "Yes, that's been followed up".

He then said, "There are going to be more incidents reported to the NPSA, but they are low no harm ones, so they won't be excise" On StEIS but then said there had been a problem and it was with Jeannette, they hadn't been reported as they should have been." I'm trying to remember this accurately, but there was a problem and those were now being gone through, they had been in touch with the NPSA to explain the situation.

So, I then asked about the clinical governance safety team and this began to feel small and I felt a right, he said, "Well, we've focussed it now in the one team" and he talked about the people who were in there, and who was to develop and I said, "We need to think seriously about that. That's

very small" and he said, "No, it's about what's available".

So, he gave me some positives, but I was feeling, thinking we've had a lot of process here but actually it may have completed that plan but has it worked; has it had an impact? I met, also with CQC and people from the NMC and we went through what we knew about the maternity unit and the Trust, and around the Fielding Report. But we could have unpicked that; that was looking backwards, our – that would have to be done at a different time. I felt our immediate public duty; our priority was to make sure about the safety of the service.

So, we came up with a plan, that the NMC and CQC would do their unannounced visit, we would – Lisa would undertake the audit as planned, that we were going to pick up from that, to look at the different standards. Helen and Jo Wildman, who were at the meeting, they were going to go to the inquest and they would feedback from that. And I would set up a meeting with the PCTs so that we could look at the incidents and it would be an opportunity for CQC to cross-check that if there was a problem.

PROF MONTGOMERY: And had the PCT raised any of this with you at all?

MS BROWN: No, before I had gone to that meeting with CQC, I'd gone and I checked with my team, had we heard anything further from the PCT, because Sue had been very active in the Trust with root cause analysis training, with human factors, training, she'd been involved, and working with the PCTs with these workshops. And she said no, she hadn't heard anything recently from the PCTs in terms of patient safety.

I went to speak to Ann ~~Haskins~~ Hoskins and Mary Bell and said, "Is there anything we should know about the maternity services?" And there was nothing, in fact, what had happened was that the Trust had done well on its maternity survey, patient survey, and that they were doing well with – they'd picked up some of the patient experience inspirations team work about the cards, and they were looking as though they were doing well with that.

And that team was monitoring some of the maternity services work that had come from the original CQC work and they felt they were making progress. It wasn't the factors in the system, it was more, you know, sort of picking up on what had happened with the fielding work.

And so I arranged the meeting with the PCT and we then had the

discussions with the PCT of was there improvement, were there still concerns around that. The CQC had done their visit by then, and identified that risks were not being escalated; that some of the teams were working well, but there did seem a risk of an incident happening and not being picked up. So, there were those kinds of issues coming together then, but they were coming to the reports.

The other piece of work that followed after that was part of clustering, SHAs who then had to meet with each of the PCT clusters to look at what they were doing around safety and quality. And as part of that I had to sort of plan the agenda and the information that we would get and we ran it as the model I'd used with the other PCT that we looked at, is the comment, you know, 'what's your patient experience, what's your governance, what's you're indicators, clinical engagement' and we ran those kind of questions, and 'Do you have a clear line that's on the Trust', which was the question we put to them.

What hit us then was we had Cumbria and Lancashire, one after the other, and you then start getting the picture; at that point Mark spoke to Mike Cheshire and Jane became involved with actually looking at setting up the risk side. So there were all sort of those sort of factors all built.

PROF MONTGOMERY: I think we need to move on. Can you help us with the risk summit to Gold Command and what Gold Command was supposed to achieve?

MS BROWN: Yes, we got to the risk summit, we had sort of planned the risk summit, some of that took a bit longer because we couldn't get the key people together – but I was helped with putting that agenda together and what I did with that was pull all the indicators, got the team looking at all the past CQC reports, the Fielding Report and everything down. Because the Trust were going to attend that risk summit, it had come be a sequence of phone calls is that instead of going round and each organisation bring it up, I thought the best way was to have it out in front, on the desk, and then they can begin to have a round the table discussion on what were the risks facing the Trust.

And it was when we got all the out-patient stuff and the rest we thought this is, we've moved from almost the initial bit that – you know, a Trust with challenges on improvement to things had stalled, things aren't going too well,

to actually we're looking at organisational failure. So it went to risk summit and there was a very broad discussion around that.

And then it was putting in various investigations to see what was happening and the PCTs were very keen to do work with the Royal Colleges actually going into the unit at Barrow. And I think it was the medical director that was asked to go in one weekend and look to see if it was safe, because I think the concerns, you know, we need to close. Great anxiety about the impact it had on that.

It came back it was safe but then it was around getting into the unit. The PCTs were meeting some resistance from the Trust, I think in trying to have those agree what as possible around clinical safety. Monitor had decided to do its own quality assessment. And it just felt as though we had an unsafe environment here, and in order to get some security around it the command control kind of approach; it was take it to major incident.

PROF MONTGOMERY: Just to be clear what I've heard; nothings actually changed in the Trust? The perception of what has gone on has changed; it was no more or less safe than it was previously? Because previously you've sensed, on an improving trajectory with a quality assurance mechanism developing, but you haven't -

MS BROWN: We have got a sense that it's not as safe as it was.

PROF MONTGOMERY: So, is your sense that it's less safe than it was last time you looked, or just that it hasn't made the progress that you had assumed it was making?

MS BROWN: My – I'm trying – because I know it's important I need to give a considered response. My view is between when we were coming in, when I discovered that the Fielding Report hadn't been shared; it was - we appear to have stalled, and I held onto that probably until the CQC had gone in. And then we'd got feedback but it wasn't ???

PROF MONTGOMERY: It might be even worse than it was?

MS BROWN: Yes, it might be even worse than it was; so I felt it's not just necessarily stalled, actually there might be a deeper problem than – and this is more widespread than a maternity unit. It is wider. Some of the early telephone conversations, the response from the Trust was because the PCTs had wanted to get the Royal Colleges involved and do that work, was resistance

from the Trust in a sense of 'Well, we've had lots of investigations. We've got lots of action plans. We need to be able to implement them.' I think the point is that -

PROF MONTGOMERY: I think there are three things that have happened; one is that your previous assurance on the quality of care has become more shaky, that is to say you've now got some indicators that it might be worse than you thought. The second is that the things that were giving you assurance turn out to be more flaky than you expected.

MS BROWN: Yes.

PROF MONTGOMERY: And the third is it moves from being a maternity issue to being a Trust wide issue.

MS BROWN: Yes.

PROF MONTGOMERY: What you have described previously as being focussed around the concerns on maternity.

MS BROWN: On maternity.

PROF MONTGOMERY: Now suddenly you've identified this might be a much bigger systemic problem.

MS BROWN: And I was, for example, I was unaware of the outpatients issue and it was when we held these PCT reviews that it all came out and you got the bigger picture; and I thought this is not just about a service issue; this might be more fundamental.

PROF MONTGOMERY: So, it moves to Gold Command.

MS BROWN: It moves to Gold Command.

PROF MONTGOMERY: And what is the success factor for Gold Command, what would tell you that Gold Command delivered what you'd hope from it? From our perspective it was an unusual technique to use to deal with that.

MS BROWN: It was different. I think, with the Gold Command what it was required to do was, as with sort of all major incidents, there's part of ensuring safety, so that would relate very much to the safety of that unit. It's continuity of business because Morecambe Bay is quite unique. We had declared a major incident as we're in patch, and that was running all that summer, and I was heavily involved in that as well; but that was all about a specific incident and you were able to call on the other units around, to bring in the help.

PROF MONTGOMERY: It was time limiting.

MS BROWN: It was isolated but that was – that had created huge anxiety, because it still has to deliver health care, and it sort of raised the concern about the whole health care process in that area. So it was about continuity of business and I think the other area was about how you mobilise help. My overriding experience of working with the other organisations, the resilience required to deal with those kinds of situations, just in terms of the execs', the organisation itself is huge.

So, it's not just where you can meet direct patients the needs of patients, it's what you can put around the Trust because by now we had a criminal investigation going on as well as Monitor wanting to do investigations. There was CQC, there was – well Manchester work came into that. There was the Helen ~~Verless~~ Bellairs work that came on around the outpatients.

So, the Trust was being needed to continue to give a service as well as respond to all these investigations and the pressure on the team to do it as well as – was considerable. So, from what we did from the HAS notes, we sourced midwifery support particularly, extra Directors of Nursing, deputy Directors of Nursing to go in and support, to help with all their serious untoward incidents. So we were putting additional support in to do it. But it was a considerable undertaking, you began to see people getting really, really tired, and some of what I did was try and support Jackie and Sascha within that in sort of finding people to help and actually trying to help in that.

PROF MONTGOMERY: I think we need to stop there.

DR KIRKUP: I do think we need to let other people have a brief go, because we're going to time out if we're not careful.

MR BROOKES: No actually I'm quite fine at the moment.

DR KIRKUP: Geraldine?

MS WALTERS: No, given the time but I just wonder if we might have to ask Angela back at some point.

DR KIRKUP: Well, it depends on how many more questions you have. I think we've had a very good, detailed account. It has taken quite a long time of the bit where the SHA is central to this. I do have a couple of specific points that I want to pick up though, so, in the absence of – I'm looking at a couple of briefings that you did in September 2011. Now you might not be able to recall

exactly what and where they were, but they were in the aftermath of the CQC's review report on maternity services. So, there's one on the 8th and one on the 10th.

There's just a couple of bits that you've said in the background that you obviously were feeling reflected the position as you saw it, in September 2011 that I'm struggling to reconcile a bit with what you've told us this afternoon. The first one is you say the Trust commissioned a further independent review of the cluster of incidents in the maternity unit at Furness General and the Fielding Report, which is what you're referring to, I think, completed in 2010 found that the incidents were coincidental; that the Fielding Report wasn't in a position to say whether the incidents were coincidental.

MS BROWN: I'm sure the Fielding Report, is that what it does say?

DR KIRKUP: It doesn't comment, because she wasn't – she actually said that she would like to have reviewed the incidents, but they said, "No, no, that's not what we've asked her to do".

MS BROWN: I thought that – and it did really make me think is that Pauline had said, in the Fielding Report, they appeared to be coincidental and not evidence of serious untoward incidents.

MR BROOKES: No, I think it says that she was not looking into them because they were deemed as coincidental.

DR KIRKUP: But not that she had found it.

MR BROOKES: But not that she had found it.

PROF MONTGOMERY: She records that that what's she'd been told.

DR KIRKUP: Yes.

MS BROWN: I -

DR KIRKUP: I'm sorry, I can see you're at a loss, but I need to put this to you because I don't want you to –

MS BROWN: You do need to put this to me. I am at a loss, because I have read that as she had reached that conclusion and I'd made the assumption that she had looked at these incidents.

DR KIRKUP: Okay. What I think I'd like to suggest is that you go away and have a chance to re-read the Fielding Report and just come back to us with how you got that conclusion from reading the Fielding Report; that would be very

helpful to us. I see that you have a copy of it.

MS BROWN: I was just looking to see if I'd got it with me.

DR KIRKUP: I don't want to push you to try and sort it out now, I think it's perfectly reasonable for you to go away and have some time to reflect on that.

MS BROWN: Yes, I am at a loss because I took that from the Fielding Report that she had looked at them.

DR KIRKUP: Sure.

MS BROWN: And reached that conclusion.

DR KIRKUP: Sure.

MS BROWN: That's what I read.

DR KIRKUP: Sure. I mean, these things happen, I wonder if it's a case of you reading what you expected to see, you know, like a little sign that says 'Paris in the Spring' you read what you expect to see. But anyway, I don't want to force you to that conclusion, or suggest that conclusion now; please do take some time to reflect and if you could come back to us and say "I've had a look at it again, and I think this is where it's come from", that would be very helpful.

MS BROWN: Yes.

DR KIRKUP: Okay.

MS BROWN: Okay.

DR KIRKUP: The same briefing mentions the Ombudsman having reviewed the Trust's response and deciding to take no further action. Two questions really, one is did you see that as a significant part of the saga was the Ombudsman's decision not to investigate significant and secondly, what was the basis for that, what was your understanding of why she had decided not to investigate?

MS BROWN: I am trying to remember where that came from. My understanding at the time was that the Ombudsman had had a clinical assessor who had looked at the case because I had seen some documentation that had indicated some debate around the ~~APCOS~~ APGAR scores as to whether they might have influenced the condition and that she wasn't going to investigate further. I'm struggling to – I wouldn't have written that if I hadn't heard it somewhere.

DR KIRKUP: I understand. If I can try and help you on that, it don't think it was the

APCOS scores; part of the decision was around the missing baby record.

MS BROWN: Right.

DR KIRKUP: I think that might have been it, but the Ombudsman was also, I don't think, in direct communication with you, but in communication with the CQC, indicating that that was because she thought that there were systemic issues in the Trust.

MS BROWN: Right.

DR KIRKUP: So, it wasn't good news that she didn't investigate, it was actually because she thought there was a better way to investigate it.

MS BROWN: I didn't understand that.

DR KIRKUP: Okay.

MS BROWN: All I knew is –

DR KIRKUP: That's fine, that's perfectly reasonable, I understand that.

MS BROWN: Go forward.

DR KIRKUP: No, that's perfectly reasonable. And you said the Trust implemented the action plans arising from the investigations; that's specifically referring to Fielding as well as the other investigations. What was the basis for your understanding of whether they'd implemented the Fielding recommendations; was that conversations with Jackie Hutt or a different route?

MS BROWN: My reasons for believing they'd implemented the recommendations was two-fold, was based on the fact that she given me continued updates that those recommendations, and the sustainability plans were being implemented and I made some assumptions in terms of the Fielding Report that had had those specifics that they would be included and the work that was already ongoing. But if my understanding wasn't until it was in 2010 that it happened. Those that had already been rolled out as part of the work that they were doing on sustainability and that from 2012 I'd specifically asked her the question, "But you have done the work haven't you?" And she said yes.

DR KIRKUP: Yes, okay.

MS BROWN: And so that's where that came from.

DR KIRKUP: Okay, the final one from me is around the details of the cases that you had in 2009, when you were deciding that; that they were clinically different. Fine, I agree they were clinically different. But you put in the summary of 10

September, some summaries of the cases that indicate that you hadn't had full sight of all the clinical details, would you agree that that was the case, or do you want to take issue with me on that?

MS BROWN: Sorry, which briefing are you speaking of, the 20th?

DR KIRKUP: Let me be specific because I think it is unfortunate it's an important point and I think we need to reflect the fact that we are now going into the part of the session where we can talk about confidential patient details if necessary and therefore the transcript isn't open at this stage.

(The hearing went into private session at 5.47 p.m.)

THE MORECAMBE BAY INVESTIGATION

Thursday 2 October 2014

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

Before:

Mr Julian Brookes – Expert adviser on Governance (In the Chair)
Ms Jacqui Featherstone – Expert adviser on Midwifery
Dr Geraldine Walters – Expert adviser on Nursing

JULIE BUCKLEY

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

MR BROOKES: First of all, can I extend Bill Kirkup's apologies. He's not able to be here today so he's asked me to chair the session.

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

I will ask my colleagues to introduce themselves.

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

MS FEATHERSTONE: I'm Jacqui Featherstone, Head of Midwifery and Head of nursing at a District General Hospital in Essex.

MR BROOKES: As you can see we're on mic' which is for recording purposes, it's not going to magnify anything. It's a bit echoey in here but I will urge you to speak up if that's possible.

The reasons for the microphone is to take a recording of the discussions today. There's two reasons, one is that we have an accurate recording of what has been said but also we've offered the families an opportunity, if they can't attend on a particular day, that they have an opportunity to listen to the recordings. By implication these sessions are open to family members. There are none in attendance and we're not expecting any today but they may wish to afford

themselves of that at a later stage.

We have asked you to hand in phones and iPads and everything else, as have we. That's to ensure that what's said in here stays in here. It's very important that we take the evidence and we look at in the context of everything we hear and everything we see. So what we discuss in here will say private but then will be looked at in the context of the report.

I do not believe we will today but if we were to get into a discussion about particular case, we won't do that in open session because of confidentiality. We would do the general questions and then come back to that at the end in private session. Again, I'm not expecting that is necessary today.

Finally, I'm not expecting a fire alarm, so we will take appropriate action if and when we need to and we will follow Oona out of the building. Is that clear?

MS BUCKLEY: That's fine. Thank you, yes.

MR BROOKES: I'm going to ask an initial question and then I'll turn to my colleagues to ask further questions.

Can you say who you are for the record and your role in the organisation now and previously in terms of what you did?

MS BUCKLEY: I'm Julie Buckley. I was head of information at Morecambe Bay Hospitals Trust. I retired in July 2013, so now a retired grand-mum really but my role there was information, previously I have been a contracts manager in the same organisation and various other management jobs leading up to that anyway. So I'm not sure how much detail you want from me but I'm quite happy to answer any questions about any of those roles.

DR WALTERS: When did you start with the Trust?

MS BUCKLEY: I think about 1987, it was 1987 but I came back to work after maternity leave and started in the NHS, so I started in medical records as a clerk and worked my way through.

DR WALTERS: When did you become head of information?

MS BUCKLEY: In 2001.

DR WALTERS: Who did you report to?

MS BUCKLEY: I was employed by the Director of Finance and there are a number of those that pass through my hands, latterly it was Tim Bennett and prior to that it would have been Kevin McGee, Vanessa Connolly, Harris, she changed her name, and previous to that was Graham Smith, and he was the Finance Director that actually employed me.

DR WALTERS: So it was always linked in to finance?

MS BUCKLEY: Always linked to finance.

DR WALTERS: What was the relationship with operations or performance?

MS BUCKLEY: I worked very closely with operations and performance. We had a hospital management team, which I was part of and we met there on a regular basis and I worked quite closely with the performance manager. Roles have changed numerous times throughout the last ~~year~~ few years but it's quite difficult to remember the variations on the theme. I worked closely with performance management and they worked with operations as well and operationally with ~~of director~~ the directorate managers and divisional managers, because they changed their title as well.

We were open as a department to them. If they needed anything from us we could help them. If they needed advice and guidance on certain topics, making sure information governance and data quality was reasonable or good, and could be improved.

DR WALTERS: Given the reporting to the Director Finance, was the main focus to make sure people were paid adequately?

MS BUCKLEY: That was a large proportion of the role,

to ensure that the data flowed for commissioning purposes so that we were paid by the Primary Care Trust or whoever was the actual commissioner at the time but to ensure that the data was to a set standard because that data was then used nationally and it had to meet certain criteria and be complete and accurate.

My role was to ensure that it was as accurate as possible. Obviously working with very large computer based system and lots of different people entering ~~that~~ data that's not an easy thing to do.

DR WALTERS: Were you into that job when the Morecambe Bay Hospitals came into being?

MS BUCKLEY: No, we merged as an organisation in 1988, which was a few years before I was in that role. I previously have been a contract manager or primary care liaison officer for the hospitals in the primary care trust and I worked on the patient improvement programmes with the hospitals and as we merged as a Trust I was a general manager in the medicine division.

DR WALTERS: What were your observations about what changed when the organisation was formed and in terms of how information flowed?

MS BUCKLEY: As I knew the information managers from the other organisations anyway we all had our set standards to work to. So as the three hospitals merged

into a single Trust we were getting together anyway to make sure we pulled the data from certain sources to ensure make sure we had one corporate ~~question~~ dataset, though I was not in charge of that area at the time, I didn't takeover until 2001. Because the data flows were standard data flows a lot was of it was a technical fix at the time. ~~CBS~~ CDS commissioning data flows were commissioning data sets which ~~were~~ are the means of ~~setting~~ getting the database to Commissioners and to the national data centres. So that was reasonably okay. It was then how do we pull the rest of the other information together so that it would be useful to the organisation to use.

From a personal point of view we ~~that~~ had a lot of work to do. I was working in out-patient improvement at the time that we were merging, so there was a lot to do to look at which patient admin systems we were using. We also had to face the year 2000 issue where we had some systems that were not going to compatible on the change over for us. So there was an awful lot of other quite technical aspects of the role that we had to pull together so that we became one technical organisation as well as working with other organisations.

DR WALTERS: Any hospitals can produce the data that the commissioners need, can't they? I suppose

underneath that is how it is done. Any observation about that?

MS BUCKLEY: Standardised data comes from the patient admin system. We had to merge with them to make sure we had a single patient admin system and we had to stand down old systems. Barrow was probably one of the older systems and I can't remember which one, it's quite a long time ago, between Barrow and Kendal their systems were more out of date and needed to be put together, so that was a case of taking on what looked to be the best part of the ~~MP~~ National Programme for IT ~~(~~NPFIT~~)Fit~~ programme, that we could actually come up with a PAS system that would be compatible to all of us.

Obviously working through there is always a bit of resistance on all hospitals sites because staff have got to use the systems on a day-to-day basis, different staff really and making sure that they all stuck to the same rules that we were working through, so national rules, people can interpret~~er~~ them slightly differently.

So we did quite a bit of work training people on site to actually work through what were the issues around using different systems, did we all understand the same rules, did we all understand how to handle say cancer two week waits and take them through quickly.

We were working to a single hymn sheet.

DR WALTERS: How was coding done?

MS BUCKLEY: I managed the clinical coding teams has well. Clinical coding was site based and three sets of clinical coders in each of the three main hospital sites, RLI, Lancaster, Westmoreland General ~~and~~ at Kendal and Furness General ~~and~~ at Barrow, that's where we admitted the patients. The staff were all trained to come through the coding system to take the qualifications. We have a high level of qualified clinical coders.

In the main the coding process was done slightly differently on each side site and we tried to take the best of all of it as we ~~have~~ matured through the last few years. In Barrow they would particularly code after the discharge and ~~we~~ would work with medical secretaries and their doctors. That sounds ~~like I have done it~~ the wrong way round but the medical secretaries would have hold of the cases notes and if they didn't get anything from the doctors they would chivvy them up and ~~they~~ then the coders would clinically code from the written case note.

Westmoreland General was a bit of a mixture of doing both ~~of~~ that and, because it was such a small hospital site wise, coders visited the wards themselves.

At Lancaster we pioneered a method of coding

actually on the wards back in the 90s to see whether we could code faster and get hold of the information more quickly because as we started to merge as an organisation case notes would move from one site to another quite rapidly and sometimes before we would get a complete set. So we had to get some information about what happened to patients to get the diagnosis as quickly as possible.

So there was quite a mixture of ways of getting the clinical coding.

What we carried on doing then was to mature the clinical coding teams, making sure they were as trained up as possible and felt able to talk to doctors and to challenge them around the case notes and how clear it ought to be, because it's not always easy in terms of, a, the handwriting but what ~~did you~~ was meant with a particular type of condition. I can't give you an example because I'm not a clinical coder myself. I could have done a couple of years ago. Bit out of date. If you are not clear enough ~~Round~~ at the time ~~you~~ the coder could record a more minor or more serious condition than it actually was.

The clinical coding was done by those groups, we monitored how quickly they were coded and where records weren't available to them chase up case notes to be

coded at that time and if we had what we considered poor coding, so if you couldn't actually find a record and you had not enough information and a, fairly weak coding diagnosis, was recorded. It might have said unknown cause of admission. We used the system called CHKS, which ~~is a~~ we subscribed to, I don't know if you are familiar with that? ~~That's~~ It's quite helpful because you could actually look at the weaker coding and go back and review it and talk to the doctors. ~~and~~ We trained the supervisors in each of the sites and some of the senior coders to go and meet up with consultants ~~there~~ and discuss the cases. Obviously we ~~suddenly~~ got a much better response because they don't like to be challenged ~~some~~ at times and improved the coding quality at that stage.

DR WALTERS: What were your depth of coding audits and coding quality audits?

MS BUCKLEY: We used to get quite good marks on the quality of the coding. Obviously there will be some~~body~~ mistakes made, in that as that might have been around what was not available at the time and some areas, some specialties would be better than others. Surgery is probably always the best because a huge amount is elective, so you know what you are facing. The doctor often knows the diagnosis before ~~you start~~ the procedure. You would get a very good record back and you have often got a

theatre record that you could use to supplement with.

DR WALTERS: Quite good marks for coding?

MS BUCKLEY: Yes.

DR WALTERS: Depth of coding?

MS BUCKLEY: Depth of coding was good as well. We did have an issue about 2010 when we merged as hospitals we had a system called IPM which is a PAS system and we were part of the ~~MP Fit~~NPFIT programme. We were going to be the first in ~~time~~ line with the PAS system called Lorenzo and that took an 18 month work up to get to the stage where we were going to go live with that and different coders, waiting lists, all of the aspects of information were looked at by different teams and work streams making sure that the PAS system was good.

When we did actually merge in to the new system, into Lorenzo in 2010 it was not as easy to use as the test systems that we'd seen. There were lots of issues around medical record ~~available ability~~ availability at the time, so coders had a very, very bad run that year for about six to eight months trying to get hold of records to code as accurately as they would have done previously and you might have noted, if you have got your information, that our mortality level looked very high there. When we discussed this with a ~~CHPS~~ CHKS consultant, ~~who~~ we talked about what were the potential issues there, what would

that do to the organisation and what we could do about it, ~~,~~ wWe reviewed then all the records for the deceased patients ~~out~~ and looked at them, we did this technically rather than case notes, and we had a meeting with our Medical Director and consultants that were available at the time to say, "Look, we have an issue here. You have not provided information to the coders as well and as quick as you could do. We know there has been a problem getting hold of medical records but. We have work together on this."

We showed them their own data and they were able to go away and review the coding to say if the coding was accurate or if the coding could be improved. ~~Reviews.~~ ~~So~~ wWe did quite a lot of reviews of the number of deaths that year and we were able to improve the coding detail, we had a very short timescale to do this, within five or six weeks, we were able to improve the clinical coding to a more appropriate level, which reduceds ~~your~~ the HSMR mortality rate. ~~but~~ iIt was a lesson learnt for the organisation that ~~if you~~ Consultants need to work ~~are not working~~ with ~~your~~ the clinical coders, ~~and~~ wWe do try and partner coders with consultants up, so a coder will have number of consultants and they would be their first point of contact and there was a back up in the team if they were on holiday. ~~and~~ it This actually helped us forge those relationships better for having had an

issue that needed to be addressed. They woke up to the fact that we should be working with them more closely.

So that's has improved or had improved, before I left, I hope it's continued to do that, the relationship with the coders and the consultants and particularly pointed out those areas where more information was needed or more accurate information was needed.

DR WALTERS: The coders used to code from the case notes with a bit of input from whoever they saw at the time and when Lorenzo came in they have to stick to coding what the doctors entered on the case notes?

MS BUCKLEY: No. We still use case notes where available. The doctors haven't yet, or hadn't at that point in time, really taken on the board the recording of all the diagnosis and procedures in Lorenzo directly. There would be information that would help supplement them but they still use the case notes where it was available with whatever was written.

DR WALTERS: But they could not get held of the case notes as readily as they had done before?

MS BUCKLEY: For some cases, yes. This is not always cases. These were cases that tended to move across site in particular.

DR WALTERS: Right. I still can't quite understand the big difference of why it had such a

dramatic effect on the UHSMR. I am not understanding what actually changed.

MS BUCKLEY: Sorry. There ~~was~~ were a few months in the beginning of the implementation of Lorenzo where case notes seemed not to be being pulled correctly from medical records because the list coming out of Lorenzo weren't being updated as quickly, so they weren't getting the lists through, so a clinic might have been pulled and they might have missed the extras that have been added on in the last week. So medical records became a bit of a nightmare scenario and they were struggling to keep up.

There ~~was~~ were obviously reviews of staffing levels and looking at what they could do to improve the situation. There was a knock on effect that people then kept back records. "I know I need this next week so I won't sent it back to records", which is best place for it to be, because your library is always the most safe place. They would keep hold of them, so there was a knock on effect through the different departments and medical secretaries and holding it back because, "I need that. I might need it the day after", so there was some of that going on we believe. It took a long time to actually get staff to realise that it was safer if they released records back to records, they could hold it

safely and then send it back out when it was needed.

So that was the knock on effect of the records not being as available because there was some issue around whether you get all the cases to a clinic in time and people holding on to them. There was just a general confusion round the system. People weren't using the system to track the record either.

DR WALTERS: Yes. So in terms of HSMR, which is really driven by the case mix, numbers of deaths with palliative care, which changes things. Just take me through exactly how this issues affected that?

MS BUCKLEY: We have very few cases where palliative care was being recorded very well.

DR WALTERS: Did Lorenzo affect that?

MS BUCKLEY: No.

DR WALTERS: I am trying to get the impact of the rise in 2010, which you suggest is secondary to Lorenzo, which has resulted in some poor coding. I am trying to pin down whether the poor coding which would have resulted from that would have affected the HSMR?

MS BUCKLEY: Palliative care recording was done normally by a palliative care team as they visited the patient and we didn't have a means of easily identifying that ~~that~~ in the record had actually had an impact.

DR WALTERS: Unless you had the notes?

MS BUCKLEY: Well, even when you had the notes when we talked to the cancer team, it would be the cancer lead nurse at the time, ~~he~~ who said, "I know the palliative care team ~~and~~ as I do ~~not~~ recognise the writing", I said, "That's not helpful to a clinical coder."

DR WALTERS: That would have been a problem before Lorenzo?

MS BUCKLEY: There were some ~~change~~ coding rule changes, I can't remember the years now, there were two changes. The national Clinical Coding Classification service sent out a clinical newsletter and they did implement some changes to the use of the palliative care codes. I can't remember what they are now, Z35 8 and Z35 9, something like that, and they stipulated when they should be used. One was quite clear as to when it should be used and the other wasn't. Because we hadn't used the one that was not clear, because it just didn't appear anywhere clearly that the palliative patient had been visited by a palliative care team, that information then, instead of it being bundled into one had been split out and we were missing some of that information.

Because it was quite a complex area at the time I wish I could have gone back and reviewed it and I would

have been clearer in describing this. ~~quite clear with that~~. There ~~was~~ were specific reasons around the fact that they sent out this instruction saying this is how it should be recorded but then there was a little bit of woolliness around a grey area. They then had to send another notification a couple of years later to clarify it, which made it a lot easier but it hadn't been clear at the time. I think the coding teams were going back to classification to say, "Can you clarify this? Its unclear." But it seemed that we'd lost our note somewhere in that. It hadn't been picked up on by the clinical coding list either.

DR WALTERS: What were the biggest issues and challenges in relation to your role around that sort of time when you were going for FT status?

MS BUCKLEY: The biggest issues I faced as a – for me in my department was making sure that we could extract data out of Lorenzo for the number of reports that were needed. The commissioning data set was the first of those, because obviously that's how payment was going to flow and we did have some severe difficulties with that in the early days.

We did manage to get them out eventually but Lorenzo has gone to so many iterations of improvements that every time they gave us an update, and I remember

a period of time we had an update a week, you would get one thing that had been corrected but you might have had a detrimental effect somewhere else.

So we were constantly checking, so that we had a lot of pressure on the department to make sure that our core systems still worked in our ~~code~~ core reporting.

We then had to look at what did Lorenzo not produce because it should it should have come with a lot of pre-packed ~~PAC~~ reports. None of those pre-packed~~PAC~~ reports would work to split across three sites. They had to develop and built all of those so that each medical records department had its own history and list of case notes.

So there was a lot of reporting that had to be built from the beginning and we hadn't expected that because we had seen all these pre-packed~~PAC~~ reports from a test system that said it would work but unfortunately when we had to use ~~do~~ it, it was not the same.

DR WALTERS: So did you go back backwards from what you had been doing before?

MS BUCKLEY: Yes, I think we did for a while. In fact, we felt quite stifled really. We were stuck. We couldn't get the data out of the system. When we did get the data out of system we had to learn because it's quite a different data ~~line~~ language from ~~on~~ the back of Lorenzo and

the way it works we, I thought we had could get access to everything we have. We had to keep going back to the software supplier to say, "We can't get that data now. We had it before. If we can have that then we can use that within our reporting systems as well."

DR WALTERS: Obviously more work for your department. What do you think were the bigger impacts of that data –

MS BUCKLEY: It was slower for other people to get what they needed from us. We would provide information to the divisions, or each of their departments really for their specialties, what information they needed. We've done some specialised reports for them as well as the standard commissioning data sets.

The way the process works is the commissioning data sets we used in finance and for any other reasons and we worked closely with finance and the finance managers that were a direct link into the division and they would check out anything that they felt was different here.

We also created an integrated performance report which would use the commissioning data set data and finance data together to try and tell the story around what our performances were against all key targets and where finance was impacted on with what. So we

produced an integrated performance report for the Board each month as well.

Which ~~W~~we then started to develop latterly for the divisions, they are a more specialist version of that. So something for each of the women and children, medicine, surgery and the out-patients we would provide a different report for, as a sub set of the main as we went through.

Each area would have its own specialised targets. A&E would have been one. In maternity there would have been things like the local development performance reporting which would be smoking cessation, smoking and pregnancy and breast feeding reports. There would be so many that we would specialise in different divisions. Waiting list targets where people were on their 18 week management which affected women and children and gynae and elective care and paediatrics.

DR WALTERS: So the effect of the information coming out more slowly, that was one affect, the fact it was slower. Did it have any other affect? Was there ever a query about whether the information was accurate?

MS BUCKLEY: Yes, yes. There was the robustness of the information as well. We got a lot of users using a new system and were they using it correctly? So we had a

lot issues with that. In fact, they had an out-patient review that looked at reviewing all of the way that out-patients was being used and what they were recording and how. We had issues with that as well.

Standard admissions data started to improve. That got better in as much as the ward started to see that ~~doing~~ recording this the right way, doing it with the staff, the nursing staff on the ward you were doing something that would have been a back room job later, they were ~~doing~~ recording it more real time which, started to improve the system.

We were trying to get them into working in a real time environment. Not easy, from a slow start, but they were getting there.

DR WALTERS: What sort of information about clinical quality went on in the integrated performance reports?

MS BUCKLEY: On clinical quality there was mortality, I forget what they are now, we worked very close with our performance and operations team to find out what they would wanted and the directors would choose which ones were appropriate to go through to the Board. There was an index at the front of the IPR which would colour code whether they were on target, off target or whether it was a key issue, whether it's going to be a financial penalty. They were colour coded on those.

Then if there was anything that was off target it would be in more detail reported on.

So we would pull the version together for the charts and we would ask the divisions or their managers within the divisions to make comment on that so they could go forward in the Board report.

DR WALTERS: What sort of input did you have to the whole clinical governance process from the information?

MS BUCKLEY: A little. Not that much. We had a Clinical Governance Team and they actually looked at the clinical governance element of this. Obviously data was some part of that and I worked closely with the head of Clinical Governance as well.

DR WALTERS: Was there any information you used to produce specifically for them?

MS BUCKLEY: No, because you could get most of what they needed so through the CHKS. If they wanted anything more specific I worked with them but nothing on a regular basis. Sometimes they would come and back and say, "We have an issue with this" and we would go and investigate whether there was anything wrong with the data or whether it was a clinical coding issue or a timing issue, we would investigate what was happening there.

DR WALTERS: What sort of interface did you have with maternity and obstetrics around that information.

MS BUCKLEY: For maternity. I'll just go back to CHKS so I can explain what that is. The data that went through ~~there~~ meant each division could work with their consultant to have their own specialised indicators built into modules that you could as soon as the data went in whether it was red, amber, green or whatever their special markings was and maternity had one of these modules.

The relationship with maternity, we had a close working relationship with them and my deputy, in fact, worked with one or two of their senior midwives who worked on a national data set for maternity which was, I can't remember whether it's mandatory this year, it was mandatory sometime last year. We worked with them on what was collectable, how could you collect it, what systems would need to be in place and they changed in 2013 as well because for commissioning purposes you had to be able to provide or approve the information about whether the patient was at risk and whether they were a high risk or medium risk or low risk in maternity and that focused their minds as well so we did quite a lot of work with them.

DR WALTERS: How did they ascertain the level of

risk from information?

MS BUCKLEY: Level of maternity risk. There were sets of key questions around - I can't remember all these now.

DR WALTERS: They were from CHKS?

MS BUCKLEY: Yes, diabetes or type of asthma, there were various, I can't remember, CHD, previous multiple pregnancies. I can't remember the questions that were on there now but there was a list of quite a lot of around this that the midwife would check through. You are supposed to check those in the early stages of the pregnancy and record that and we managed to take that data and work that way all the way through because some of the conditions could change part way through as well but that determined the level of payment we would get in 2013, 14. Whereas we'd been paid more like a block contract from our Commissioners previously but they then started to split the maternity, paid for maternity as three separate elements, standard, intermediate and high risk, I can't remember what the titles were.

DR WALTERS: Were midwives good at doing that?

MS BUCKLEY: They were getting there. There were some that were quite good. It was a method of collecting it that was difficult. If you ~~that a~~ could get hold of the hand held records that the patient had everything

was in there. So the physical record would be very good.

What we were working with our informatics department was having digital pens and digitised forms, so data it was collected via a tick box that we could enter and enter it once. The idea was that, this was happening as I was leaving, that would be entered into Evolution, which was the maternity system for collecting the birth data. We would then extract that and analyse it. But the pens hadn't worked by the time I left. We were actually using that on a spreadsheet basis and updating systems.

DR WALTERS: When did they start doing this?

MS BUCKLEY: I think we started the pilot in about January 13. So it's later. It was 13/14.

DR WALTERS: They were not collecting the risk information data before?

MS BUCKLEY: On the hand held.

DR WALTERS: When did they start collecting from the hand held?

MS BUCKLEY: I don't know.

DR WALTERS: Really the CHKS would have been only able to use what --

MS BUCKLEY: It would have used commissioning data set, the standardised data. It wouldn't have used any of

that because it is not on the commissioning data sets. I do not think they were measured really in the maternity section. It would be the number of Caesarean, tears. There was probably a standard set of things that you could get from the clinical coding data.

The only other thing that would mark up risk is if it was clear that the patient was an admitted patient and the diagnosis was clear that would show in the risk of the diagnosis but that's clinical coding, what happened on the admission.

DR WALTERS: When there started to be issues around maternity, around 2008, '9, '10, did anybody ask you for any specific information?

MS BUCKLEY: Probably not until around 2010 which was when we were going into Lorenzo. I would be asked, "Can you look at ...", in fact, it was probably later than 2010, 2011, '12 because I think we had gone through the Lorenzo period, it was almost like we got to normal working after that. We had a lot of requests for freedom of information about the period in time ~~in~~ the 2008 period in particular, but also looking back over a period of time over 10 years to look at the number of stillborn, the number of deaths peri-natal deaths and of any maternal deaths, to look at that in detail and

what we did to try and answer those questions we looked at a number of data sources to see if we could actually match them up.

DR WALTERS: You have never been asked to that by a Government Committee or --

MS BUCKLEY: No, no.

DR WALTERS: This was generated by external --

MS BUCKLEY: Yes, yes.

DR WALTERS: Did you generate any information which gave you any concerns or gave the Trust concerns?

MS BUCKLEY: What created concerns was the fact that we were having difficulties actually matching information up. You would have our main PAS system that may say that a child was stillborn or might had been live born and then died, then matching that back with the Evolution system around with birth was not easy. So we found some that were mismatched.

One of the problems with the maternity system in particular was it was not that well managed in some cases. If there had been -- I will give an example, if there that been a pregnancy that had been terminated with a miscarriage and they hadn't gone back to Evolution to close that record down and the mum was then pregnant again, often we would pick up the same record and add information on, which gave a distorted

picture of, a, an ~~inundated~~ elongated pregnancy but, b, you have got a mixture of information that didn't necessarily relate.

We did have some problems with that. We fed that back to division right away and the department knew about those as well.

DR WALTERS: That was really only generated when the external request asked you to try and --.

MS BUCKLEY: Yes, when we started look at all that. What I was also trying to do, one of the questions that we have been asked was how many babies had died after they left the organisation. So ~~it would be~~ if transferred elsewhere, how many deaths have we got? We didn't have that information as a standard set of information. You can record where you have transferred the child to, a baby to. It's not mandatory, so quite often that was not recorded, it was in some instances but not always. But there is no way of getting that information back into our system. We're not necessarily reported to.

Lorenzo, when it came on board, uses a system where if you manage the record probably and checked the demographics of the patient and accept them it will synchronise to the National Data Centre. So had a death been recorded elsewhere that information would come forward. The problem is once you've got a baby

that has gone away and died elsewhere you will probably never touch that record again so it won't be synchronised. When you're asked how many babies had died that left the organisation ...

DR WALTERS: You didn't know?

MS BUCKLEY: ... we didn't know. We did think there might have been a way that we could try to find out and, in fact, what we implemented, some people I left behind have implemented since, was to take the whole of the Lorenzo demographic data and get to it through to the national HES people to check back against their records and they provided a service and looked at a number of years' worth of data, this was all deaths, not just babies. They sent back any deaths that we weren't aware and then we updated the system and now there is a process going where every month we sent our normal data out and asked for an update,"Has anything changed on this."

There is a process now in place but it was not in place at time, it was not something that we would have expected to have had to have done and Lorenzo, with it being a new system, people weren't synchronising all the records because it took a long time and if you had to synchronise the screen would go away for a minute or two and there was a hesitation for the staff using that

and they wanted to get on to the next job.

DR WALTERS: If people had wanted to look at data prior to 2010 they might look at your Trust system but if they tried to match that with the maternity system they wouldn't get the same results. If they wanted to look at deaths, they would only be looking at those that happened in the hospital, they wouldn't be looking at other deaths? They.

MS BUCKLEY: In the main, yes. There were some patients where information had come back about them and that would have been synchronised. One or two of the medical ~~reports~~ records departments tried all sorts of ~~reasons~~ means to keep their main patient master data up-to-date and they would look at the local newspapers, look would look at death notifications and ~~think~~ check that is a patient we know, we will mark up the death but if they hadn't died in hospital there is not necessarily a notification. Which is a very old fashioned way of doing things but it worked. But not everyone is going to notify deaths in newspapers, that's the difficulty.

So the national Lorenzo system was meant to be able to sort all those things out. Had everybody in the country been on a national system we would have got all the information shared and it would have been a lot easier.

DR WALTERS: I should give my colleagues and opportunity.

MS FEATHERSTONE: You talked about the information was not always put on the system. What was the compliance with staff then? Why were they not putting it on? Because they didn't understand --

MS BUCKLEY: Are you talking about deaths?

MS FEATHERSTONE: Just generally, when you were talking about maternity, why wasn't the information being put on the system in the first place?

MS BUCKLEY: Timeliness really. Sometimes they would leave to their ward clerk until the record was available to them, keep that back and then they would have a backlog and have to catch up, so there would be some timeliness issues.

MS FEATHERSTONE: Was that raised as an issue?

MS BUCKLEY: Oh, yes, yes.

MS FEATHERSTONE: That went back to the department?

MS BUCKLEY: That went back to the department, the head of midwifery and some of their staff saying, "You need to be able to catch up with all of this, make sure it's as up-to-date and use the system as widely as you can.

There was thoughts around capturing other data, risk data, more recent risk data is much more likely to get people on board with that because it was an actual

part of what they were doing.

If the digital pens worked that data would be captured at the same time.

MS FEATHERSTONE: You talked about when the mortality rate was particularly high. So you raised that issue? Your department raised the issue?

MS BUCKLEY: Well, I met up with the consultant from Dr Foster, who was the person who alerted me that Dr Foster was likely to publish that if ~~– so we needed to know that if it comes up with Dr Foster~~ you are likely to be the highest death rate in the country and I ~~thought~~ realised that, ~~hang on a minute,~~ I need to get hold of the Medical Director and ~~let's~~ talk this through. So we did that within a day or two, sat down and talked with this chap and said, "What are you looking at and what is it?"

Then we also went back to our own service, CHKS, "Help us. What do we need to do?" So we looked at the data used by Dr Foster and ~~d~~ the methodology used to analyse this.– ~~They~~ CHKS had obviously experienced some of this in other organisations, "So the things you need to look at are these." and this is why within a week we pulled together the consultants at one of their regular meetings with the Medical Director and clinical coding staff and myself and ~~gone~~ went through ~~all~~ the data sets of all the records ~~and that was something we did ourselves~~ with them..

MS FEATHERSTONE: Then did it get escalated to the

Board?

MS BUCKLEY: Oh, yes, yes.

MS FEATHERSTONE: Then to the PCT, were they then involved?

MS BUCKLEY: Yes. They were aware that this is what had happened and what we were doing about it, the fact that we still didn't look good but we couldn't possibly have ~~pre-~~recorded all the cases that had gone through our hands in a year but what we had done is put improvement steps in place, we had a mortality review and we had -- we've got a work plan, a work stream and a work plan to actually improve on that that, which included involving lots of different people, including PCT.

Also making sure we had a reporting system that people could understand where they were, making sure they set up review groups with the clinicians on each site to say how are you going to do it? Do you want to do it as surgeons? Do you want to meet separately? Do you want to work as a group? They had a means of working their way through that.

We had one consultant lead, ~~they tried~~ to lead across the Trust as well, plus an overview from information, from the Clinical Governance Team and the Medical Director being the lead of that really. So he was aware of that. That was flagged back to the Board.

They The board said that needs to be on our work stream link, so we put a work stream together showed an improvement with a monthly marker about where we were and what we were doing.

MS FEATHERSTONE: Did that continue with a good flow back and forth, you giving information to the Board and the Board coming back to you?

MS BUCKLEY: Yes. But the reporting mechanism was via -- I can't remember what it was called now, we had an electronic link system where all the issues were raised, the Board prioritised which issues it wanted to see, all issues had to be worked on but which ones it wanted to see real progress on and this was one of them and the overview of that was reported in the monthly integrated report to the Board but they have access at any point in time to ask us questions about it and that was updated by the work stream leads and the work stream group.

MS FEATHERSTONE: You talked about difficulty getting notes. Were notes kept off site at all or were they just within the Trust?

MS BUCKLEY: At the time they wouldn't have been kept off site. Of course, we have got five hospital sites that we worked on, two were out-patient sites, there is one in Morecambe and ne in Ulverston running

out-patient services. Then there ~~is~~ are the three hospital sites. There ~~is~~ are five sites. In the main a lot of patients wouldn't ever change sites, they would be a local patient with a local issue that would be dealt with locally, though some people chose to go to the quicker waiting list, "I will move site if I can be treated/seen ~~move~~ quicker" and some wouldn't, they would want to stay on their own site.

So it became much of more of a flexible movement of patients around the system because if they chose to go to Barrow or Lancaster or Kendal or vice versa then the notes would move there but they might have been having other treatment for other conditions on other sites and that was usually were the case notes went.

MS FEATHERSTONE: Just one more thing. You talked about the midwives using the Evolution system. How did they collect their data in the community? How did they collect their data beforehand? What did they use?

MS BUCKLEY: They didn't have an electronic system in the community. They used the handheld record and put information into their GP systems, which was not much use to us as a hospital Trust at all. So we would get a summary of the birth record from Evolution only at that point in time and any appointments that the patient had had in hospital, in the clinics, the scans

or it if ~~could be seeing~~ being seen by a consultant or midwife in the hospital, we would have that information. That's the only information we had from them.

MS FEATHERSTONE: Years ago we used to use a Kalamazoo and they used to fill out a card and that used to go in the card. They never used a paper system that used to come in directly to you or anything?

MS BUCKLEY: No. For maternity?

MS FEATHERSTONE: Yes.

MS BUCKLEY: No. We used Kalamazoo system way, way back ~~where we the a~~ for waiting lists but nothing else for that.

MS FEATHERSTONE: Thank you.

MR BROOKES: Just a couple of things. There has been in an issue flagged with you which we have become aware of in terms of out-patient follow up. Can you take me through what the issue was there?

MS BUCKLEY: The issue with out-patient follow ups was once we got Lorenzo you could see the patients had had an appointment and the outcome of that appointment had been marked "An appointment at a later date."

MR BROOKES: Sorry, say that again?

MS BUCKLEY: An appointment had been given at a later date, so a follow up appointment.

MR BROOKES: No dates has been given, just a to do

thing?

MS BUCKLEY: Yes. That was around supposedly managing the out-patient pressure really. If the patient then hadn't been added to a waiting list immediately for a follow up ~~ing~~ appointment or saying this patient needs to be seen in three months' time or in December '14, whatever, it was left with a marker saying, "APL" appointment later, they were in a sort of holding position and those built up over the years because people had left them and it often was the case that they didn't need an appointment later but they hadn't got a definite discharge note from doctor. So they had been left.

So what happened with the out-patient follow up issue was when they were highlighted there ~~was~~ were lots and lots of patients that we had to review, there was clinical review, how many have actually been treated elsewhere. There was a big Lorenzo issue in there. Whilst it gave us the option to find them now but we also had, let me think, let me get it right in my head, it's quite a complex area this, you could see that the patient could be seeing another doctor in the same specialty for the same condition and they closed their own record down ~~so~~ as it streamed a specific referral and left ~~that~~ the original one open. To see another doctor you would

have another referral and that opens up. That might have been closed off successfully but the original referral left open that that patient still needed a follow up.

MR BROOKES: I am trying to be clear in my head. Was this an issue that was exposed by Lorenzo which was about a practice that had been happened prior to that?

MS BUCKLEY: It certainly exposed by Lorenzo. Prior to that you wouldn't have known, I don't think and I think the same with a lot of PAS systems. Very few of them had an area where you could have an out-patients waiting list.

MR BROOKES: Tens of thousands of out-patient follow ups was identified because of the change to the new the system?

MS BUCKLEY: Yes.

MR BROOKES: But it was a problem that was in the system but unknown prior to that?

MS BUCKLEY: Yes, but it was a problem that we didn't know whether they needed to be seen or not. Obviously there were patients in there that did need to be seen and they were found, but the rest of them they had to undertake a series of review clinics to find that they didn't really need to see them but this patient said I have been back and to —? treated?

MR BROOKES: I am just trying to clarify in my mind because I've been involved in some transfers of information systems and I have seen the paralysis they can cause in an organisation.

MS BUCKLEY: Absolutely.

MR BROOKES: One of the ones I was thinking of is where the new system generates duplicate results but what you are saying is this was something which was actually identified through the implementation of the new system?

MS BUCKLEY: Yes. There would be some duplicate records as well. There was a number of passes through of data that we did over a period of months and months to actually get the data as clear as possible so the patient that needed the appointments got them. So that was going ongoing whilst we carried on clarifying ~~this~~ the outstanding patients. In fact, sometimes contacting local GPs as well saying, "Can anybody else find this record?"

MR BROOKES: I understand both the complexity and also the sheer scale of the amount of data you are collecting and the system problems that you have got with that. I would like to understand a little bit about how it was used by the organisation because there is a very big difference between data and information. So I know there was information provided for the

integrated performance report and information back to the Directors. I am wondering how that information was used proactively by management on a day-to-day basis to manage the organisation?

MS BUCKLEY: Okay. On a day-to-day basis the information that was available, we had -- there is so much of it which you can go into. We worked very closely with the performance and operations team. So from an issue about patients, saying, what can we do next, what needs to happen to, a, stop, it going forward and how do we monitor it and how do we make sure that the divisions are working through any backlog and how do you filter those down. There were operational teams set up to work through those processes.

On a day-to-day basis you then had to an keep an eye on the reports that we sent through to them so we could have access to a report that would say, "This is how much you have improved or deteriorated from last week."

MR BROOKES: This was really about activity levels in finance?

MS BUCKLEY: Yes.

MR BROOKES: What about quality?

MS BUCKLEY: Quality of the data?

MR BROOKES: No, quality of service.

MS BUCKLEY: Quality of service.

MR BROOKES: Based on the information you were collecting around the data?

MS BUCKLEY: I can't really comment on that. It was more of a clinical governance, quality of service. I mean, quality of service you are looking at patients getting through the 18 week journey in the appropriate times and how much backlog did they have in any of that. So for elective care there was a lot on that. We've been through A&E with all the various measures that are in A&E and we have all of that regularly available to them but the quality of service I couldn't actually measure that from where I was.

MR BROOKES: Were you asked for reports or information to support clinical audit or clinical –

MS BUCKLEY: Absolutely, yes. We did provide information to clinical audit and they had a series of audit programmes that would agree each year that we would run through.

MR BROOKES: Okay. Can I turn to something else, information governance you mentioned earlier. What was your role and responsibilities on information governance?

MS BUCKLEY: My responsibility was to ensure that we

ran the annual assessment and looked at making sure that we met the appropriate level of all the standards that were in there, they changed over the years, mainly merging into two or three others. So that set us on a course of looking at policy and procedures, making sure they were all up-to-date and were being implemented and used across all of the sites, across a whole range of various systems. Making sure that staff had been trained to use the systems, understood the accuracy but also understood where their responsibility was in information governance with data protection and freedom of information and the normal stuff, the clinical stuff must be entirely accurate, relevant and up-to-date.

MR BROOKES: Who was the accountable officer for information?

MS BUCKLEY: The senior information risk officer, which was Tim Bennett, who you saw last week, and I would be his reporting officer from a local perspective but we also started to merge in with our informatics team before I left the organisation and we created an Information Governance Team which was needed because we had had a lot of other requests.

MR BROOKES: Did you have any involvement in the FT application?

MS BUCKLEY: Yes, a little bit.

MR BROOKES: What was it?

MS BUCKLEY: Mainly providing data for, you know, the sort of --

MR BROOKES: Were you asked to provide and assurance surrounding information governance as part of the FT application?

MS BUCKLEY: Yes, we had to provide what was our assessment.

MR BROOKES: What was your assessment?

MS BUCKLEY: We met the standards and time. I can't remember what the question was that we were asked at the time, but we were passed the 70 odd per cent mark that we needed to at the time. There was obviously some areas that we still needed to work on but ...

MR BROOKES: Lorenzo's implementation, where does that fit again the FT application and the Trust becoming an FT? Was it before or after?

MS BUCKLEY: I think it was before.

MR BROOKES: That's what I thought.

MS BUCKLEY: We went live in April 2010 with Lorenzo and the FT application was --

MR BROOKES: So you would be in the midst of your problems and issues as you became an FT Trust?

MS BUCKLEY: Yes, we would, yes.

MR BROOKES: I find that interesting that there was not

a significant issue considered by part of the FT application. What kind of discussions did you have with the Commissioner?

MS BUCKLEY: I worked on the commissioning team with them so I met up with -- finance, myself and performance would meet up with the Commissioners on a monthly basis around the contracting side of things.

MR BROOKES: What kind of information did you provide to the Commissioner? Was it mainly about the commissioning data sets or did they ask about policy?

MS BUCKLEY: It was mainly commissioning data set but there would be quality markers as well.

MR BROOKES: Such as?

MS BUCKLEY: Let me think what we sent to them. There would be stroke information, stroke patients. A lot of them would be financially related that they would be interested in as well. So looking at the various aspects of did patients get through the system appropriately. Did they see the right people in the right time frame. There will be A&E data. Something similar with audiology, where there was a service set up for any qualified providers. Audiology had to meet a certain criteria so we would provide separate information for those.

Other information that did go to the Commissioners

was about the clinical governance group around complaints. Where they were up to. There would be other things, I can't think of the list off the top of my head.

MR BROOKES: Okay. Thank you. Have you got any questions for us?

MS BUCKLEY: I don't think so. I do not know if I have been useful?

MR BROOKES: You have been very helpful.

MS BUCKLEY: Would I get a copy of what you are writing later or ...

MR BROOKES: Yes.

MS BUCKLEY: Do all the people being interviewed get a copy of the report when it is published?

MR BROOKES: It will be on our website, so that may be the best way to do it but there will be quite a lot of interest, so you will know when it is being published.

MS BUCKLEY: Right, yes. Okay.

MR BROOKES: Thank you very much.