THE MORECAMBE BAY INVESTIGATION

Tuesday, 2 December 2014

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

Before:

Mr Julian Brookes - Expert Adviser on Governance (in the Chair)
Dr Geraldine Walters - Expert Adviser on Nursing
Professor Stewart Forsyth - Expert Adviser on Paediatrics

GRAHAM HALL

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(At 11:35 a.m.)

MR HALL: How do you do.

MR BROOKES: Make yourself comfortable. There's water there if you need it.

MR HALL: Okay.

MR BROOKES: So welcome, I'm Julian Brookes and Bill, who normally chairs these sessions, is unfortunately unavailable today, and has asked me to chair this particular session. I'll ask my colleagues to introduce themselves, and then I'll just go through some of the rules, in terms of how we're going to operate etc.

MR HALL: Okay.

DR WALTERS: So, I'm Geraldine Walters and I'm the Director of Nursing and Midwifery at Kings College Hospital in London.

MR HALL: Hello.

MR BROOKES: Good morning, I'm Stewart Forsyth; I am a Paediatrician and Medical Director from Dundee.

MR HALL: Hello.

MR BROOKES: Okay, so you will see that we have microphones in here.

MR HALL: Yeah.

MR BROOKES: They are to take a recording of the proceedings so that we've got an accurate record. As you will be aware as well, these sessions are open to the families, and as it happens nobody is attending this particular session, but the recording is available for them if they wish to have a listen to it at a later stage.

MR HALL: Yes.

MR BROOKES: We've also asked for you to hand in your mobile phones and anything else which potentially could be used as recording equipment. That's mainly to ensure that the sessions are not taken out of context; that we've gathered our evidence, having the opportunity to consider it in its totality and then take that forward. Is that clear?

MR HALL: Yes that's fine, yeah.

MR BROOKES: That's the process. Okay, I'm just going to start with a couple of general questions and then my colleagues will pick up some further questions. So, it would be really helpful to understand when you started at the Trust, the roles you've had and what your current role is as well.

MR HALL: Okay. I've been in NHS 29 years.

MR BROOKES: And how much of that time have you been – when did you join Morecambe Bay?

MR HALL: It's the whole time has actually been in the various forms of Morecambe Bay was Lancaster Health Authority I think originally, when I started. I started in the works department, in the Moor Hospital, which was a big mental health institution; then moved out to the Royal Infirmary and various other sites that were operated by that over a number of years in an engineering role; my background is in engineering.

MR BROOKES: So, when did you start as a governance manager?

MR HALL: That would be the mid-nineties.

MR BROOKES: And how long were you in that – is that -

MR HALL: Basically up until – I finished about –would it be about 18 months ago. I took early retirement.

MR BROOKES: So would that be around the beginning of April 2013 was it?

MR HALL: Yeah.

MR BROOKES: Yes, okay, so you took early retirement at that stage?

MR HALL: Yes, yes, I was – I don't know if this is relevant, but I was off ill at the time.

MR BROOKES: Yes.

MR HALL: Enough was enough, and I went.

MR BROOKES: Okay and if you don't mind me asking, how long were you off ill for?

MR HALL: 3 months.

MR BROOKES: 3 months?

MR HALL: Yes.

MR BROOKES: So, the time before, so that this gives me a bit more detail, as governance manager, what was your main role?

MR HALL: My initial appointment, which probably is going back to the mid-nineties was a non-clinical governance manager and that was looking after the NHSLA scheme, RPST, things like controls assurance, developing into assurance frameworks, working with internal audits, more and around the corporate side of governance and risk.

MR BROOKES: Yes okay.

MR HALL: Obviously all of that was in the early stages, when things were emerging

and changing quite rapidly.

MR BROOKES: And was that the totality of your role towards the end as well or was that –

MR HALL: Yes, it expanded a little to – I would compile things like the quality account, introduce the risk management software packages over the years, introducing and implementing and developing that, along to online incident reporting and the management of the incident data that way, which was all incidents, not just non-clinical.

MR BROOKES: Yes.

MR HALL: It was a compact -

MR BROOKES: It was both, yes.

MR HALL: Yes.

MR BROOKES: Gerry?

DR WALTERS: Hi Graham.

MR HALL: Hi.

DR WALTERS: So, who did you report to?

MR HALL: Initially the Director of Facilities and Governance; that changed probably 5 or 6 years ago when I reported to the – it may be slightly more than that, the Medical Director. That then changed to reporting to the Medical Director and the Director of Nursing and then finally the Director of Nursing.

DR WALTERS: Okay so who else worked in the team, were you still doing a lot of the risk and controlled assurance type stuff then?

MR HALL: Yes, it did evolve, when I ceased working for the Director of Estates and Facilities we became an integrated risk department was established, in a central location; so I was sharing an office with the clinical governance and clinical risk team. And that department also brought together, for a short period of time, health and safety, clinical audit and complaints, as they were known at the time.

DR WALTERS: So, that sort of team sort of really worked like that until you left did it?

MR HALL: No, it was very shortly after clinical audit was separated out; quite soon after that complaint; became it's a customer owned customer services department, reporting directly to, and solely to the Director of Nursing. Health and safety were eventually hived off under the Director of Operations.

DR WALTERS: Right.

MR HALL: So fundamentally, in the end, there was myself and clinical risk, clinical governance.

DR WALTERS: So were you dealing mainly with the risk side then, and the incidents and the reporting; that kind of thing?

MR HALL: Yes, not in the clinical side of that, obviously in the operational side of it, and with a bit of assistance from some admin staff on generating reports; that type of thing.

DR WALTERS: So more what I would call health and safety end of risk?

MR HALL: A little yeah, yeah.

DR WALTERS: So if –

MR HALL: But if you – if I can just sort of clarify that a little; when you're talking about risk, I would be looking, with all the divisions and departments, at their risk, so there would be specifically clinical risk within that. But then there would be the more operational management risks so it would be like assisting them and guiding them into managing and pulling the risk elements together, which could include financial, HR risks, that type of thing as well.

DR WALTERS: Right, so there was a lot of overlap.

MR HALL: Yeah.

DR WALTERS: Between your role to start off controls assurance.

MR HALL: Yes.

DR WALTERS: And then moving into risks in general.

MR HALL: Yes.

DR WALTERS: So, how did the governance structure around quality and safety, the whole piece, how did that sort of work? What were the committees to support that?

MR HALL: That changed an awful lot.

DR WALTERS: Take us to about 2008 or 2009, about then.

MR HALL: Would that be – am I allowed to mention the name?

DR WALTERS: Yes.

MR HALL: Would that be while Ian Cumming was there, as Chief Executive?

DR WALTERS: Probably a bit after that actually.

MR HALL: Right, because very shortly after Ian left the structure that was in place I feel it got diluted slightly. There was a massive emphasis on the divisions

being accounted, the clinical and corporate divisions being accountable solely for their own management of risk.

DR WALTERS: Right.

MR HALL: And we lost what I felt, personally, was a good forum in that the Trust had. It was called a governance group, which met monthly, usually on a Friday; there was always exec representation at that group, and usually it was the Chief Executive, Medical Director, Director of Nursing and Clinical Directors as well. Although it did dissolve because it was felt by the newer exec team that it had become a talking shop. I always felt it was a good way of actually getting some of the nitty-gritty up to board level, and discussed quite openly, and it was open to challenge and discussion. And it gave people a fairly good structure to work through.

And reporting into that were the various risk related committees, some, I can't remember them all at the moment but there was a risk management advisory group, which was basically the operational risk committee, which I would have been responsible for organising and running; and it was chaired by an exec.

On top of that there would be reports from the audit group, the clinical audit group, medicines management, that type of committee would also report into that governance group, and it was all quite a formal, documented structure.

DR WALTERS: So that was the Ian Cummings time, then so if you had a risk that came up from the clinicians, how would that get dealt with?

MR HALL: Usually, for example, it would probably go through the risk management committee first, risk management group or advisory group, they were called various things. If it was felt that that needed escalating to the governance group it would be formally reported up as a report from that group.

DR WALTERS: Well when that system changed what would happen then?

MR HALL: It lost that stage, if you will, or that level; and it would be up to the divisions to report in through their divisional structures. They would still report in to what I can't remember the exact title, but it was the risk management group, it wasn't the formal Trust risk committee, but it was like a sub-committee. They would report it into there, on a regular basis. But then that evolved into – good grief, I can't even remember the name of it, and it was

probably established about two to three years ago.

MR BROOKES: Is it the Clinical Governance Advisory Group?

MR HALL: Yeah. Then the divisions would report direct into that.

DR WALTERS: And that was chaired by an ITEC?

MR HALL: Yes.

DR WALTERS: And then a Nursing Director used to attend?

MR HALL: Yes, yeah.

DR WALTERS: So what would happen then, if the divisions brought some risks up to that committee; how would they get dealt with?

MR HALL: I'm not sure, because I didn't attend that committee.

DR WALTERS: Right.

MR HALL: I was not part of that; by that time there was a new management structure and I was – I then had two senior managers above me who they would attend.

DR WALTERS: Right. So we've heard some people who say that the later structure was better, and now you're saying that you think that the previous structure was better.

MR HALL: In my opinion yes.

DR WALTERS: And just sum up why you think that was then.

MR HALL: I felt that it was – over a period of time it had become an open forum that people trusted, felt confident that they could take issues to there, felt that they were listened to, maybe not always happy that that high level of committee didn't always provide the support, or the finance that was required to help resolve those risks, but it wasn't hidden, if you want; and I don't mean hidden in a negative way, it's just the way that it felt.

DR WALTERS: Okay. How were serious untoward incidents dealt with?

MR HALL: Right, more recently with the – there was a serious untoward incident meeting group, which met very regularly.

MR BROOKES: Sorry, just for clarification, when you say "very regularly" is that monthly, fortnightly?

MR HALL: Certainly initially, when it was set up I think it was weekly, and then it may have moved out to fortnightly or monthly. And initially that was involving primary care, other partners and supervised initially by – I can't remember what it was like a regional advisor. Prior to that they would be dealt with

through the execs and previously the governance group in the sort of interim period, the risk management group would be involved, it was certainly strengthened towards the latter end.

DR WALTERS: And what was the profile of serious incidents like across the organisation, you, as a governance manager, were there hot spots; were there areas that were dealt with better than others where they caused a concern?

MR HALL: There certainly were, if you will, areas where individuals dealt with them much more proactively and constructively and involved a wider team very quickly. There were others that certainly needed help.

DR WALTERS: Were they dealt with well, in your opinion?

MR HALL: The problem I've got with that is a lot of them were actually clinical.

DR WALTERS: Right.

MR HALL: And from my perspective they could have been handled better; certainly in terms of process, speed, and the whole way that sometimes they were dealt with, it could – different people would deal in many different ways sometimes. At times, as well, one of the major faults that I came across was the first question that was asked was who did what.

DR WALTERS: Right.

MR HALL: Rather than what's happened and why did it happen; and there was an element in there sometimes, of a culture of looking for somebody.

DR WALTERS: And in terms of maternity and obstetrics, which is what this is all about; what's your view or profile on who was there and who dealt with it?

MR HALL: Going back a couple of years, a few years, we didn't hear an awful lot about them, as a wider organisation, I think, up to a point, and this is purely my opinion, that things were kept slightly in-house there. Where they were known about in the wider organisation it appeared to me that there was a genuine attempt to get to the bottom of them, and put them right. Latterly nearly everything that happened within that division was perhaps overreacted to at times.

DR WALTERS: Right.

MR HALL: In that there were people saying that that should be a SUI, and other people saying no it shouldn't, and you got this conflict in there, mainly on clinical opinion, which I obviously wasn't directly involved in that. But my

thoughts were while the spotlight is on, while we know that there's harm being done; why not treat them at a higher level than perhaps somebody else would. So I would support that view that they were perhaps escalated.

DR WALTERS: And within the divisions, who was responsible for quality and safety?

MR HALL: Well that varied enormously.

DR WALTERS: Right.

MR HALL: In some divisions, well particularly recently, when they were reorganised, you will be aware of all the review teams and everything else that went on, some divisions were actually reorganised, following external recommendations, there were no recommendations in there for a governance structure. So there was obviously no money for that, and then you get the problem that you've got to rob Peter to pay Paul, which is always a bone of contention.

Eventually I would think that overall the governance arrangements within divisions were strengthened but again personally my opinion is that they weren't strong enough. There wasn't enough resource allocated, it would be one or two people, perhaps a job share in some divisions, no cover for illness, or people had other demands on their time. They could have been stronger.

DR WALTERS: So, was it a resource issue or was it engagement by the clinicians and managers within the division that were the issue?

MR HALL: I think a little bit of both but I think the engagement was initially – I'm going back over a period of years, had been a problem and I don't think we were on our own as a Trust in that, in that wherever you went, in any risk related, or governance meeting field, it was the same old faces, the same old people all the time.

It took me a long time to get involved with some of the clinicians and some of the work I did, for whatever reason, I'm not here to judge that but there was always the willing and not so willing.

DR WALTERS: So, round about 2008 there were these five SUIs, which were all linked to maternity and gynaecology.

MR HALL: Uh hum.

DR WALTERS: Do you remember those, and how they were dealt with?

MR HALL: Not in any detail, no.

DR WALTERS: Do you know what the outcome of those five were, in terms of how the Trust responded to them?

MR HALL: Again, not in any real detail, no.

DR WALTERS: Were you involved at all in the Fielding report?

MR HALL: No.

DR WALTERS: No?

MR HALL: No.

DR WALTERS: Can you remember how the Fielding report was publicised, or dealt with in the Trust?

MR HALL: I am aware of it yes, but how that was communicated throughout the Trust, to be honest with you no, I'd have to say no. I am aware of it, but I don't have any specific recollection of the detail of that.

DR WALTERS: Were you involved at all in the preparation of the CQC, or the central managers' visits?

MR HALL: Yes.

DR WALTERS: What did you do around those? What was your role?

MR HALL: Around, particularly around CQC, when they first came into being I was the point of contact for CQC; with the Director of Nursing being the named individual. So I would receive all the communications and arrange for any documentation, any visits, anything like that that they would – obviously the planned visits, unscheduled.

DR WALTERS: So, they came to do an inspection of the maternity services didn't they?

MR HALL: Yes.

DR WALTERS: What happened after that? What as the outcome of that visit?

MR HALL: Was that the first one?

DR WALTERS: Yes, that was after the SUIs had happened. [*Pause*]

MR HALL: If I remember correctly, they gave us a reasonably positive report. Now please stop me if I'm going wrong here because they did give a reasonably good report if I'm thinking about the right time frame here. I don't recall anything coming back rapidly demanding that X, Y and Z be put right immediately. But again that would have gone through the Nursing Director, who would have then taken that through the maternity structure.

DR WALTERS: So there were the SUIs, the Fielding report, there were some visits

from the CQC around that time. Did that make maternity an issue in the Trust?

MR HALL: Yes.

DR WALTERS: Or was it fairly contained?

MR HALL: No, I do feel it became a concern, particularly in Barrow; and there was a lot of activity around that concerning staffing levels, and training. It certainly raised the profile at the time.

DR WALTERS: And did it make a difference; did changes happen?

MR HALL: Certainly a lot of staff changes at the time, quite senior ones; following on from there, when those staff were replaced, there seemed to be a little bit of a more dynamic and high profile approach from the division.

DR WALTERS: And what time was that, what sort of time period was that?

MR HALL: That would have been about 2009, 2010, roundabout that time.

DR WALTERS: So, the quality account in 2011, which I think you wrote.

MR HALL: Yes.

DR WALTERS: Maternity doesn't come over as a big issue in that.

MR HALL: Mmm.

DR WALTERS: Which seems a bit unusual?

MR HALL: Yeah. Again, I can just recall what – how we compiled that would have been myself just literally liaising with the divisions and on their concerns, whatever indicators they picked.

DR WALTERS: Right, and then the top strategic risks at the time, there wasn't really anything maternity raised there, was there.

MR HALL: I can't recall in detail certainly I know at times certainly paediatric cover was up there.

DR WALTERS: Yes.

MR HALL: But no, I think you're correct, yeah I don't think there was anything major on maternity at that time.

DR WALTERS: How do you explain that? What do you think the perception was, in the Trust?

MR HALL: The only thing I can think of is that people actually genuinely believed that things were okay.

DR WALTERS: Right, and do you know what assurance – where they were getting any assurance that that was the case?

MR HALL: I couldn't point you at any evidence for that, no.

DR WALTERS: So, was there any monitoring going on, given that there had been some SUIs, some attention from Monitor obviously, at that time and an external group or you'd had a CQC visit? It sort of doesn't seem to fit that then the Trust don't seem to be explicitly recognising it as a risk, unless they were having other assurance that it wasn't a problem anymore, and I just wondered if you –

MR HALL: No, I can't really help you. I'm struggling to think of anything, whether you could get any positive reassurance, no.

DR WALTERS: Right, did the governance system in the organisation sort of look at any metrics of performance that it would get assurance from?

MR HALL: There were various systems; there were dashboards for covering all sorts of things. There was also a clinical information system, which the name escapes me at the moment, but I don't think that would have covered maternity.

DR WALTERS: Right.

MR HALL: I'm struggling to think of any metrics there would have been.

DR WALTERS: Yes, it's not clear is it?

MR HALL: Yes.

DR WALTERS: So, why did you leave in the end? You don't have to answer that if you don't want to.

MR HALL: Obviously the whole process around following these incidents and other inspections became extremely difficult, police investigations, things like that; and although I wasn't sort of personally clinically involved, you're involved in the process and on the side lines and compiling the evidence. That was, I won't say stressful, it put a lot of pressure on.

DR WALTERS: Yes.

MR HALL: We had three key members of staff either went part time or left, which left us extremely shorthanded and then following innumerable interviews, reviews, some of which I thought were absolutely excellent, gave the right sort of conclusions, were done very well; some of them, I think, were just there to criticise.

DR WALTERS: Which were the ones you think we done well?

MR HALL: Some of the Monitor ones certainly; I've always worked well with the

CQC, I found they were very fair, sometimes perhaps the individuals involved in those were a little bristly; which wasn't always helpful at the time, but the point they were getting at was valid. Some of the independent experts that were brought in, I thought, were absolute garbage, particularly the ones that advised around the governance and criticised everything, and they didn't put anything in its place. Anybody can do that.

DR WALTERS: So -

MR BROOKES: Sorry, can I just press you on that?

MR HALL: Yeah.

MR BROOKES: Who are you referring to, precisely? Is that the McKenzie external review or is that -?

MR HALL: I don't know who exactly.

MR BROOKES: PWC that's right.

MR HALL: It was a lady called Helen and her partner in crime. I can't remember his name.

DR WALTERS: Were they the ones doing the outpatient stuff?

MR HALL: They did do some on outpatients yeah, but they did a lot on governance, and basically everything we did was criticised. I'd be the first one to hold my hand up and say, we could have done better on everything, everything that we did, but you can only do what you can do with the resources that you've got. And I think sometimes it just – it's so negative it doesn't help. I don't mind criticism at all, if it's valid, and you can do something about it.

Some – if I can just follow on slightly from that, some of the interim staff that were brought in, certainly on the governance quality and risk side, had very little experience, which became apparent very quickly. And certainly, for the last 12 months that I was there, I was under a lot of pressure because I felt I was teaching somebody their job who was allegedly being my manager, and another layer above that. Whilst they may have been very good managers, they weren't very good risk and governance and quality managers. They didn't have the detailed knowledge or the experience; and that put me under an awful lot of pressure because their communication was awful.

For just a brief example is that what I didn't know about was a meeting that had been arranged with the health screening committee; I was told 20

minutes before and had to get to Carlisle and I turned up on my own, an hour late, through no fault of my own, unprepared. And believe it or not we got a hammering and there were a lot of instances of things like that, certainly in the last 12 months, and I just ran out of steam.

DR WALTERS: It's easy to criticise isn't it.

MR HALL: Yes.

DR WALTERS: I suppose, thinking of obviously once the situation got very difficult, there was an awful lot of input from lots and lots of angles, which seemed to generate an awful lot of work; in your view, and you mentioned a couple of reports, but in your view was there anything that was put in place that really did make a significant difference?

MR HALL: Certainly not on the process or the organisational structure side. I think within maternity services quite a strong team evolved on the management and the governance side. But again, they were under a lot of pressure and there weren't enough of them.

DR WALTERS: Right.

MR HALL: But some people that were brought in did actually get stuck in and seemed to be but they were under an awful lot of pressure in they were working extremely long hours to try and get through.

DR WALTERS: So, when you got an amount of new people and support then that is really when it made a difference, you say?

MR HALL: Yes, I mean, I know this may not be helpful, but I know that when the new Head of Midwifery was appointed, and when she was interviewed, this is Sascha Wells I'm talking about; at her interview she actually asked "Is there anything that I should be aware of? Is there anything waiting for me?" And she was told no.

DR WALTERS: Okay.

MR HALL: A month later, oh dear. That type of thing, to me, is just wrong.

DR WALTERS: Okay. Thank you.

PROF FORSYTH: Okay thanks, can I just follow that point up; so to whom did she ask the question?

MR HALL: Well, I certainly wasn't on the panel, the interview panel, but I would imagine there would have been, at least, the Director of Nursing there, the Director of HR at the time.

PROF FORSYTH: And so just too again focus on maternity, you said that obviously the improvements in governance at that time, presumably lay – you didn't say at the time, but Sascha Wells made a difference though, did she?

MR HALL: Yes, I think so, yes.

PROF FORSYTH: And I wonder if there was anyone else, feel perfectly free for you to say as to who; that improved and the timing of that again would be quite helpful.

MR HALL: Well, Val Wilson came in.

PROF FORSYTH: Sorry, who?

MR HALL: Val Wilson, I am not sure of the original capacity that Val came in as, but certainly within a 6 month time frame she was taking a big lead on risk and governance. She seemed to make a noticeable difference. There were other people who supported that, and there as a lady called Jane Kenny who - I'm just trying to think how the divisions were actually split up at that time, but she was certainly providing some support in there. There was – the name escapes me completely [*Pause*] if I think if it I'll -

PROF FORSYTH: It doesn't matter. So why do you think that these systems that were being developed around that time, were not there previously; what was preventing that happening?

MR HALL: The only thing I can think of was that there was a perception that the service was okay. Things like CNST and things like which were in place must have given people that impression that there was no real, major issues there.

PROF FORSYTH: What about the staffing, the staffing issues within the governance concerns, risk concerns around maternity services?

MR HALL: Yes, there were; I do recall that that was particularly midwives was a concern; but not something that was raised too high; but that was in common with virtually every other department in all the hospitals were a similar thing. Particularly the Barrow end of the patch has historically had recruitment problems, because of its location and I assume that's it, I mean I would love to be working there, but not everybody – it's not everybody's cup of tea. And whether that was just a perception that it was a difficult place to live and work I don't know. But that had been historically recruitment problems in that area.

PROF FORSYTH: Is that not a long-standing governance issue? A number of

people have told us that they had recruitment problems in Barrow, but continued to try and run a service.

MR HALL: Yes, I can remember that coming up ever since Lancaster merged with Barrow, and Kendal, that Lancaster and Kendal inherited the deficit financially and everything else, from Barrow and the perception was all the time that it's purely because you can't get the staff up there, as well as the geographics of the location and the problems associated with that.

PROF FORSYTH: And so, where were you based, where was your office?

MR HALL: Kendal, central.

PROF FORSYTH: So, did you see differences in how governance was delivered between Lancaster and Barrow?

MR HALL: Initially, yes.

PROF FORSYTH: In what way?

MR HALL: I felt that, and this could have just been because I was involved that we had stronger arrangements in Lancaster than they did in Kendal and Barrow; a lot more engagement; but that may have been coloured by my role at Lancaster and the involvement that I got from the executive team at that time. There's a cultural – I don't like to say but there definitely was a tangible – at the time of the merger and for a few years after, and it's probably still exists, to a point. There's like a barrier there, an 'us' and a 'them'.

Not so much so now, but it does still exist and anecdotally I have heard, and including within women's and children's services, "Oh that's the Lancaster way" or "That's the Barrow way". But I couldn't give you any evidence of that. It's hearsay, if you want.

PROF FORSYTH: But as being part of the governance team for the whole Trust, was this not a risk in itself?

MR HALL: Yes.

PROF FORSYTH: Raising the difference between the two centres.

MR HALL: There certainly was, and clinically it was a risk because we were trying to, if you will, move staff between the two, so that there was some learning and shared experience and improving practice. To begin - and one of the key things that I remember Jeanette Parkinson, who was the first sort of maternity risk manager, was to get in place a standard set of practices and procedures documented, which was a CNST requirement as well as anything

else. But I do recall that she did have some challenges doing that, in establishing.

PROF FORSYTH: So consistency across the two centres?

MR HALL: Yes.

PROF FORSYTH: And I see, from what you were saying earlier, that a lot of this was from the Barrow end, or is it in both cases?

MR HALL: Not always, no. No it could – I think initially that would have been everybody's perception, but I think the same thing happened at Lancaster.

PROF FORSYTH: Can I ask you a bit about what your views are in relation to how the senior manager of the executive team responded to the incidents, the inquiries, the reviews, from a governance perspective; do you feel that they conducted themselves at that time?

MR HALL: Yes and no. Personally I felt that a lot of criticism came down from the executive team to the likes of ourselves and lower, with very little acknowledgement that maybe some of it had been led by themselves, or they'd contributed to the situation.

PROF FORSYTH: Can you just expand on that?

MR HALL: One comment that came out from the executive team was if we'd have got CNST level 2 at the time, I think it was, these investigations would never have happened. Well, to me that, regardless of what your CNST or anything else is telling you, those investigations happen because people had been harmed, and I thought that was like denial, if you will, from the executive teams that perhaps we weren't doing everything wonderfully.

The communication of some of the outcomes from the reviews and the investigations wasn't terribly good at times. Some of it was, some of it – but there were bits that you sometimes felt I don't know how to explain this, you should have been told a little bit more of the detail. You got the flavour of what – 'Oh the governance on this was okay', or it wasn't, and I sometimes would have perhaps liked a bit more detail, but -

DR WALTERS: Do you think the –

MR HALL: Certainly I think that they were bombarded with this as well, and I'm trying to think of good examples, but I can think of another couple of bad examples which -

PROF FORSYTH: Well carry on.

MR HALL: The CQC report that came in, in 2012, July time, had about 40 – 41 points on it, something like that. I'd never actually heard of this report and although that had, in the past, been my role to receive those reports, compile reports from that, engage with the divisions and get the action plans up and running; I'd never actually heard it. In December 2012 that report was put on my desk, in between Christmas and New Year with a note from the associate director 'Please get on with this.; CQC coming back in, in January. See critical care action plan.'

So, I looked at that, looked at that and thought it doesn't bear any resemblance, 'What is this?', looked at the dates, went back, found that it had gone to the board in July and not a very positive – it was while we had an interim board, not a very positive response to it was – and it seemed to be an assumption that it would all be dealt with and the project management team would – or project management office as it became, would pick everything up and do it.

When I contacted them they were aware of elements of that plan, but not all of it, and other action plans that we had in place, to address various issues, covered an awful lot of it. But I was trying to pull information, there was no structured plan and I could not get an answer from anywhere as to why that had happened, why had it not been a dedicated work string, and then, for it to finally drop on me and try and do 6 month's work in a month while I'm trying to do other things as well; that was the last straw and I handed my notice in and said that's it, I'm -

DR WALTERS: Why did they give it to you? Why didn't they give it to -

MR HALL: I don't know.

DR WALTERS: Did anything go down the operational route, or is it if it's documents, it goes to the governance team instead of if its operational and relevant it should go to -

MR HALL: It should have gone to both, you know, let's not tuck it away somewhere and assume that somebody's going to do something. There were enough people in place, the director and associate director to pick it up and run with it and say 'Okay, let's split this up'. But for it to just sort of – I'm assuming it sat with either a director or an associate director for 6 months and somebody thought 'Oh, best do something about this' but nobody had actually checked

that all the elements were covered elsewhere.

MR BROOKES: Can I ask you if that's a typical experience?

MR HALL: No, that's not. Normally I've – in prior to the interim arrangements I would have received that directly. I would have taken it back to the board or if that was appropriate, or the directors and directorates that were involved and said, 'Come on, we need – this is what we need to do. These are the weaknesses or the faults that have been identified. What's stopping us putting that right?'

MR BROOKES: So, do you think it was a symptom of the interim arrangements that people weren't clear on their roles?

MR HALL: Yes, it was that and the sheer mass of reports and requirements that were – everything that was going on at the same time. I'd like to think that it wouldn't happen now; I don't think it would now but – and I don't think it would have happened previously; it was just within that interim period and perhaps somebody just made an assumption that it would be dealt with, and it wasn't; and when it had to be dealt with, we fell short. An awful lot of things had been addressed but I don't think at, certainly as I sort of disappeared out of the scene, we couldn't provide sufficient reassurance to the CQC that everything had been put to bed.

PROF FORSYTH: So, just to check on the date of that, so that would be around this Christmas, New Year period that would be 2012?

MR HALL: Yes, I think the report came into the board July 2012, June or July.

MR BROOKES: Okay, I have a couple of questions just before – on something slightly different; were you involved at all in any of the arrangements around the FT application?

MR HALL: In so far as compiling information and submitting that information to the application team yes, and various reports.

MR BROOKES: Because one of the building blocks at the time, in terms of the assessment by Monitor was the self-assessment of governance arrangements with the organisation. Did you have any involvement with that?

MR HALL: Yes, but I can't recall that much of the detail of it, I remember putting in an awful lot of information together, but I certainly wasn't involved in that on a day to day basis.

MR BROOKES: Because the recommendation to the board was that the governance arrangements and the organisation were fit for purpose, which we feel that it's quite difficult to see that.

MR HALL: Yes.

MR BROOKES: Do you think that was a fair assessment on the information they had, or was that an optimistic assessment?

MR HALL: I think yes, it was optimistic.

MR BROOKES: Okay. So, there was sufficient information to have made the board well aware of the concerns there might have been about elements of the governance arrangements in the organisation?

MR HALL: Yes. I believe so, yes.

MR BROOKES: Okay.

MR HALL: I do recall at the time that there was enormous pressure on that this must be done, 'We must be an FT'. And a new – perhaps a new style of management, I don't know whether I can explain myself very well here, you would be asked a question and rather somebody say 'Has this been done yet? Where are we with this?' It would be 'Tell me that that has been done'.

MR BROOKES: Right. Yes.

MR HALL: Which, depending on the individual who was getting that, some would say yes. I personally didn't but –

MR BROOKES: That's very interesting.

MR HALL: I have seen that where people have.

MR BROOKES: You're not only person who indicates that that might have been the case.

MR HALL: And that was coming across most of the execs, not all of them, most of them.

MR BROOKES: So, there was a yes culture, rather than a 'this is the situation'?

MR HALL: Yes, 'Where are you with this? Is there anything you need help with?' it was 'Tell me that this has been done'.

MR BROOKES: And if you said no, it hadn't been done?

MR HALL: You'd probably get your head pulled off.

MR BROOKES: So, it was quite an aggressive management culture at that time?

MR HALL: Yes.

MR BROOKES: Okay.

DR WALTERS: Can I just butt in?

MR BROOKES: Yes.

DR WALTERS: So the problem with board sign off that their governance arrangements are okay, what sort of evidence might there have been to – for them to say no, they weren't okay?

MR HALL: I know there were an awful lot of guidelines on what you should have had and not had in place, and what documentation you needed and things like that.

DR WALTERS: But it's quite easy to get the document in place isn't it.

MR HALL: Oh yeah, yeah. Oh yes, it's implementing that and having the evidence that it's working.

DR WALTERS: So, if you had gone in now and you were making the same assessment, would you advise them to say 'You're governance arrangements are okay, or would you be advising them to say 'Actually these are not really fit for purpose?' for some reason, did you really think that they weren't fit for purpose?

MR HALL: That wouldn't have been my call, but certainly in -

MR BROOKES: So what was your personal view?

MR HALL: They could have been stronger.

DR WALTERS: But I would say that.

MR HALL: I would say that perhaps slightly prior to that process they may have been okay; and that process may – going into post Ian Cummings and all the other changes, I felt that the governance, by being devolved into divisions was not wrong, there certainly should be structures within the divisions, but I think we lost some of the strength in central governance, and we lost some of the communication channels, I think.

MR BROOKES: Yes, and I know exactly what Geraldine means, if the board receives, in good faith, a report that says it's excellent, and a recommendation on the evidence that they have on these issues, the question is whether that is an accurate representation of the position in that organisation, and the information that is required as part of the FT process.

MR HALL: Yes, I'm certainly not aware of anything would have misled the board when they came to that decision, I'm trying to think of the things that would back it up; that would give the board some assurance, which would be like

RPST, CNST, standards for better health at the time and all that, but as I say, much of that was documentary evidence, and that would have been more my role in putting that. There was a full team put in place to handle the FT application.

MR BROOKES: Yes. Okay, that's helpful. I just want to be clear that I have gone away with an accurate view of what you're describing, and it seemed to me that there was quite a lot of fragmentation, different elements of the governance processes; is that a fair assessment?

MR HALL: Yes.

MR BROOKES: So, where would it all have come together or should it have come together?

MR HALL: I felt we lost, no, regardless of what you call this, there should have been a central group, Trust wide, that you could call the risk management or governance or whatever; where there was opportunity for discussion for bringing issues that we didn't have that forum, we lost it. And it just became exec committee, chaired by a non-executive, basically down in the divisions; there was no central point, which I felt was a massive weakness.

MR BROOKES: Okay, and I just want to ask one last question; I just want your honest opinion about what it was really like, because there's all the structures in the world, you can have committees in place and it can look great on paper, but what was it like, what were the challenges on a day to day basis, in terms of governance interface?

MR HALL: It was always difficult; the biggest challenge in any of those sorts of roles is actually trying – it's this is all around communication and I'm struggling; but the communication is the big issue. But it's to engage with people and get them on board; certain groups of clinicians were difficult, were challenging, rightly so in most cases.

But just getting people to buy into the whole risk and governance and not see it as an add-on. And when you said to people, 'Well actually you're doing risk management every day of your life, every minute of your life. And all we're asking you to do is formalise the more serious aspects of that." And that's always been a challenge to get buy in, at all levels of the organisation.

We got various, varying levels of support, a quick example was the patient safety first initiative that came along; trying to get senior clinicians

involved was virtually impossible, and their not put an intensive care specialist who leapt on board, and we really started moving things, sadly he became very ill and passed away but he had the credibility to go and bash his colleagues and encourage them. I didn't. You can persuade so much but –

MR BROOKES: You need somebody with –

MR HALL: Yeah.

MR BROOKES: Okay and finally –

MR HALL: I don't know whether that's answered your question but did I drift a bit?

MR BROOKES: It helps, it helps thank you. And just finally, I just want to be clear on – I'm just triangulating some things I've heard; were you ever asked to alter reports to make them more positive?

MR HALL: No.

MR BROOKES: Okay thank you. Are you aware of anyone who might have been asked, or put in a difficult position?

MR HALL: Sort of; they weren't specifically asked to change a report, but we would generate a lot of reports, graphs, figures, for example falls; rolling dashboard, bang, bang, bang. If those figures were not going the right way, it would sometimes be 'They can't be right.' But we were never told to alter them, but certainly it must – we can't possibly be having more falls, your reporting system must be wrong.' So, it's slightly different but it's that there was pressure in there to re-examine should I say.

MR BROOKES: Thank you.

DR WALTERS: Yes, the whole thing about clinical staff not wanting to get engaged in risk assessments is very familiar.

MR HALL: Yes.

DR WALTERS: But normally they are quite good at saying, 'Oh this is an accident waiting to happen' when it's something which they are particularly concerned about. Was there much of that going on, or was that responded to?

MR HALL: There were certainly pockets of excellence, and people that would come to you regularly and report - near miss reports were sporadic, but there were pockets where that would happen, yes. It wasn't all bad.

DR WALTERS: No, I know, but sometimes the sorts of things that people are really needing to come up and say 'This is a real risk' because it's not something

that can be dealt with very easily, the perception is that it's not being dealt with. So, I suppose what I'm getting round to is where there people within obstetrics and maternity, who were worried about the service very much, and reporting that up, whistleblowing in those terms?

MR HALL: I'm struggling to find any specific examples that I can recall, but I am aware that yes that was happening and certainly, in paediatrics I know it was a major factor for a number of years about paediatric consultant cover and things like that.

DR WALTERS: And did that actually – did they report that formally, did it get to the risk register?

MR HALL: Yes.

DR WALTERS: Was it scored appropriately, those sorts of things?

MR HALL: Yes, I know it – I think sadly it was a high profile risk for a number of years. I'm not even – I don't know now whether it's ever been resolved.

DR WALTERS: And was that a recruitment thing; was it anything else do you think, or was it a funding thing?

MR HALL: No, I think it was recruitment.

DR WALTERS: Okay.

MR BROOKES: Okay? Is there anything we should have asked you, anything you wanted to say to us? You don't have to, but if there's anything you feel that would be useful for us to know about this is your opportunity.

MR HALL: I don't think so. I think it's certainly been a very, very challenging time for the Trust and to an awful lot of individuals in that Trust, but I'm hoping it all gets resolved and everything moves on.

MR BROOKES: Okay.

MR HALL: Yeah, I can't think of anything else.

MR BROOKES: That's great, thank you very much for your time.

DR WALTERS: Thank you.

MR BROOKES: Thank you.

MR HALL: Thanks a lot.

MR BROOKES: Thank you.

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

TONY HALSALL

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(At 10.03 a.m.)

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

DR WALTERS: I'm Geraldine Walters, and I'm Director of Nursing and Midwifery at King's College Hospital in London.

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

PROF MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Healthcare Law at University College London, and Chair of the Health Research Authority, and I've previously chaired an SHA when there were 28 [inaudible] provider trusts and PCTs.

DR KIRKUP: You'll see that we're recording proceedings. We'll produce an agreed record at the end. You'll also know that families are invited to be present as observers. We have a family present, and there may be others who are delayed who might join us, and others might listen to the recording subsequently. You also know we've asked you to hand in any mobile phones, laptops, any other recording devices. Just to emphasise we don't want anything to go outside the room until we're ready to produce a report with everything in context. Do you have any questions for me about the process?

MR HALSALL: No, that's fine.

DR KIRKUP: Okay, I'm going to start off with a general question, and then hand you over to Geraldine, and my question is, can you just outline when you started at the trust and [inaudible 09:38]...

MR HALSALL: Yes, I started – that's a good question, that – I started in 2007.

DR KIRKUP: Okay. Can you remember what month it was?

MR HALSALL: It would have been March.

DR KIRKUP: March 2007. Okay, and you were there until?

MR HALSALL: Until I left the building on the 20 – I think the 20 February. Three years ago this February. So 2012.

DR KIRKUP: 2012. Yes. Okay. Thank you. Geraldine.

DR WALTERS: Alright, Tony. So where had you worked before?

MR HALSALL: Before here? I was the Chief Executive at Clatterbridge Cancer Centre.

DR WALTERS: Right.

MR HALSALL: I'd been there for three and a half years. Before that I was the Director of Nursing and Patient Services at Wrightington, Wigan and Leigh. And before that I was a Director of Nursing and Midwifery at Stockport.

DR WALTERS: Right, and what were your impressions when you got there?

MR HALSALL: What? At Morecambe Bay? Well, I mean it was always going to be a difficult and complex Trust, because when I got there, I hadn't been there long, and we had, I think 3,500 people holding hands around the hospital, you know, at Westmorland. So, you know, it was I think 5,000 did a candlelit vigil through Kendal. So it was always going to be a difficult – difficult job in that sense.

But an organisation that had gone from having three stars, down to either none or one. We had – they had just gone through a public consultation period, around the closure of key services at Westmorland. That was coming to a conclusion when I got there, but although the public part of that had concluded, it was clear that none of the organisations involved had an answer to the – to the actual consultation plan. So it was stepping into that type of fray.

So quite noisy. A lot going on. So quite difficult. The one thing it didn't get – because I knew that in terms of going in there there was a lot to deal with, in terms of – well the biggest issue about the clinical configuration really, and, you know, the Acute Service Review being a small step towards trying to make sense of that. But again, sort of step by step, year by view, moving it down the performance track and, I guess the bit that I didn't realise when I first got there was shortly after they issued the staff opinion survey – staff opinion survey was probably the most alarming so, you know, in terms of trying to get our first year together, you know, priorities were around about a) dealing with, you know, a sensible outcome from Acute Services Review; b) was getting some work done on sensible clinical strategy, improving performance and, of course, there was a huge financial problem in terms of – in terms of our movement forward. I think we needed something like £35 million quid in the next three years and we had a £6.5 million deficit.

DR WALTERS: Right.

MR HALSALL: And there was something in place called the – was it Rope[?] at the time? Where you got a fine equivalent to the size of your own [inaudible 12:52], so we'd walked in with 6,500 – a £6.5 million deficit, and that was doubled to a £13 million deficit because you hadn't balanced the books. So some fairly big challenges when we first started.

DR WALTERS: And what were the sort of messages and the issues coming from the CCG and the SHA? Were they around that? Or?

MR HALSALL: Well obviously the biggest issue was the Acute Service Review and the noise that was being played around that. Because politically, you know, it's a complex – it's a complex set up, Morecambe Bay, not just because of, you know, the location of the hospitals. Because in any clinical strategy it'll be very difficult in terms of some of those areas, you know, sensibly. You know, that can't look like it does in the middle of Manchester or somewhere, so you know, so some of the issues around the clinical strategy I think really were being fudged a little bit in terms of – so the push for us to try and get hold of some sort of angle on what we could or couldn't do, in terms of the money. I think SHA at the time, I think the view was much more around there was stuff to do around efficiency, but other than that, you know, it would get there type thing.

CCG, well, it would have been PCTs at the time. And there was an issue – Morecambe Bay, just before I got there, you know, in terms of the last reconfiguration, had gone from having a single Morecambe Bay PCT to splitting and having two PCTs. So it was a bit different than most areas in that you ended up with two Commissioners rather than a single Commissioner. So it was the creation of North Lancs PCT and Cumbria PCT that – that sort of the Trust sat in the middle of, and I think it was a roughly 60:40 split, something like that, between Cumbria and North Lancs.

But again, the more difficult issues around, you know, politically there was two County Councils involved in that Acute Service Review, it's the City Council and there's a couple of town councils, and politicians wise there were five sitting politicians, and a representation from all parties really, including a member of the Cabinet and a senior member of the Lib Dems. So it was – so from a complexity point of view, I think the big thing for people at the time

was to get the Acute Service Review, and to – to bring it to some sort of sensible and safe conclusion.

DR WALTERS: Yes.

MR HALSALL: That was, I think, what people saw the priority.

DR WALTERS: How did you think the financial deficit was going to be dealt with? From the Chief Executive and Management point of view. How were you addressing that?

MR HALSALL: There's two things really. First of all – a number of things. First of all, you know, we did have a plan in terms of a lot of – so some more efficiency stuff. So doing things, you know, more sensibly than we did do it. Clinical strategy would have said that, you know, longer term what we needed to do was rationalise some of the emergency rotas for example. But that is around reconfiguring some of the services rather than just trying to cheapen them in that sense. So Acute Service Review was around – or the public consultation that was launched was around taking four medical wards and a coronary care unit and an A&E Department out of Kendal.

What we actually – what we actually delivered was two sort of sub-acute step up step down GP led wards, but with some consultant input, and primary care assessment service. So I think that's quite a big chunk more than originally. But again, I think a lot of the cost improvement problem when I first went there was signed up to sort of just, you know, it was almost a rush to just close this and have done, because was quite a large cost improvement. I actually think it almost missed the argument about safety. Because, to be quite honest, you know, for as much as people got well looked after in terms of caring at Kendal, the lack of facilities, for me, meant that that was a dangerous place in terms of going with certain acute medical conditions. And, increasingly so, as we've seen medicine change. Heart attacks being the best example. But again, that's changed.

DR WALTERS: How did you sort of quality assess your cost improvements?

MR HALSALL: So I think as we went along what we tried to do was to get the clinicians involved in the – in the [inaudible], you know, what are the reductions? What are the cost improvement issues that we can deal with? So, for example, and I'd have to say, you know, in terms of a journey, there's a difference between start and finish in a sense. Because, you know, by the

time I'd left, you know, all of our cost improvement programmes were signed off by clinicians. Now, I'm not going to sit here and say that actually I think that was a great sign off procedure in that the clinicians were all bought into actually saving money. They weren't. So I mean I'm not going to say that. But we did have a clinical sign off of procedure.

We did a lot of things that other trusts do, in terms of working with Ernst & Young for example, in terms of benchmarking services against other services, and trying to look at some of the things that were successful in other organisations and how they may or may not save money with ourselves. So I'd say there's quite, you know, there's a whole range of different stuff that come up from the divisions, that we would then sense check and then set up on targets.

What I would say though is that, you know, we didn't take a blanket view that actually, you know, you take a nurse off every ward, or you do such and such thing because, you know, again, just not the way to do it. I think what we did have was less of an opportunity than other organisations to actually – to put right what – or to prop up some of the areas that we were concerned about.

DR WALTERS: When did you first notice the problem with Maternity at [inaudible]...

MR HALSALL: The first time I was alerted to an issue in Maternity was – was the Joshua Titcombe case. I'm not saying that there wasn't any – there weren't any issues, and there weren't cases, but I mean there are, you know, whichever organisation you're in, whichever hospital you're in, you know, there are complications in maternity services. So what's, you know, striking the difference between what is, you know, a fundamental problem in maternity and what are, you know, cases that need to be dealt with as an individual basis.

Again, 2008 there were – 2007, 2008 there were a cluster of cases that we dealt with, and that I was involved with, that, depending how you look at them, would be related or unrelated to each other in that sense.

DR WALTERS: So did you notice that cluster as part of the FT application?

MR HALSALL: Yes.

DR WALTERS: Had you not noticed it before?

MR HALSALL: Well, we knew there was a cluster. We knew there were a number of

cases but, as I say, depending how you look at it it would depend on whether or not you believed them to be related to each other in terms of a fundamental underlying issue or, you know, a cluster of cases.

To this day I don't know whether or not the complication rate was higher, lower, or indifferent there compared to any other comparable unit. What I did know was that we had a handful of cases that we looked at, and that we looked at in detail and, throughout the – throughout the process of FT application - and don't forget we went through the application on two different occasions and there was 15 months between them on two board to boards, and the board to board with the SHA – as part of that process we went through the cases, individual cases, in detail at both boards.

There was also a transfer of system in terms of, again, the other – another reorganisation where the primary care trusts took on responsibility for monitoring incidents from the SHA. So when the SHA handed that over. So – and we had a meeting, between the PCTs and ourselves and the SHA, chaired by Professor Ashton, where we handed over all of the open cases, which would have been, again, each of the cases that were open. So the five cases that we looked at were again discussed in detail at all of those meetings.

DR WALTERS: Did you report all the cases to the SHA? Was that part of your process at the time?

MR HALSALL: I would be unaware that we didn't report any cases.

DR WALTERS: So these five would all have gone...

MR HALSALL: Definitely.

DR WALTERS: Through board to the SHA? When you say that you looked at them in detail, what did you actually do?

MR HALSALL: So, well it was different in each of the – each case, to be quite honest. So, in terms of – am I able to say the names?

DR WALTERS: We can't talk about details and individual cases. Just tell me generally.

MR HALSALL: So in one particular case we brought in...

DR KIRKUP: [Inaudible] confidential details but you can talk about it in general terms.

MR HALSALL: That's why I asked the question.

DR KIRKUP: [Inaudible] by name, but you can't talk about the details at hand.

MR HALSALL: Okay. So on one case we brought in some people, external, to review the case. Because I wanted, and had agreed with the family, that's what we'd do. In another case we relied on the coroner brought in an external medical opinion. So we relied on the external medical report and on our own internal stuff. So it was a collection, really. Slightly different in each different case. It's difficult without saying – you know, it's difficult without saying like I remember the five cases and this is what we did in each case.

DR WALTERS: Yes. But you were convinced that they weren't related?

MR HALSALL: I was convinced that the circumstances were different, and there was a different reason for them. You know, when you look back, five six years later you can say well, actually, you know, were they a symptom of the same type of – the same thing. But, at the time, I definitely believed that we – we had worked out what had gone wrong, or what hadn't gone wrong, you know, because there's an assumption that when things go wrong actually that there is blame, that, you know, there is negligence and that there is – and that is a system, I think. So I think we had convinced ourselves that we were doing the right things to trying to put right the issues that had come up from those – from those cases.

DR WALTERS: So I suppose if you were a non-exec sitting at the board, and sort of know there are five cases in a short period of time, what was their take on that?

MR HALSALL: I think it was quite mixed really. I mean it was something about the board – again, you know, we had discussed each case individually at the board in terms of the details of what we believed had or hadn't gone wrong and what the, you know, the fundamental of the case. I don't think there was anybody at the board who didn't know the cases individually and inside out in that sense.

I think we would understand that our maternity service was a difficult service. By saying that, I mean, you know, we had – there's almost a point at which, you know, there are points in time where people just recruit, you know, if you can get somebody that can turn up with the right qualification and look alright we say, 'Right, okay' who would, in different circumstances, in a competitive process you may not have put in place and, you know, we

had, I think, quite a few people in that guise.

We also knew that we have difficulties in terms of keeping peoples' skill levels to a satisfactory point, especially in terms of being in an isolated hospital and – and we had a fair bit of resistance from people who didn't see this to be a problem. So you got this thing about saying, 'Well actually, you know, our complication rate isn't any different than anybody else's and, you know, that wasn't our fault', and with some cases you think, 'Well okay, yes, that could happen somewhere else but, you know, but why did it happen here?' So I think from a board point of view I would have said there was a range of understanding of the implications and where they, you know, where we needed to target effort and attention, in that sense.

DR WALTERS: So what did you do then, in the end? What was the [inaudible] board's decision on?

MR HALSALL: What, a board decision?

DR WALTERS: to deal with?

MR HALSALL: I mean there was obviously a number of reviews. I mean I'd implemented a number of different reviews to try to actually bring different opinions to the table. I think we listened to the senior clinical team, and that was probably an error, to be perfectly honest. Because I think they were too close to it. Had time – if I had my time again I would have replaced the Associate Medical Director for – and this isn't trying to pass blame, it isn't. It's just an observation of, you know, where you get to. But I would have replaced the Associate Medical Director for Obs & Gynae. I would have replaced the Head of Midwifery earlier. I think we only really started to get an opening up of it when we – when we got a new Head of Midwifery that came from outside. We did...

MR BROOKES: Sorry, just for my clarification. You're talking about the Associate Medical Director? You're not talking about Clinical Director for that division?

MR HALSALL: So for the divisions the senior clinical was called the Associate Medical Director.

MR BROOKES: So it was the same, effectively, okay.

MR HALSALL: But we would have had...

DR KIRKUP: As we've done with previous interviewees, what we need to do is be absolutely clear that we're talking about Mr Hussain here?

MR HALSALL: Yes.

DR KIRKUP: Right. And the Head of Midwifery?

MR HALSALL: Well the Head of Midwifery – the Head of Midwifery did change in my first year, funnily enough. And I think we thought that was a good opportunity, because that was the right thing to happen. But I think again it was an internal appointment, and so that was, I think when we thought we were making progress we weren't. Because there was still that internal resistance. So we then replaced the – she left, and we replaced her in 2011. If I'm right.

DR KIRKUP: Okay. Who was the Head of Midwifery up until 2011?

MR HALSALL: Angela Loxley[?].

DR KIRKUP: Yes. That was my understanding, but I just wanted to confirm we're talking about the same person. Okay. Thank you.

MR HALSALL: So I think it was different. I mean I had several meetings with all the staff in the Unit. With the, you know, with the – because we forget and just say obstetrics and gynaecology, but there's obstetrics, gynaecology and paediatrics.

DR KIRKUP: Yes.

MR HALSALL: And you can't – and you can't – and then over here, on the side of it, and interrelated, is anaesthetics. So there's a bit, for me, about being clear this isn't just about those. I mean I think – I think there was very little integration between the teams, across the sites, in that sense. Even though they had a single Head and had had for quite a long time, and they had a single Head of Paediatrics that they had for a long time, you know, and even though Paul Gibson worked some time at Barrow and other times at Lancaster he was Lancaster based, and I don't think – so I think people almost sort of defended the sort of status quo, and nobody really wanted to break the rotas and the system in that sense. So – but it's very difficult to actually create massive upheaval in the middle of stuff.

DR WALTERS: So you're sort of talking now a little bit with the benefit of hindsight, but at the time went to talk to them and they were giving you reassuring [inaudible]...

MR HALSALL: At the time, you know, we got good reassurance that things were moving in the right direction, that the, you know, that midwives were being

dealt with appropriately, that we had changed the Head of Midwifery, and therefore actually we're starting to move things on. That there had been a closer relationship with the other units in terms of trying to get down to, you know, single protocols and stuff.

DR WALTERS: And what year was this? Which period are you describing now?

MR HALSALL: What am I describing?

DR WALTERS: Yes.

MR HALSALL: I'm describing probably the 2 7-8 up to Angela leaving in 2-11-ish.

DR WALTERS: Right.

MR HALSALL: Without being exact.

DR WALTERS: So the different reviews that you initiated, who did those? Which are those?

MR HALSALL: Which are those. So I looked – we looked at the management structures, and our relationship in terms of how they worked out. So whether they were fit for purpose or not. And we - so I got Charles Flint to do that one. He's a management consultant that – a lot of experience in terms of NHS managements etc., and we were trying to build a relationship with the local women's hospitals, you know, and their expertise in that sense, and so he reviewed our management structure and compared it to – it was a direct comparison, but he looked for some of the key features that they would find at the Liverpool Women's – which is a specialist women's hospital, obviously.

We did the – I commissioned the report from Pauline Fielding, which was around, when I asked her to do that, that was around trying to look at clinical governance and – not to review the individual cases, but to come back and say, 'Look, in terms of the governance across this patch, what could we do? What structure could we put in place to governance, that would get us past this?'

Because what we had is almost a denial from one part of the Trust that actually the problem was anything to do with them. So, you know, these issues happened at Barrow and therefore nothing to do with Lancaster and Kendal and everything else. So what I wanted to do, when we – when I commissioned that, was to say, 'So what are the structures then?' So putting that at one side, in terms of cases, what are the things that we would start to build was a sensible single clinical governance structure. Because I liked the

idea of that.

Sorry, I'm lost there now in terms of...

DR WALTERS: External reviews. So they were looking at the management structure. You got some clinical review. You got somebody to look at the governance. So while all that was happening were you assured that the Unit was safe?

MR HALSALL: It's a strange question on safe, isn't it? I mean I had no reason to believe that anything had happened or changed there that changed the overall safety of the Unit. I was assured by the Head of Midwifery and by the – and by the Associate Medical Director that the Unit was safe.

We hadn't changed anything in terms of number of midwives or doctor's rotas or anything that would have unstabilised it – destabilised it in that sense. So I guess we were as confident as we could be that, you know, that we were dealing with something that we thought we understood.

DR WALTERS: Did any of your reviews look at whether the number of staff were adequate?

MR HALSALL: We did do the – we did – I'm trying to think what it's called. I'm sorry, I mean, I'm not being vague, but I haven't set foot on the premises for the last three years and I have no documentation or anything like that to review. So completely off memory.

DR KIRKUP: The staffing review was Birthrate Plus, wasn't it?

MR HALSALL: The Birthrate Plus. Yes. Thank you. But we did instigate a – the Birthrate Plus methodology, which was looking at the – looking at the staffing. But it was over a longer period of time, so there's quite a bit of work-study type analysis that drives you to those numbers, and we kept that as an ongoing – as an ongoing mechanism.

DR WALTERS: What...

MR HALSALL: Sorry, can I just – just slightly [inaudible] was that my understanding when we did that, if I remember rightly, is that the area with the biggest issues in staffing was Lancaster not Barrow, and I know that we, you know, we focused on Barrow, but in terms of trying to understand maternity services in that patch it would look very different if you ran a maternity service for that number of births in one place. Would look very different.

DR WALTERS: But this is to set a scale [inaudible]...

MR HALSALL: Yes, definitely. But again, as I say, the issues – so one of the limitations on Birthrate Plus I think is in terms of benchmarking, is the fact that, you know, you've got – so if you've got small units you've got to overstaff those units to deal with, you know, to deal with the number of cases. You'd almost say then actually they can deal with more cases coming in with the same numbers. But you would have to overstaff to have people there, you know, 24 hours a day, 7 days a week.

DR WALTERS: Yes.

MR HALSALL: And I have had cases where, you know, people have tipped up and said, 'Look, we're not happy. We need to shut the Unit tonight.' And we've looked at, you know, in terms of what the risks are. Well the risks are far greater in Barrow if you turn up and you can't get through the door than if they are if you go in, you're looked after and then triaged.

So I think, you know, safety was almost a day to day thing I think, in terms of Barrow in terms of trying to keep an eye on what you could or couldn't sensibly do. So when Lancaster were full, if they, you know, if they were short of capacity we would move people to pick up capacity in Barrow.

I think one of the big issues for me, and one of the things, the quieter things, that you don't see and one of the fundamental issues sat at the back of this: There's a positive and negative part to Barrow. One is that the positive part is that, you know, sometimes actually because of the isolation and because of the issues people, you know, find a way to get through difficulties. The problem is you don't always know they're finding a way to get through a difficulty. They're just dealing with things that don't bubble up. But there's no doubt, you know, Birthrate Plus was a good guide. But you still need to take into account that in small units you need to overstaff small units rather than understaff, if that makes sense.

DR WALTERS: What role did the SHA have in the Fielding Report? Pushing the Fielding Report?

MR HALSALL: In the Fielding Report? I don't remember is the easy answer.

DR WALTERS: Were the SHA interested in these five incidents and how they were dealt with?

MR HALSALL: In terms of the incidents, because, again, the Fielding Report wasn't based on the incidents. You know I was really clear when I commissioned

that report it was about saying, you know, if we brought Pauline in as a senior manager, NHS manager, she brings a senior midwife and a senior clinician, what we wanted to do was make sure that actually the clinical governance structures were fit for purpose for an organisation that was as spread and as complex.

In terms of the individual, I know that she ended up commenting on individual cases, but it was, you know, fairly scant comment compared to what we'd had. The SHA, as I recall, were aware of the cases. As I say, there was definitely one particular meeting where the SHAs handed over responsibility to the PCTs. Where we handed over case by case, and each of those cases were live cases that were discussed openly in the room. So I know that from the SHA – I know that we had the board to board, two occasions during the foundation trust process, where they were discussed. At the two board to boards that we had with Monitor the cases were discussed in detail. And I know they were discussed in detail with the CQC.

DR WALTERS: So in terms of the – what happened to the Fielding Report, once you'd got it back, and how did you handle the...

MR HALSALL: Okay. First of all, just say, you know, we handled the Fielding Report incorrectly. So, you know, even if we hadn't liked the Fielding Report and didn't think it was, you know, credible, or we didn't like the information, it should have gone to a minuted meeting of the Board from a governance point of view, without any doubt. So, you know, I don't believe for one second that that was done in terms of trying to cover up a report or to, you know, anything else. But there's no doubt whatsoever we were wrong in terms of not ensuring that went to a minuted meeting of the Board, and I don't think you can get past that, and I've never tried to sort of – to get past that, and I think in my dealings with Monitor etc. I've never tried to make – make that any different...

DR WALTERS: [Inaudible] compliant?

MR HALSALL: In terms of – pardon?

DR WALTERS: Do you know why it didn't?

MR HALSALL: I was just going to set the context. At the time of it coming in, the first – certainly I remember the first draft coming in, I remember – I do remember meeting with Pauline. We were sort of – so we'd been put on hold with

Monitor in terms of the FT application, because at the time, just – so the first – so let's go back the first time we applied to be an FT. Just before the Monitor's meeting where they make the decisions around granting a licence we changed from having the Healthcare Commission to the Care Quality Commission, and so the day before their board I got a phone call to say, 'Look, we've gone back, as part of the new process post Mid-Staffs we now ask the CQC did they have any concerns around an organisation. Just before we authorise.' That's fine. CQC is a new organisation. Don't know. We've got this cluster of five cases. We don't understand it and therefore we're going to put them on a red risk rating and that stops the process. So that's fine.

So that set off then a whole set of work with the Care Quality Commission, with Monitor almost in the background of that, you know. They're saying – so what we said is, 'So what do we do from here?' you know, so you know all the cases, we've discussed everything, where do we go? So the process at that point then was Monitor wanted the Care Quality Commission to then say, 'Right, okay, we've reviewed everything. They're on a risk rating and we've reviewed the risk rating down to green.' That's what the process was.

We went – myself and Eddie Kane DR KIRKUP man went to see Bill Moyes and Miranda Carter at Monitor to say, 'Right, okay, this is where we think we are, what is it – you know, what happens? What is it we need to do? What is it people want to see?' So we tried – we tried to get a clear angle on, you know, what had changed.

So fast forward to Fielding Report. That was very much around, as I say, about trying to get an angle on clinical governance across the system. That first came back in around about the time where the Care Quality Commission had downgraded our rating from red to green and Monitor then triggered the next part of the process, and so we were just being asked for, literally, you know, hundreds of documents.

I don't believe we purposely decided not to do anything. But I actually think – I come back on that one – I don't think we thought that the Fielding Report did what we asked it to do, but again, that doesn't change the fact, you know, if you're going to say, 'Well actually we're not going to do anything

with that, the Board need to do it' after minuted meeting the board we would say, 'Actually we don't think that does what it needed to do.'

So, at that point, going through that process, I know it was mentioned in a number of meetings. We shared and discussed the terms of reference for that review with the Care Quality Commission and with Monitor. I don't know about the SHA. I'd have to say – I'd like to say all of them, but I don't know. But we definitely shared the draft terms and conditions – terms of reference with Monitor and the Care Quality Commission and I do remember there being an email trail between Jackie Holt, the Director of Nursing, and somebody at the CQC on that one.

I know it was mentioned in a number of the meetings. But, you know, in terms of the fact that you hadn't gone anywhere or shared with anybody, you know, we just have to say we got that wrong. I don't believe it was done on purpose but, you know, in the middle of everything else that was happening, it was missed.

DR WALTERS: [Inaudible].

DR KIRKUP: Okay. Julian.

MR BROOKES: Can I just follow up on the Fielding. I just want to be clear in my mind a couple of things [inaudible] different things I just want to be clear. When you're talking about the commissioning the Fielding Report, was that – what were the reasons for generating the Fielding Report?

MR HALSALL: Well what I wanted to know was whether or not – so we had a big issue with people thinking actually if there was a small number of cases that were about Barrow, and they happened at Barrow that, you know, part of the organisation just said, 'Well that's just Barrow', you know, like it's nothing to do with it. That's just sitting over there. But actually, you know, the issue about asking Pauline Fielding to do a piece of work was about saying, 'Well, you know, what clicks?' So if we've reviewed the management structure, and if you put that to one side for a second, what would be the clinical governance arrangements, clinical governance structure that would improve, you know, that we would try to actually, you know, I was hoping stuff they'd come back around, you know, medical education for example. You know, how do we stop midwives and doctors being isolated in terms of, you know, expanding their range of skills and knowledge and their exposure etc.

So what we wanted was something that very much said clinical governance arrangements, some advice – advice from outside around rebuilding the clinical governance arrangements across you know, the Bay's maternity services. That wasn't about responding to an incident in one of the hospitals, if that makes any sense. Because I think there's a difference. Because I think if you're just responding to incidents in one place, people then turn around and say, 'Well that's nothing to do with us actually. I don't have to change anything here, we're all okay.' So that was the premise on which...

MR BROOKES: Was there a relationship to – or in your mind – about assurance in terms of the FT process for the issues with CQC? Or was it very much you, as an organisation, wanting that anyway?

MR HALSALL: No, that's me – it was me that did it. It was me that wanted the Fielding Report in terms of the clinical governance stuff. Yes, it happened during the time where we were working with the CQC and with Monitor but, you know, I wanted to know what we needed to do and what the advice would be around rebuilding a clinical governance structure around maternity services that was nothing to do with individual cases.

MR BROOKES: Okay. Because it – you can understand it would be potentially seen as being as part of the picture of you providing assurance to those organisations that the organisation moved on from the concerns. So it wasn't commissioned with that purpose but could have been used for that purpose?

MR HALSALL: It wasn't commissioned for that purpose. There's a bit for me about understanding that, you know, lots of people come at this from different angles, and if you're not careful all you end up doing is responding to different people, you know, as oppose to saying, 'Well, you know, what is it we should be doing?' and, you know, what would we want our people to do in terms of single structures?

So I would hope that if we got – if we got something good out of it in terms of a programme or activity that got us there that, you know, that would assure us. But it was never going to be something, a report – or never intended to be a report on something that said, 'Actually here's your problem...' I don't think – I don't think there's anything in there that we didn't already understand and were trying to deal with. I think what I wanted was

somebody else's view on what the answer might be, in that sense, on a more structural stuff. I didn't expect any short term, quick fix answer that we could say, 'Oh we've done that now. We've ticked them off and that's sorted out.' That wasn't the objective.

MR BROOKES: Okay, that's very helpful. You've accepted, in terms of not going back to the board minuted, and that's really helpful to understand that. But it's still quite a long period of gestation, isn't it, through that report. It's just useful to understand – you receive a draft relatively quickly after the review. What were your – what was your initial take on the first draft?

MR HALSALL: My initial take on the first draft, and again, I haven't looked at this report for the best part of four years so I'm not, you know, I don't remember it. I do remember having the conversation about, you know, some of the terminology in it. So it talked about, for example, bits that stick in my head talk about, 'Middle class area in Ulverston' for example, and you know, and shutting the clinics in Ulverston and moving the staff to Barrow, and that was part of the conversation we were having, and stuff around, you know, 'We shouldn't aspire to be like the Liverpool Women's. We should pick another DGH somewhere' and things like that. Which I didn't agree with, because like, you know, why would you aim to be – why would you aim to be sort of less than best? If you understand what best is, then you might have to turn round and say, 'We can't deliver that' or we can't – but at least you know you're not doing that, if that makes sense. Rather than saying, 'Well, you know, what's going to be the easiest fit?'

I remember there being a whole bunch of stuff around medical leadership, and the only recommendation was that we unify the job description for support workers. Which I just didn't see how. I just couldn't see the relationship. So that – they're the bits and pieces that I remember about thinking, 'That just doesn't do what we want to do' and I think it starts of with talking about the incidents in Barrow, which again, they just switched off the whole of the Lancaster team.

So it didn't do what I wanted it to do in that sense, and it wasn't about whether or not it gave us bad news or good news. It was about saying, 'Well, you know, how could you bring this together? And different strands and a different governance structure?' But I do remember – they were bits and

pieces that I remember at first take, you know. Can I read it and it says actually we think, because it's middle class and everyone gets on alright and consultants live in Ulverston that we shut the clinics down and move the staff. And like I said, there was a disconnect about what they said about medical leadership and the recommendations. The single recommendation on the first draft, if I can remember, was about unifying a support workers' job description. I just didn't see – I didn't see the link between them.

MR BROOKES: So the report wasn't necessary – it wasn't satisfactory for what you'd hoped with in turn on the first draft?

MR HALSALL: Definitely.

MR BROOKES: So what...

MR HALSALL: It didn't – I don't think it changed significantly on any subsequent...

MR BROOKES: Well that's why I ....

MR HALSALL: On any subsequent area, and I know that – I know we didn't discuss it at minuted part of the board, but I know we discussed it on a number of occasions, and I know some of the board members, the non-execs, were also involved in the – in the interviews around the report itself. So – but I don't remember it changing significantly.

MR BROOKES: Okay. Which is why I'm asking. Because you're right, as far as we can see there are some – there are some changes but, you know, significant – difficult to say. But therefore the question is why did it take so long still to get through? If there'd been some significant changes because of factual inaccuracies, or wrong recommendations which were relating to policy or whatever, then you can understand a delay in the process. But we're still talking quite a long delay about a report which doesn't, fundamentally, change, and I'm just trying to understand why there was that such a long period of time where it was still in draft and hadn't been finalised.

MR HALSALL: Yes. Well I think – I think it got lost in between everything else that we were doing at the time, if I'm being honest, and again, from the Board point of view the easiest thing to do would have been taken the first draft in front of the Board and saying, you know, it really isn't up to scratch, it's, you know, it's a poor quality report, poor input, what are we going to do with it? And if the Board then turn around and say, 'Well actually we don't believe it's fit for purpose...' But we didn't do that, and I think fundamentally that's the

piece we missed.

I think if we'd had a good Board Secretary that would have been – that wouldn't have been missed. That wasn't knocking a Board Secretary. We didn't have one.

PROF MONTGOMERY: I know.

MR HALSALL: And again that was a management decision taken that the Board didn't want a Board Secretary. But I think it would have been one of those things that, had the Board supported the commissioning of it, you know, you would expect that to be picked up.

MR BROOKES: Okay.

MR HALSALL: So there's no doubt that that's a breakdown in governance.

MR BROOKES: Okay. If we move to the FT application...

DR KIRKUP: Just before we do that, there's a couple of other points on the Fielding Report that I think we might take now. Bearing in mind what you said about what you wanted it to do and what came out, what action did you decide to take in August, when it was finalised?

MR HALSALL: I don't think we took any decision, to be quite honest with you.

DR KIRKUP: Okay.

MR HALSALL: And that's what I'm saying about from the Board of governance point of view.

DR KIRKUP: Okay.

MR HALSALL: I think it got lost in the middle of everything else that was going on. Because we were, you know, we were exchanging documents with the CQC and Monitor at that rate, you know, literally hundreds and hundreds and the Board were going through – what they going through it, it just got missed. Lost.

DR KIRKUP: Okay. So when the action plan came along later, and it was quite a bit later, that was done in retrospect?

MR HALSALL: That was done in retrospect.

DR KIRKUP: Yes. Okay.

MR HALSALL: And it was done as part of Monitor's input, I think. If I remember rightly.

DR KIRKUP: Okay, and that would account for the fact that the recommendations were seen as optional?

MR HALSALL: Yes.

DR KIRKUP: Okay. Thank you.

MR BROOKES: Thanks, that's good. Thank you. So you already described moving into a complex acute environment, difficult geographies, and key issues in terms of moving in, and a series of trusts which – a series of [inaudible] which didn't necessarily work as a single organisation. Is that a fair assessment?

MR HALSALL: Yes.

MR BROOKES: Yes. So you embark on a foundation trust process. I'd just like to understand the reason for that, and the motivation for moving into it?

MR HALSALL: Yes, okay. So first of all, before I got there, the Trust hit three stars at one point, and the reason I point that out is that when the FT application process all started off you had to be a three star trust to be able to apply. And then, by the end of the – and you have wave 1, wave 1a, wave 2.

MR BROOKES: Yes.

MR HALSALL: By the time I think wave 1 come along – I'm not sure whether or not they'd had the second year's worth of star ratings out at that stage, but even so the Trust didn't hold onto its three stars. So it dropped from three to two to one. In consecutive years. So dropping your three star takes you completely out of the frame.

So when I go there they saw themselves as having been an applicant, and that the desire was that, you know, to get to foundation trust status. So it's clear when I was appointed that that was the ambition of the organisation, to become a foundation trust. And at the time, of course, the whole NHS was geared towards providers becoming foundation trusts, or being part of foundation trusts so, you know, the better providers wanted to be recognised as being FTs. So in terms of embarking on the Trust thought that actually they weren't far off being an FT when I got there. They believed that they'd started the application and that they'd got so far.

MR BROOKES: And what was your view?

MR HALSALL: Well, the initial application, in the initial phase when FTs were first mooted, and you were three star, the initial application was, you know, a very short sort of letter saying, 'This is why we think we're great and why we should be an FT'. So as a process, you know, that really wasn't, you know, and then we had dropped – they had dropped down the ratings in terms of

performance in virtually every target, and the money was pear shaped.

So as far as being an FT is concerned, you know, a million miles away in that sense, you know, from a Board governance point of view the Board set up and stuff like that was pretty poor. I remember my first Board meeting started at 8.30 in the morning and finished at 6.30 in the evening, and we had a sort of a part 1 and a part 2, but we had a dress rehearsal for part 1 and a dress rehearsal for part 2 in the middle bit, and then after each we had a post-part 1 and post-part 2. So you sort of did every agenda three times in a day. It was not – it was mind blowing.

So there were issues in terms of – in terms of getting that sorted out. So my view, having just led a successful FT application and a very successful trust was that, you know, we were a million miles away. So besides having the money to sort out, and performance, we also had this thing called the Acute Service Review where, you know, you ain't going to become an FT when you've got people marching on the street and, you know, the clinical configuration issues that had come from that.

So the issue for us was about what I described at the time as being an improvement journey and sort of getting to grips with some of the systems. One thing that I do remember a couple of people saying, a theatre porter said it to me, Ibrahim Hussain said it to me, couple of people said it to me, was that, you know, everyone told us we were great, and then nothing changed, and suddenly people felt that we weren't great any more. So what happened?

And fundamentally I think what happened is that the systems changed, and the Trust didn't, if you know what I mean. So they unexpectedly peaked and if nothing changes, and as the [inaudible] is tightened up, so you know, as you go from 18 months to 12 months on a waiting list targets type thing, you know, if you scraped home on 18 months you failed on 12. So it was that type of image.

So in terms of FT, there was an ambition in the organisation to become an FT. I don't think anybody understood what that meant. My view on being an FT has always been that actually if you get the organisation performing appropriately, and get the Board right and you get performance right, you know, you'll become an FT by virtue of the fact that the organisation is

running right, as oppose to, you know, the FT application becomes the thing. Because ultimately the whole thing centres on around how your organisation performs so it's, you know, the two things are not...

MR BROOKES: So what changed? Year and a half later you're embarking on a FT application?

MR HALSALL: Was it a year and a half later?

MR BROOKES: Slightly later...

MR HALSALL: So – so from our point of view actually getting that grip on the money, getting an angle on the money, was an important one. Getting the clinical service review to some sort of conclusion that people believed could be implemented was a huge, huge piece of the jigsaw. Improving our performance against the national standards again was an important one, and we did do that. There's too much evidence, I think, to suggest that that didn't happen.

So if you take things like when I got there the auditor's local evaluation score, for example, was a 1, which was the poorest. By the time we got to our FT application the ALE score was 4, which is the top. So, you know, there were enough indicators to say we were moving in the right direction. We'd put a lot of time and effort into building a clinical strategy. It – the clinicians were brought in to.

The biggest issue, for me, in terms of – and I do genuinely believe, when we got to the first application, I think we were in pretty good shape and on an upward trajectory. I'd say by the time we got to the second and the successful one, I'd say we'd plateaued, you know. I certainly think that, you know, the money had, you know, had tightened up and everything else. We firmly believe, when we started off, that actually once we got the – once we got the money in – sorted out, we got the money in place, then actually that would be about investing in services, and that would be about then saying, 'Well actually efficiency stuff is about them doing the things that we need to do and expanding the right areas and developing our services.'

But I think by the time we got to that point, you know, we were on our £20 billion NHS trust savings, and savings then were for sake of savings plans rather than anything else, and certainly in our first year of an FT we put in our plan for the year was that we would be – that we would break even

rather than produce a surplus, which again then puts us on – on Monitor's radar. But we didn't believe that actually we would generate a surplus.

MR BROOKES: So there's correspondence from the commissioners in 2008, 2009, basically saying commissions, outpatients, A&E times, cancellations, and some of those are very similar to the ones which CQC in 2011 etc. raised as being the major concerns. So it's easy for us, but to conclude that there were some underlying problems in those areas throughout that time, and I'm just trying to square that with a improving position which was satisfactory [inaudible] according to foundation trust.

MR HALSALL: Yes, okay. So in terms of – in terms of – so where my first impressions there and first conversations with GPs and stuff, some of the bigger issues that came up were around outpatients, particular around outpatient follow up appointments and the number of outpatient forms. And the second part was about discharge letters, and particularly in terms of speed at which discharge letter was done.

A&E were difficult issues in terms of numbers going through A&E at that time. So I don't think – I would never paint the picture that, you know, as you sort of deal with those issues, that suddenly they go away again, you know. We're sat in the middle at the moment in terms of some of the best A&E systems in the country at the moment are creaking under pressure. So I think we did do quite a lot of work in terms of moving patients more appropriately. I think probably – probably Barrow, funnily enough, were – I was going to say it's one of those double edged swords, better or worse, depending how you look at it. So they dealt with pressure better in terms of finding ways around things, but you weren't always sure how they found a way round it. Whereas Lancaster was much more traditional. Traditionally set up. So I brought, at one stage, I brought somebody called Theresa Fenwick in to do a piece of work around A&E at – particularly at Lancaster, because of the configuration issues. So yes, there were issues that go back historically in terms of some of those...

MR BROOKES: Were you satisfied, at the time, in terms of your FT application, that they were sufficiently under control?

MR HALSALL: Well I think – I think I was satisfied at the time that we were doing something significant about this. So if you take medical records, for example.

On my first week there, in the medical records department in Lancaster, there were three and a half thousand case notes just on the floor. In medical records. Being used almost like carpet, and it was a mess. So we threw a lot of money into – into digitising records in terms of – I don't mean actually electronic medical records...

PROF MONTGOMERY: Yes, I understand.

MR HALSALL: I mean scanning and sort of getting rid of the paper type thing, and a whole drive in terms of getting, you know, records where they should be because, you know, governance goes to pot once the records are in a mess. So I believe that we did a lot of work and got that, you know, that area that just a significant – in a better place, and we brought in monitoring in terms of the number of clinics.

One of the big issues was people turning up for clinics and the case notes not being there. So I think we did a lot of work in terms of getting that improved, and in monitoring and in putting those mechanisms in.

MR BROOKES: I'm sorry, I understand. I need to move on if that's okay. In terms of the – what was the governance arrangements of the organisation that you inherited?

MR HALSALL: Okay. Just before we do move on, I do need to just make one quick point there.

MR BROOKES: Sure.

MR HALSALL: Because you asked me what's the difference between then and the CQC.

MR BROOKES: Yes.

MR HALSALL: So one of the big pieces of work that we did was implementing Lorenzo.

MR BROOKES: Yes.

MR HALSALL: [Inaudible]. Now, strategically, you know, the way we saw it was really important. That Lorenzo wasn't just about a computer system. It was about giving us an opportunity to change the way we managed patients and the organisation. It was about making sure that medical records didn't go missing. It was about making sure that medical records, you know, medical records in Morecambe Bay could clock up air miles if you, you know, if you let them, you know, they'd be backwards and forwards to different places.

So if a patient had two or three appointments in different places, you know, I think people forget the distances between those hospitals, you know. So medical records could basically do hundreds and hundreds of miles a year, and not be traced and all the rest of it, and there were no tracing systems. No digital tracing systems.

So the move to an [inaudible] electronic patient record, at pace and with cash behind it, was strategically too important not to embark on. It did – one of the issues in terms of when the CQC came back and we looked at medical – we looked at a follow up outpatient appointments and records, one of the biggest things it did is you couldn't lose a patient. And that's really important, because although it looks like people blame Lorenzo for it creating a major problem, it didn't. It just meant you couldn't miss the problem, because it said, 'All of these records haven't been completed'.

So, you know, you could see where people haven't followed the rules in terms of how to use the system and completed records, but you could also see people – you couldn't lose a patient to follow up – people kept describing it as losing patients to follow up. But actually in Lorenzo you couldn't lose a patient to follow up. So in terms of safety, although it highlighted a massive problem, in terms of safety I would have said the system was safer having that backstop in it, than not doing it. So I think the difference between the two, at the time, was that in one we had a very clear picture of what the size of an issue was [inaudible].

MR BROOKES: So if we could just move on to in terms of you've arrived. What was the – what was the governance arrangements for the organisation? Were they fit for purpose?

MR HALSALL: I mean it's difficult to go back and just say, 'It looked like this at the time' so I don't remember what all the Board committees were in place at the time. I know there was a finance – a finance committee that the chief exec wasn't on, and sort of wasn't invited to, so...

MR BROOKES: You made some changes to the clinical governance arrangements at the time. You instigated a new clinical governance committee, which you chaired, I believe?

MR HALSALL: Yes. Yes.

MR BROOKES: So was that as a reaction to the current system? Or was it just

something you felt was important?

MR HALSALL: No, it was a bit of both really. Because the current system didn't have in place a clinical quality committee of any description. So that was about saying, 'Well actually...', you know, so on the finance committee I wasn't on the terms of reference a member of it as the chief exec. The medical director and nursing directors I think were told, 'It's money, so you don't need to turn up'. So what I tried to do was make sure that we had a clinical governance committee that met – that was on equal par, in that sense, and that was the theme that we continued with in terms of what we ended up with.

MR BROOKES: Okay. So you've got systems in place, you've got committees in place. How did you, as a chief exec or/and as part of the Board, receive assurance about the quality of the clinical care that was being provided in the organisation?

MR HALSALL: Okay. It's a difficult changing picture, isn't it. Because you remember sort of how you left it rather than, you know, the detail of what you walk into. But I think it was a couple of things. First of all, you know, we had – we had a management board as well as the Trust board. So the management board were the, you know, senior clinicians and senior managers from the operational divisions where we would discuss any operational and any management issues and, you know, a lot of the clinical issues would also come to that. We had the clinical governance structure that the medical and nursing directors led. So again we had that in place. I think in terms of clinical quality, one of the issues for me that was a real difficulty was trying to fill the Nursing Director's job. That took quite a lot of time, you know. I almost feel apologetic to Jackie for appointing her to that job, to be perfectly honest.

MR BROOKES: Why's that?

MR HALSALL: Why? Because I mean ultimately it ended up being a huge undertaking, and one for which she's been publicly vilified and, you know, she was an extremely successful individual who put masses and masses amount of time and effort into trying to change things, and I think I don't believe deserved the treatment that she got in terms of the improvement that she made and in terms of the work that she put into it. But it was an

extremely difficult job to appoint to.

So, at one point, I had made an appointment and, for personal reasons at the last minute the individual backed out, so it was a job that was sort of caretaker in the background? It hadn't been put a lot of – there hadn't been a lot of effort put into – into the nursing leadership, I don't think, for quite a long time. So it was one that I was conscious of for probably the first two years. It was difficult to actually get somebody in that could lead that. So I did have concerns around that.

MR BROOKES: Okay. So how would you assess – well, there's been a number of people in giving comments and testimony saying that they felt that where there were concerns at a ward level, individual level, that these were raised but never got acted on. There seemed to be a barrier, at sometimes a clinical director or sometimes at medical and nursing director. Is that a picture you would recognise?

MR HALSALL: Is it a picture I would recognise? It's a picture – well you could look at it two ways really. You could turn round and say if it got at that level I wouldn't know it so I wouldn't recognise it. I don't believe at medical or nursing director that it would be – that it would be squashed. I don't believe that. Knowing the individuals and, you know, some of the cases we got involved with, I don't believe that for one second...

MR BROOKES: So if...

MR HALSALL: I think there's...

MR BROOKES: In your meetings with nurse directors and medical directors, were they raising concerns about individual commissions or about quality of service and safety of services to you? I mean [inaudible]...

MR HALSALL: It would have been a mixture. I mean so I know that, you know, we've dealt with cases where clinicians have been a concern. And I know that, you know, Peter has been in my office, and relayed, 'Look, this has happened and this is what we need to do.' I can think of occasions where Jackie Holt has done exactly the same things about nurses or midwives or whatever.

I know, from a Board point of view, we've had discussions around staffing levels, for example. I mean before I left we'd done a review, Jackie had done a review of medical – the medical – the nursing staff levels in the

medical unit, and what we were trying to do was to – because there's always an issue, isn't there, about, you know, you can always say we need more staff and all the rest of it, you know, it's what type of methodology do you decide on that you're going to accept that says, 'Actually, this is how we measure'. And I think we put half a million pounds into improving nurse staffing in medicine. But that was about saying, 'Well, actually, we want to be there. The benchmark at the moment, minimum standard is there, where are the areas that we need to actually uplift?' So you know, and we'd done things like – led by Jackie and Pete – around we closed an elderly care ward on a Lancaster site because we didn't have enough staff around, you know, we'd got to the point where the medical staff – the nurse staffing around the elderly medicine, medical areas, you know, we were unhappy with.

MR BROOKES: Okay.

MR HALSALL: So we again, you know, consolidated into one less area, and used the staff then to prop up...

MR BROOKES: But there still is – there's a different thing between the right levels of staffing and the competence of the staffing as well.

MR HALSALL: Yes, there is.

MR BROOKES: And were there any issues raised about the clinical competence of staff in midwifery, obstetrics, paediatrics?

MR HALSALL: Yes.

MR BROOKES: And what was the response to this?

MR HALSALL: I'm sorry, I wasn't being obtuse about that. So in terms of – sorry, I am trying to think back. So in terms of midwifery, individual competence issues usually arose out of concern, you know, if there'd been a case that somebody was looking at, whether something had gone wrong or not was irrelevant, you know, and we were trying to drill into detail.

I think, as I say, when the new Head of Midwifery started, I think that was – that was a real opportunity, because it was somebody from external – externalised that, you know, you didn't then get the sort of almost, 'Well that's okay, that's, you know, that's how we do things here' and that type of stuff. Because that was a real approach. I mean one of the issues, for example, the one that sticks in my mind about the – about that sort of cultural thing was the one, the CQC got us on, which was moving patients from the Labour

Ward to theatre, and it wasn't about the health and safety issue, it was a privacy and dignity issue, and one in terms of, you know, so that Unit had been open 25 years, and they'd found a way around getting patients from the back end of the Labour Ward to the theatre. You know, it's a very short run of maybe a minute and a half, but it involves a piece of main corridor, if that makes sense.

I'm not sure I would even have known that if – unless I'd been there when a, you know, if somebody was rushed past me, and in fact I remember dealing with a reporter at the time, and the reporter had had a baby at the Hospital and said, 'That's what happened to me, are you saying that that was wrong?' I said, 'Well, actually what I'm saying is, you know, there's that double sided, double-edged sword, you know. They deal with things in terms of making, you know, finding a way round something, but once you find a way round something you don't identify it as a problem. If that makes sense, and therefore, actually, I think in some issues people just got used to keeping hold of things and not passing that.

MR BROOKES: Okay, I'm going to talk [inaudible].

DR KIRKUP: Okay, Jonathan?

PROF MONTGOMERY: Thanks. If you'll bear with me, a few things just quite specific to pick up from what you said, and then I'd like to understand a little bit about the relationship with the SHA and the PCTs and the CQC. You talked about the board to boards with Monitor, and you talked about going through the individual cases, can you give us a feel of how much of the board to board was based on those individual cases? What the main issues in the Monitor board to boards were?

MR HALSALL: I couldn't say how long in...

PROF MONTGOMERY: We need to get a sense of perspective...

MR HALSALL: How long, in terms of putting...

PROF MONTGOMERY: Well it's a sense of perspective, you know, was that their main concern? Was it a minor concern?

MR HALSALL: Oh it was a big concern. I mean at the end of the day, you know, the Care Quality Commission had raised a flag around, you know, we don't understand these cases until we do – do the red rating. So it was a fairly big part of the first board to board, but obviously by the second board to board it

was still a big part of it, and it was a reason why the application hadn't proceeded in the first place. And it was 15 months on so, you know, a lot of detail in terms of governance around maternity and that type of thing.

So I'd have said they were fairly significant pieces of those board to boards, and of the – sorry, the board to board's an interesting thing in terms of Monitor because, you know, they send a team in and – that work in with you for three months and, you know, there's a huge amount of information that flows between yourself and them, and they're interviewing staff on wards, they interview management team, they're interviewing the clinicians and all the rest of it. So it cumulates in them actually producing a board pack for their board that says, you know, here we see as the key risks and key issues.

So the board to board is, you know, the tip of a process, which is extremely intensive and one where, as I say, you know, people do a lot to you in that short space of time.

PROF MONTGOMERY: And was the board to board with Monitor similar or different to the board to board you had with the SHA? Because they would have had one with you the year before. So did it cover the same territory? Different territory?

MR HALSALL: Similar-ish. I mean it's hard to say they're the same or not, because I don't know what experience the boards – the SHA board had at going into, you know, on the other side of the table for a board to board with Monitor, if that makes sense, and then when FTs first started off, you know, there were experts I mean at the time it was £1,750 a day to help you with your board to board preparation, and none of them had actually been through one, which was a fascinating concept. So I wouldn't say they were identical, and, you know, but we tried to sort of prepare for them well, and we tried to sort of take it as a serious part of the process...

PROF MONTGOMERY: What I'm particularly interested in is sort of the balance, because you've described the quality issues as a big part of the Monitor board to board. I'm wondering if they were also a big part of the SHA board to board, or whether they were more bothered about staffing or money or...

MR HALSALL: No, it was a fairly – I don't remember it being significantly different to be quite honest with you. Not in terms of what they were looking for. I mean

they obviously, the SHA had – have obviously got a bank of information about you and about the governance stuff etc. that they've got, so I guess they're trying to second guess what Monitor might be, you know, going to look at and push you on type thing. They've still got the conversations they can have with Monitor, which they do, and with CQC and that type of thing. So I wouldn't have thought the issues would be different in that sense. I mean they're obviously got a – they're obviously responsible for our performance at that point of view...

PROF MONTGOMERY: And leading up to that you would have had meetings with Mike Farrar and others at the SHA. What were their biggest priorities of getting assurance from you?

MR HALSALL: I can't say I remember what their priorities were. I mean I can't say that – I mean certainly in terms of whilst the Acute Service Review I think they felt that we'd done a good job with that. I think they felt that we'd – they'd come and taken part in some of our – some of the work we'd done, some of the workshops we'd run in terms of the clinicians, in terms of trying to build a clinical strategy, and I think they were impressed in terms of the level of input from – clinical input.

I don't remember there being a massive concerns about our systems, or about anything we're doing at the time. Certainly my one to ones with Mike were very positive...

PROF MONTGOMERY: And did Mike ever raise maternity as a particular issue with you? Or was it just in the mix with other issues?

MR HALSALL: In the mix.

PROF MONTGOMERY: Thank you. I mean you...

MR HALSALL: I don't – sorry, sorry – I don't remember maternity coming up at the SHA around anything other than particular individual cases.

PROF MONTGOMERY: That's helpful. You mentioned that you'd been up to see Miranda Carter and Bill Moyes with your Chairman. Can you just take us through the – what were the reasons for going to see them? What ...

MR HALSALL: Well the reasons were obviously we'd gone through a very long and drawn out FT process. We, I think, had worked hard to try to get things right and get the organisation right, and there's one of those things, isn't there, where, you know, if you can create some momentum people will go along

with the momentum, so you can – you can actually do other things based on the fact that people see momentum and an inevitability of sort of movement.

So I think, at that point, we were moving in the right direction. I wouldn't say – you see, if you said to me, like, 'Was it a really good organisation?' I'd have said, 'No, you know, there's huge things.' I'd just come from sort of a regional cancer centre where I think, you know, we did provide really good services and where we, you know, we worked like mad to get the board governance right and stuff. Into something that was completely off wall. Off the wall somewhere.

The stuff that really got us was around the, you know, the staff opinion survey, so you know we'd done some really targeted work around the people strategy, and saying, 'Well you don't just turn around from being there, you're one of the, you know, lowest quartiles to up a quartile in terms of that in a year, so we've got to start to think about...' and it's one of those things that was indicative that you got improvement in the areas you focussed. And if you then went and focussed on something else, you'd have, you know, it would slide backwards in the areas you moved away from, if that makes sense, and it seemed to be a real feature of – feature of the organisation. What was the question?

PROF MONTGOMERY: I was trying to understand what the purpose of meeting with Bill Moyes and [inaudible]...

MR HALSALL: Sorry. Bill Moyes. So when we got to that point, and we had been, you know, we'd got the...

PROF MONTGOMERY: And was it before or after the board to board?

MR HALSALL: It was after, so...

PROF MONTGOMERY: So, yes, post board to board.

MR HALSALL: The phone call I got, in terms of the day before Monitor's decision board, where they were going to take a deciding – decision whether to authorise us or not, I got the phone call to say, 'Look, you're not going to go to the board tomorrow because we've asked the new CQC this question and...' okay. So then overnight we went from sort of looking like we're going to be authorised, to having a red risk rating. Without anything happening, if that makes sense.

PROF MONTGOMERY: I understand.

MR HALSALL: So the issue for us was about saying, 'Well okay then, you know, what are the concerns? You know, can we understand what the concerns are and what we need to do, and have we missed something fundamental?' So we went – we just went down to meet with Bill Moyes and with Miranda Carter to say, 'Can you explain it to us? What is it we have to do? What have we missed? Is there something?' and to understand – because my question was quite clear, I said to them, you know, 'Look, is this, you know, just an issue that, you know, that you're dealing with and that you expect to be able to come back and make a decision? Or is it kicking us into the long grass in terms of time-wise, in which case we need to be concentrating on other things other than, you know...' You can't end up with this thing where all you end up doing is a continuous FT process that, you know, you've got other things to do, and if that's not – if that's not what we're going to be doing then we'll get off and we'll carry on running the hospital and all the rest of it and we won't worry about that until you come back.

PROF MONTGOMERY: So out of that meeting was your understanding that you had things to do or that they had things to do?

MR HALSALL: Our understanding was that we would only move on, that we would move back into their process, as soon somebody at Care Quality Commission changed the rating from red to a green and communicated that to them, and they couldn't be clear who it was, but it had to be someone of equal stature to, you know, one of Monitor's directors, basically. Beyond our control, in that sense.

PROF MONTGOMERY: So how did you then communicate with CQC to find out what they needed, [inaudible]?

MR HALSALL: Well it's an interesting one because we had – we worked with the CQC for quite a long time, and we had been working with the Healthcare Commission, to be quite honest. It wasn't that we suddenly, you know...

PROF MONTGOMERY: So was it a surprise to you that CQC had suddenly changed the rating?

MR HALSALL: Yes. We knew nothing about it. And talking to the person that was the lead for the Healthcare Commission at the time, you know, they believed that they had dealt with the issues or, my understanding and remembrance of the conversations, is that they hadn't raised concerns and that they

thought that...

PROF MONTGOMERY: This is your internal lead for relating to the CQC? Or someone in the CQC?

MR HALSALL: No, this is my personal take on...

PROF MONTGOMERY: Right.

MR HALSALL: On that. So again in terms of the Care Quality Commission setting up its systems, instructions and stuff, here was one where there was a number of cases that had a flag they didn't understand, didn't know about, so in terms of – so if you ask somebody at a particular level that is new to it, and Morecambe Bay they've never heard of, and there are a bunch of issues that have or haven't been dealt with, then they put their hand up and said, 'We don't know about that, so I can't comment.' So, you know, I can understand that.

PROF MONTGOMERY: At that point, one thing's happening in the CQC was they were considering whether they should undertake an investigation. Were you aware of that?

MR HALSALL: No.

PROF MONTGOMERY: Okay, and did you become aware of it later? Or I just raised that for the first time?

MR HALSALL: The only time – so no is the answer. I didn't even know there was anything like that until, you know, a reporter was sat outside my house one day when I came home and said, 'They're just about to publish a report that says that the CQC destroyed a report.' I had no idea that they'd even done a report.

PROF MONTGOMERY: Okay, thanks. If I can ask you about one other thing you picked up, before I raise a few other areas. You talked a bit about the – where the PCT went through individually. All the cases, and I think I've seen the notes of that meeting, and I'm particularly interested in whether you remember that meeting discussing the question of whether the incidents were linked or whether they were separate? It's a theme that we may need to come back to. I...

MR HALSALL: I don't remember the – I don't remember the – I don't remember the detail. [Inaudible] be wrong. I mean, to be quite honest with you, I did make a detailed Data Protection Act request to the Trust recently, in order to help

me prepare for not just this but also in terms of questions that I've been asked at various stages, and that – they made no attempt whatsoever to deal with that. But that was one of the – the minutes of that meeting was one of the pieces that I would have wanted to understand, and one that I've been denied access to.

PROF MONTGOMERY: Okay. I've – I can understand that makes it difficult to you answering the questions. I mean you picked up earlier on on the question of whether this was a cluster of connected case or a cluster of cases in the same place, and you were clear at the time, I think, that you dealt with them one by one. So I'm just trying to get a sense of whether you remember, at any point, discussions around [inaudible] might not be connected?

MR HALSALL: Okay. There's two pieces to this. One is were the individual cases connected? Or do you think, actually, there's something – did we need to – did we need to be looking at improving clinical quality and professional standards within maternity...

PROF MONTGOMERY: And you described the Fielding Report [inaudible] the second.

MR HALSALL: Because I don't necessarily think there's – when you look at the individual cases I don't think you necessarily think you get both answers on that. So as we looked at individual cases, some we believed that actually things had gone wrong and so the causation – if the causative factor was either error or omission. On not all the cases do we believe that actually something had gone wrong in the Maternity Unit that caused particular issue, and its different the way I'm saying it, without going through each case and saying, 'Well, look, that's what we thought.' That doesn't mean that we didn't think, 'Actually, from a clinical governance point of view, there were individuals or systems that needed improving in terms of – in terms of Maternity', and certainly I think, across the Bay, there was a need to get single systems in place and to get the clinicians to buy into single systems. Because if it wasn't their hospital, they didn't want to know is the clear point.

I think, you know, there was too much of an input in terms of things seemed to move right in terms of risk management, for example, in terms of having a single risk managed for Maternity, but again, it was based in one place, and I think didn't have the respect of all of the teams.

I think one area that did concern me, I'd once spoken to the head of the LSA at the time. I think I was fairly new in post at the time and she'd said something about, you know, all was looking great at Barrow and stuff, but we never hear from anybody at Barrow and we don't hear from anybody at Lancaster. And that was a bit about, you know, so could you believe that you would – you would practise every day in terms of [inaudible] like that, and never get to something that challenges you professionally or, you know, in terms of your professional responsibility. Which I would find extremely hard to understand and, having headed up nursing and midwifery at both Stockport and at Wigan I would have concerns that actually the LSA say to you, 'Actually well we never really come out here very often, because we never get people raising issues' and that, to me, would say well isn't that an issue? Isn't that a reason to actually go out and [inaudible] because you can't not have issues. You can't not have times where people are professionally challenged by what's going on.

And I think that did change, fairly significantly. Certainly I know I got involved in issues where people had – not necessarily about individual cases that had gone wrong or anything, but cases – so for example, in the Lancaster patch, there were some real issues about advice being given to new mums about home births, that almost any circumstances, and the midwives would come and say [inaudible]. Really challenged by the fact there were some very high risk people who wanted a home birth, you know, and don't want to take any advice and where do we stand professionally? How do we support them and stuff? So I think that did change over time. But I think the system was set up that, you know, people just dealt with what they felt they needed to deal with.

PROF MONTGOMERY: Okay, thank you, and when you had those cases coming through, who were you asking to look at the clinical notes? To reassure you about the care?

MR HALSALL: So it depends really. So obviously one particular case I brought an external clinicians in to look at, and that was having had a discussion with the family, the whole, and them believing that they, you know, they didn't want somebody internal to look at it. They wanted an opinion, and that they wanted to – they wanted whoever looked at it to speak to them before they

spoke to anybody internally, so they got their version first. So that's...

PROF MONTGOMERY: So it's a family that you – I mean I can understand why you'd do that in addition to having one of your people look at it before you did. Had you not already asked someone to give you a look at [inaudible]...

MR HALSALL: Well, initially I would have asked the, you know, Head of Midwifery and the Associate Medical Director to have looked at it. Because of two things: first of all, has something gone wrong that we need to do something about right this very second? Because somebody else will be at risk, you know, that you can see that glaringly obvious, I don't know, like say there was a piece of machinery faulty, or something missing or whatever, that you needed to deal with right this minute. Or is there something that, you know, you can then – so the initial thing is about immediate safety. The second part then is about, you know, what are the issues coming through in terms of safety. In other cases it would have just – it would have just been the internal team that we'd ask.

PROF MONTGOMERY: And the internal team would have been – who would you have asked?

MR HALSALL: Well, it would depend what the issue. So either the Director of Nursing and Midwifery, and the Head of Midwifery – although I wouldn't have done that without Assistant Medical Director's input, and the same in terms of medical issues in terms of the Medical Director and the Associate Medical Directors for whichever...

PROF MONTGOMERY: So you had a direct connection with the Associate Medical Directors? You didn't go through the Medical Director?

MR HALSALL: No I would have gone through them, but I would have ensured that they were part of it, and that's where the information was coming from.

PROF MONTGOMERY: Okay, thank you. Can I...

MR HALSALL: Sorry, I've just – also include the fact that would have been paediatrics as well as obstetrics?

PROF MONTGOMERY: Yes.

MR HALSALL: Because I think that's important to keep – it is an important one to keep an eye on, because I don't want to miss the fact that actually, you know, one of the two huge risks that at – was going to say Stockport then, I wouldn't get forgiven for that. Two huge risks at Barrow that I think don't get

flagged up enough, one is paediatrics. And the second one is anaesthetics. So if they said to me, 'What keeps you awake at night at Barrow?' I'd have said anaesthetics. Not maternity.

PROF MONTGOMERY: Thank you. Can I ask about CQC and the registration process? So you talked in some detail about the FT application process. Another thing that's going on at this stage is the registration, and was [inaudible] you getting the Trust registered, without conditions, in April 2010. Was it your understanding that was always likely to be the registration? Or did you think that there might be conditions or concerns attached? Trying to understand what the discussions [inaudible]...

MR HALSALL: I really don't know.

PROF MONTGOMERY: Right.

MR HALSALL: I mean, to be quite honest, it was a new process. I don't know what peoples' expectations were to be quite honest. So, I guess, I don't know is the easy answer.

PROF MONTGOMERY: Okay. We've been told that you had a meeting with your Chair and Alan Jefferson to discuss that, sort of in the lead up. Can you tell us anything about that meeting?

MR HALSALL: No. I'm not being obtuse. I don't remember – I don't remember the discussion. I'm not saying it didn't happen. I'm just saying I don't remember.

PROF MONTGOMERY: Okay, thank you.

MR HALSALL: I did – sorry – I did have some meetings with various members of the CQC, going through the process and in terms of....

PROF MONTGOMERY: So tell us about those meetings?

MR HALSALL: I can't remember any specific individual meetings, but I do remember having meetings in my office with one or two people around that time, which would have been about making sure that we got the information that they required or needed of us.

PROF MONTGOMERY: And is your memory that they were raising particular concerns? Or is it just about making sure all the information was available to...

MR HALSALL: I don't remember them raising particular concerns in terms of part of that process.

PROF MONTGOMERY: Okay. One more thing about the FT process. We

understand there's an email, we've seen email that you sent to your Chair which is – and it included the phrase, around the FT process that you, 'Understood that the Care Quality Commission Chief Executive might cover off the Ombudsman's view' and we're struggling to understand what that might have referred to. Could you have any recollection of that?

MR HALSALL: No.

PROF MONTGOMERY: So you've got a situation where the Ombudsman is considering whether to investigate one of the complaints, and was that raised with you by Monitor as something it had to resolve before it could take its decision?

MR HALSALL: I really don't remember, and I mean I'm, you now, I'm sit here, I don't know when the email was written, or what the context around it was, and I've certainly never seen it since I was – since that time. So, you know, I'm not able to answer that. And I'm not being obtuse. I just have no recollection of the email.

PROF MONTGOMERY: Okay. Two things I want to ask about though, which I'm sure you will recollect. One is Gold Command. So if you just tell us a little bit about your understanding of how Gold Command arose and what it was supposed to achieve, and what it did achieve?

MR HALSALL: Yes. Gold Command is almost a sort of a taking control of a system, rather than maybe just one organisation. Although I think it was just about taking control of one organisation. There's some positives and negatives to it. I think there's a point at which, if you said to me in retrospect what would you do differently, I'd probably have resigned a year earlier than I left the organisation, and if I'd have known that we were going to get to the Gold Command and the issues that – I wouldn't have saw, being the Chief Exec of that organisation, of being – adding any benefit, to be quite honest, at that point.

Gold Command, I think, has worked in some areas in terms of it was new to people. A lot of people really didn't understand what they were doing there. A lot of people, I think, believed that they were then managing and taking responsibility – well, not taking responsibility for the organisation, but managing the organisation without the accountability.

If I give you one good example, I hadn't had a day off for six months,

and that includes being, you know, passing all the weekends and everything else and doing long hours, and I took a day's leave, on a Friday, and Friday was always a shocking day. Because people tried to clear their desks on a Friday, so if we were going to have bad news it was always on a Friday and it was always, you know, Friday was just horrible for me and it took us, as a family, it took us probably a year to get over, you know, Fridays.

But one Friday morning, when I was taking a day's leave, I answered the phone at quarter to eight in the morning and, you know, within an hour of being on the phone I was dressed and back in the car and still on the phone. It culminated in the afternoon. I got DR KIRKUP man to – who at the time was ill, to come into the Trust, and it took us – it culminated in the late afternoon with about three dozen people on the end of a telephone conference in London, Leeds, Manchester, ourselves in Lancaster, someone in Barrow, somebody in Carlisle.

And the issue that we were dealing with is, you know, what are we going to do about Maternity in Barrow over the weekend? And somebody from the CQC said to me, 'What's happened, Tony?' and I said, 'Nothing's happened.' 'Well what's different?' Well what was different and what was frequently happening is that somebody who hadn't been part of something would see a piece of information and react to it, even if that had been dealt with, and even if we explained that this has been dealt with, you very often got to the point where you couldn't persuade people that it had been dealt with.

When I say, 'Persuade', so this particular issue, this particular day, was that people said, 'Well what are we going to do about Barrow at the weekend?' and I said, so I just, in the end, said, 'What do you want to do? What is it that people are concerned about?'

So when we looked at the workload for the Maternity Unit at Barrow at the weekend there were, I think, two expected deliveries. We had a full staffing rota in terms of midwives, and there was an issue in terms of the medical staffing rota where the middle grade had been replaced by a consultant. So instead of being, you know, SHO, Registrar-ish, and then a consultant on call from home, middle grade had gone – was vacant and so a consultant was doing an additional session, on site, 24 hours a day, with

another consultant from home. So you could argue we were better staffed than usual.

Somebody had seen the rota that didn't understand it and raised the questions about, 'Well there aren't any doctors'. So I remember John Ashton saying down the phone, in the middle of this conference, 'If you had the balls you'd put a consultant in a car and get them from Lancaster to Barrow' and I had to say to people, 'Has anybody asked me what's going on in Lancaster?' and saying, 'What's going on in Lancaster?' We've got three additional beds in the post-natal ward up at the moment. Because it's snowed under with admissions. I've got, you know, the consultant is on site because like, you know [inaudible] and we've booked additional members of staff in every shift across the weekend.

My concern, at that stage, was Lancaster not Barrow. But Gold Command somebody had seen a rota, and so, if you had the right people in Gold Command, and it was very focussed, you know, you could make some progress and you could get cover to actually do the things you need to do, if that makes sense.

So the outcome of that one, I got home about 9 o'clock that evening, and the outcome was that on the Monday we were going to ask a consultant from Manchester Royal to come and have a look at Maternity Unit in Barrow and give a view about whether it was safe or not. But that was Monday. So the issue was about what we're going to do over the weekend. You know, the answer was on Monday, and everyone went home feeling okay about it.

So there were sometimes I think people, you know, took soundbites without actually saying, you know, at the end of the day you're responsible for, you know, what the decision that we're taking though is Gold Command, and I think it got to the point where, you know, my role was much more around managing the system than it was around managing the organisation. And I think at that point it's a slippery slope, because the organisation – and I did some work with the Confederation after I'd left, where we interviewed a number of Chief Execs in – in difficult organisations and, you know, the organisation stops making decisions because it's almost scared of making decisions. And I don't just mean – I don't just mean at board level, I mean at grass roots level, operational level, people like rabbits in the headlights, and

they almost wait for you to make a decision about what they do each day, and you don't know they're waiting for you to make a decision about that.

So the really difficult part of an organisation in distress is the fact that yes, actually it's a downward spiral, you know, and there's an issue for me about how quickly can you break that downward spiral?

PROF MONTGOMERY: And I'm conscious we need to move on quickly, at the end of Gold Command, was life easier or more difficult in terms of managing the Trust?

MR HALSALL: I don't know, I'd left. I mean at the end of the day, depending on who managed Gold Control, so when Jane Cummings was involved in Gold Control it was very clearly structured and you had the right people involved in it. Mike Buick, when he was – if he was at – hold of Gold, you know, would try to keep it as focussed as possible in terms of inputs.

But you could never guarantee who would – [inaudible] organisation was going to actually be part of Gold Control. So if you got – so if you didn't get people like, you know, the right level of people, and you ended up with, you know, a couple of dozen people trying to decide on what to do about something that they didn't understand, then it was a really difficult concept. Because if you don't go along with the flow, then actually it's because you don't understand the output, and that's Monitor's view whenever you – you know, if you didn't go along with something Monitor said. It's because you don't understand, and so it's – it's an issue when you almost then manage an organisation by – by poll, if you like.

PROF MONTGOMERY: I think just one more question for me, and it's really a question to [inaudible] whether there's anything we should explore in a confidential session, but I think I should ask it at this stage, and that's that whether you, at any point in relation to maternity care issues, had to refer to your vexatious complainant policy? If you did, I'd like to ask about that. I think it's an appropriate...

MR HALSALL: I don't remember. I don't remember a vexatious complainant policy.

PROF MONTGOMERY: Right. Any – I'm aware in other places there are sometimes cases where you feel you can do no more for a complainant than you've already done...

MR HALSALL: I mean there is definitely a point where you get to – point where you

think there is very little else you can do. In one particular case, you know, I reached that point.

PROF MONTGOMERY: Okay. In which case I will ask about that. But that's...

DR KIRKUP: [Inaudible] in confidential part. I've got a number of specific follow ups. But do you want to come back before I do that, Geraldine?

DR WALTERS: Yes, in the five cases, I think you've sort of described the difference between, 'Are they connected to each other?' or, 'Are they indicative of a need to improve clinical standards across the whole patch?' Did you ever consider a third option, that this is a particular Barrow issue?

MR HALSALL: Well, it would've been – it would've been hard, I think, with five cases happening in one place that actually there wasn't something specific about Barrow. Whether that's more about isolation and what services are available at Barrow is different than if we think, there is something fundamental about the way people work or beliefs, value sets, whatever it is in terms of Barrow. There's definitely an issue about the fact that, you know – about there being difficulties there.

I'm not – but I still think the big issue from Barrow's point of view was around clinical and professional isolation. So whether you say that's a feature of any or all of those cases, it doesn't change the fact that I think the clinical and professional isolation of Barrow – so people not seeing enough clinical cases, normal clinical cases as well as complicated, to be honest, in terms of maintaining their professional status – were issues. Even without those five cases – so if those cases hadn't happened, and again, I've worked in maternity services and I've had cases that happen that are not dissimilar, some circumstances. I have spoken to people since who can describe similar cases, so it's what is – so knowing that you can have difficult cases in maternity units and things don't always go right, and sometimes it's about fault, it's then saying, 'What is the difference between that unit and any other unit?'

So if you put that to one side, there's a second part that says: the thing that is different about that unit – and it's not just about that unit, because Lancaster is not that close to anything else either – is how you get past the fact that you are going to – that you will recruit from a limited pool; that you, when you look back and we dig into it, people say, 'Well, that wasn't the

candidate we really wanted', or 'That's the only person we could get', or, 'If you couldn't get somebody then you just bring in locums', and that's extremely variable anyway. So, there are issues around the clinical confederation, the clinical safety, if you like – long-term, clinical model, that you need to invest in in terms of Barrow. One of the big issues for us was, you know – and in my view, not having a maternity services in Barrow, is a massive risk, and one that, you know – you may need to change the model but to have nothing there would seem to me to be just – well, almost a disaster.

One big issue that we did deal with while I was there in terms of the neonatal network wanted to downgrade across the patch. I remember being very clear that I wouldn't support it because I don't think that in terms of tiered response to neonatal services is right. But what people forgot in terms of Barrow is that if you had a sick baby – I remember talking to a paediatric registrar in Manchester who said they'd just spent a shift – it took them an eight-hour shift to actually physically go out to Barrow to pick the baby up, stabilise and bring the baby back. If you're in the greater Manchester outer ring road, that's fine – it can take you an hour or two. So there's an issue for me about downgrading cots, but actually, if you're going to have maternity services in a place that's isolated, it's alright saying, 'We've downgraded these cots', etc., but you still need to look after a sick baby for an extended period of time, longer than most DGHs, with less support, if that makes sense. So –

DR WALTERS: But one is clinical isolation; also saying, actually, 'Are all these people competent?'

MR HALSALL: Yes, but that's what I'm saying to you about my view, in terms of putting the individual cases to one side, it doesn't change the fact you've still then got to deal with the clinical and professional isolation that creates and how you ensure that people get enough exposure to normal births as well as complicated births –

DR WALTERS: But that sounds like a long and medium term plan, whereas here you've got a clear and present danger, haven't you?

MR HALSALL: A lot of that was about trying to get better interflow between the staff that we had at Lancaster and at Barrow just to get a change in that. For me,

in terms of some of the issues there, one part that we did need some real clarity in, in terms of trying to understand it was, again, not long before I left: we brought a senior midwife from the London area who came and did some work for us in terms of working with the staff in Barrow. Worked with them, went away and then came back, periodically, and the issues that she sort of sold me on, if you like, was about the decision making at critical points in time. So you're not there to see the decisions they make or don't make in terms of individual clinical care. So when you have an incident, you say, 'That happened', and you measure back from what happened, and you say, 'Who took what decision?' What you can't measure are decisions people didn't take. Some of that for me was about the professional isolation bit, was about trying to understand – so if you review an individual case, like I say, you get those points in time that you go back and say, 'Who did what and when?' and you take a view – you don't get – but if you started here, 'What were the decisions that could've been taken at various points in time?'

DR WALTERS: So these five cases, you said you went to see the unit, what assurances were you getting from your Medical and Nursing Director about their view, whether the incidents had been reviewed properly? Whether the staff were competent to deal with the incident reviews?

MR HALSALL: I'm not sure that their view would've been different than I've expressed in a sense.

DR WALTERS: Did they go and look at the cases? Did they visit the unit? Those sorts of things?

MR HALSALL: Absolutely. I mean, they both spent a considerable amount of time in terms of those units. I know that Jackie Holt certainly, you know, was very involved in a lot of the, sort of, review and the work that we were trying to do in there, especially in terms of trying to get change to stick. And to understand, as I say, some of the silent decisions that are made on those pathways, that you don't see or hear about. It's not – it's something that people - and that bit about having highly competent professionals dealing – working alongside your staff, to me seemed to be – we'd got to get somebody that would come and work on that, seemed to be massively different. I know that we also held a recruitment day for maternity and I think we were looking at something like 19 midwives – 17 or 19 midwives – in one

go in a big recruitment event, which, considering the amount of pressure the service was under, and the amount of publicity around that, was fantastic. I mean, I would have to say there were days I'm not sure why midwives turned in for work in Barrow; they were under that much pressure. When you've got Sky News sat outside the building, there was a point at one weekend where the police believed they'd said nothing had changed, then Sky – it was shortly after the deaths in Stockport – that they believed a big story was about to break and they sat a Sky News van outside of the maternity unit, and we said, 'Nothing has changed', and the 'Breaking News' was, 'Nothing's changed'. So, in terms of interviewing people going in and out of maternity unit, and stuff like that. My personal view is that, the safest thing to do is that, 'Let's close for business, re-do things and re-open', but actually, you don't get that opportunity. I think in terms of trying to keep a system running and keep the maternity unit running at some sort of safe level through that period of pressure – it's okay saying that the Board were under pressure. But actually, you know, I can't underestimate the level of pressure people were, at an operational point of view, and a clinical interface –

DR WALTERS: Okay, thanks very much.

DR KIRKUP: Quite a few points to follow up, quite a lot of which will need to be in the confidential bit, for the individual cases, but I'll do as much as I can in the general session. Actually, I just want to pick up something you said when you were talking about downgrading cots, to Geraldine. Isn't the point, rather, having to avoid transfer babies to Manchester, by appropriate risk assessment –

MR HALSALL: Completely and utterly agree with you, and that was part of the difficulty in terms of getting clinicians to understand that's what you were doing. From a Barrow perspective – back to that thing about, they get used to finding a way of dealing with things, or believing that they could deal with certain circumstances, so I do remember having a conversation with the Head of Midwifery around six months before I left, around a case that she believed, you know, was a high risk case, and where we believed that we had criteria in place that said, actually, 'In this criteria, you will transfer the patient rather than risk delivery'. I spoke directly to a consultant and gave him a direct instruction to transfer the patient. Now, that's difficult from my

point of view, because obviously if something happens on the way down the A590, but ultimately, it wasn't about whether or not he was competent to deliver the baby – which I think was 32 weeks gestation or something – it was whether or not you had the support mechanisms in place to actually look after that baby when it was born. The safest thing to do is to transfer that patient with the baby in place to a unit that can deal with the baby. But I believe that the clinicians there were used to making that assessment.

DR KIRKUP: Yes, okay. One or two of the clinicians involved in paediatrics, particularly probably the ones based at Lancaster did have reservations about the fact that paediatricians in Barrow had got used to keeping babies there, before birth and after birth, and did try and tackle that. You remember that that created some reaction from the people –

MR HALSALL: I'm not sure how they tried to tackle it. What I would say is, again, it's about where you are in points of time. So we did change the Associate Medical Director for Paediatrics –

DR KIRKUP: Again, a name would be helpful –

MR HALSALL: Yes, Owen. I can't think of his second name –

DR KIRKUP: Paul Gibson?

MR HALSALL: No, Paul Gibson -

DR WALTERS: Owen Galt?

MR HALSALL: Yes, it was Owen Galt. I can remember Owen. Paul Gibson had been the Head of Paediatrics for quite a long time, and we replaced him with Owen. Owen had a completely different, fresh eyes. I sat with Owen one night with all of the clinicians in a room to say, 'This is what...' – he came up with a clinical model and some big changes. He even positioned himself at Barrow – so moved out his clinical workload to sit in Barrow to actually ensure that, but to create some changes. So he and I had a couple of very difficult conversations with large groups of clinicians, but I think it was the first time that anybody had actually tackled the issue around – and I don't think it would've happened if we hadn't changed – put Owen in charge, and changed leadership.

DR KIRKUP: Well we did hear an account that Paul Gibson had tried to tackle the problems at Barrow which resulted in a complaint about his behaviour, that he had to be investigated for?

MR HALSALL: I don't remember that.

DR KIRKUP: You don't?

MR HALSALL: I don't.

DR KIRKUP: Okay.

MR HALSALL: I definitely don't remember an issue with Paul being investigated. But I'd have to – unless you refresh my memory, but I don't remember Paul being investigated over a complaint. I remember – I mean, clinicians didn't like anyone from Lancaster telling them what to do –

DR KIRKUP: Exactly, it was that he systematically undermined the FGH consultants, the consultant paediatricians, that in effect, he was bullying them because he had concerns about the clinical practice and one of them wrote to you and the result was an investigation that was commissioned into Paul Gibson, which on the face of it – what it probably is, it sounds like you've got a clinical director who's trying to identify and address problems and he doesn't get the backing to do it; in fact, he ends up on the receiving end of an investigation?

MR HALSALL: I genuinely don't remember an investigation into Paul. I mean, if people raised an issue bullying and that type of thing –

DR KIRKUP: You're bound to investigate it?

MR HALSALL: You're bound to investigate it, so you would have to look at it. I certainly don't remember us giving Paul a heavy time on anything, whatsoever. [redacted]

DR KIRKUP: No, this is a separate issue, but if you've got no recollection, you've got no recollection. While we're on the subject of letters, you weren't a recipient,

but clearly you found out later the letter that Mr Misra wrote about his concerns about the relationship between midwifery and obstetrics staff. But what was your view of how that letter was dealt with?

MR HALSALL: By who?

DR KIRKUP: Well the principal recipient was Peter Dyer, I think, the Medical Director?

MR HALSALL: I don't remember responding directly to that, I mean, I think there was an issue around the link between midwives and medical staff – I'm not knocking that, I don't think it was different – I think it was relating to a specific case and I'm not sure that that –in relation to that specific case it was the issue. I think it was fundamentally a palming off in terms of saying, 'It's not our responsibility', type thing, and I think there was a joint responsibility in terms of the particular case they were referring to. It was brought up to me by the coroner in an Inquest.

DR KIRKUP: Yes, okay.

MR HALSALL: I think there was a relationship issue.

DR KIRKUP: Exactly, which is why I'm interested to know whether you thought that had been properly dealt with?

MR HALSALL: What the relationship issue, or in terms of his letter?

DR KIRKUP: The fact that he had brought attention of the relationship issue, fairly unmistakeably, to light?

MR HALSALL: Yes. I think we were dealing with it. I don't think we would've just said there wasn't a relationship issue. I'm not sure he raised it, and certainly in terms of follow-up, and certainly when I spoke to him, I'm not sure he raised it in order for there to be, if you like, subsequent action around – I think the raised it in relation to an individual case. Certainly in terms of when I've had all of the midwives and doctors in one place – because when I went to talk to them about cases and whether the unit was up to – I tried to make sure that I spoke to everybody at once, and it wasn't like – the medics would've liked it just to be the medics and the midwives. So I think the relationships – I think the relationships weren't just sort of midwives and doctors. I think there was a male and female thing in there; I think there was some sort of differences in ethnicity and that type of thing, and it was a whole mix of stuff in there in terms of relationships.

DR KIRKUP: Okay, I will come back to one of those points in a minute. But, as far as the response to that letter specifically is concerned, it's difficult to see that there was one. Is that something that concerned you? Or do you think that's...?

MR HALSALL: I don't recall a specific response to that letter in terms of actions that we took or did anything different in relation to that –

DR KIRKUP: Or even acknowledging that it had been received?

MR HALSALL: Well, I wasn't the recipient of it.

DR KIRKUP: That's true, but as it was drawn to your attention later, I thought you may have looked at how it was handled at the time?

MR HALSALL: Yes, I don't remember.

DR KIRKUP: Okay. You talked – we've spent quite a lot of time talking about the Foundation Trust drive. Where did you perceive that drive coming from?

MR HALSALL: What when I first started?

DR KIRKUP: Yes.

MR HALSALL: I mean, it was clear at interview that the organisation perceived itself to be close to being a Foundation Trust and that that was their priority and it was clear, I think, in terms of clinicians that they saw a Chief Exec coming as being, you know, getting them to the promised land in that sense.

DR KIRKUP: Was that anything you questioned?

MR HALSALL: Say again, sorry?

DR KIRKUP: Did you question it at all?

MR HALSALL: Did I question it?

DR KIRKUP: Yes. Did you say –

MR HALSALL: The whole NHS?

DR KIRKUP: 'Not right for this organisation yet'?

MR HALSALL: Well, two things then: first of all, the whole NHS was being driven to Foundation Trust status, so there was a deadline by which time everybody had to have an application in, so you know – the view internally and externally in terms of what the NHS was pushing people to – in terms of where we were up to, and I was really clear that we were nowhere near it, you know – I don't think I've ever disguised the fact that we were nowhere near at that point, and there was a lot to do in terms of sorting out performance, in terms of the acute service review, in terms of getting a plan

to deal with the money without those things. Without those things being done, you know, you were never going anywhere. Like I say, the acute service review was the biggest thing on the landscape at that point.

DR KIRKUP: Okay, so you've got an organisation which is under a lot of pressure anyway to try and resolve all those issues, and in a sense, some of those, regardless of FT status –

MR HALSALL: Well, the FT thing – the way I see the FT thing, is you're only involved in the FT once you get to the point of applying. So the organisation felt it had applied and was a live applicant when it wasn't. So the issue for me was dealing with performance – the performance, the money and acute service review. Until you did those things – and actually, forgetting FT status for a minute, the organisation needed to deal with those things anyway, so my view was, if you deal with the things that we you need to be dealing with then at some point, an application will fall out of it, rather than you do the application and just worry about putting the pieces together. Like I say, sorting clinical configuration around acute medicine, until you'd done that, nothing else was relevant to be perfectly honest.

DR KIRKUP: Okay. I just want to check something that you said right at the start which was that each of these individual incidents in 2008 went to the Board, but there isn't a record of them going to the Board.

MR HALSALL: They weren't necessarily in 2008. There was a cluster of cases over a short period of time. Without looking at each individual case, I couldn't put a date on them.

DR KIRKUP: It's 2008. It is, take my word for it. But there are the five cases that people talk about, that we've mentioned a number of times, they were all in 2008.

MR HALSALL: Then I'd find that almost impossible to believe that they weren't minuted -

DR KIRKUP: Okay.

MR HALSALL: Points that the Board were over those five, because the amount of time that the Board spent on those case, and the amount of follow-up in terms of Board-to-Board, etc. was quite extensive.

DR KIRKUP: Certainly later, there's discussion about it later. But not on an individual basis as they arose?

MR HALSALL: Right, okay.

DR KIRKUP: Okay.

MR HALSALL: Sorry, it's hard to respond directly to it, without going through the individual cases.

DR KIRKUP: I understand that. The concerns that I have about that is that you're indicating that each of those incidents was carefully at whatever level, whether it was minuted or not, your view is that each of them was considered carefully as they arose over the course of 2008? The question, really, is: why did it take until the Joshua Titcombe incident to flag that there was a definite problem there? Some of the features of some of the earlier ones I would've thought would've raised those concerns.

MR HALSALL: But Joshua was 2008.

DR KIRKUP: Yes, but November 2008.

MR HALSALL: Yes, okay.

DR KIRKUP: Some of these other ones were distinctly earlier. Do you see what I'm getting at?

MR HALSALL: I get what you're –

DR KIRKUP: The fact that you were talking about each one individually.

MR HALSALL: I see what you're getting at but in terms of issues raised – so for example, and I don't remember the timing, the exact timings in terms of the occasions, but I do remember us doing a timeline around when individual cases had happened. But I don't remember the detail of that. So there were – some of those cases were subject to Inquests, and some of the Inquests, there was criticism, and in some there wasn't. So I guess – there were two particular cases, without saying them, were the ones where actually – I think we were criticised. I'd have to clearly think about the timing of those two cases.

DR KIRKUP: Okay. You said that you listened to the senior medical team and in hindsight, that was an error. What do you think they should've told you?

MR HALSALL: I don't think the – what should they have told me? There's a piece that says, actually – so the clinicians on-site would say, actually – I can see them clearly saying to me on a number of occasions, 'We're no different to anywhere else and our complication rate is no different – neonatal death rate is no different' etc. And I can see other people saying, 'Well actually some of

those doctors wouldn't get a job on this site.' So, I think their response is different. I think it was always defensive. I think even if somebody exposed something I think they would then probably have found a way around why it wasn't somebody's individual fault. I think certainly the Associate Medical Director and Head of Midwifery, I think sometimes we were really clear about what I thought should be happening. We'd get feedback to say, 'We're doing that, and that's what's happening', and then actually you'd find out that wasn't quite what had happened or it wasn't quite they'd put in place. So, I think there was a period of time probably – like I said, we had changed the Head of Midwifery around about that time, so there's a bit about saying, 'We've got somebody different', which I think was false assurance, in a sense.

DR KIRKUP: The last part of this section: it sounds to me, listening to all the conversations that we've had, the sum of them, it was pretty unmistakeably by the early to mid-part of 2009 that there's pretty serious issues in that maternity unit. Not across the whole patch but at that particular maternity unit, to do with clinical competence, knowledge, attitudes, dysfunctional team working. That's pretty difficult to sort out isn't it?

MR HALSALL: It's impossibly difficult to sort out, but I'm not sure by early 2009, that would've been recognised.

DR KIRKUP: By that stage, you've had five incidents, which although clinically they may have been different, indicated the same sort of dysfunctional relationships. You've had the difficulties about inadequate external investigations, the LSA investigation. You've had the Flynn and Fielding Reports, both of which alluded to dysfunctional relationships. You've had the letter from the consultant talking about dysfunctional relationships, which looks – I'm working –

MR HALSALL: Which, sorry –

DR KIRKUP: It seems to me emphasising how it felt at the time –

MR HALSALL: Sorry, I get that, but –

DR KIRKUP: You had all those –

MR HALSALL: By early 2009. So, what I remember –

DR KIRKUP: Okay, later in 2009. And the Fielding Report was later than that, I'll give you that. Take the Fielding Report off the table.

MR HALSALL: The Flynn Report would've been later than that as well.

DR KIRKUP: That was in 2009.

MR HALSALL: Yes, but I mean, it wasn't early-2009. Early-2009, we'd obviously – I'd obviously had the initial review of Joshua's case; we'd had one Inquest in terms of – that was critical. I'm not sure what else we'd had at that point.

DR KIRKUP: Okay, you've persuaded me that I should rephrase the question.

MR HALSALL: Yes, I'm just trying to say, if you say it that way, 'Within a couple of months, all of this happens in a couple of months...' – and in actual fact, so what happens then, for the next four years, type thing. It wasn't quite as that.

DR KIRKUP: Okay.

MR HALSALL: I think there was a lot of sort of – I don't know if denial is the right way of putting it – but I think what I said before about the clinical isolation of the unit and the clinical competence of staff. I think that was taken as read that that's what we were dealing with. I don't think we tried to say that wasn't what you were trying to deal with.

DR KIRKUP: Okay.

MR HALSALL: Because just keeping the rotas moving in terms of some of those rotas, and trying to keep the rotas safe was a huge issue, week in, week out, let alone anything else. In terms of then trying to recruit additional staff and recruit the right people, again, it was difficult as we go along. I don't think we did enough – and that's what the Fielding stuff was about – about saying, 'So what are the structures, then, that we would put in place from a clinical governance point of view that deal with some of that isolation'.

DR KIRKUP: I think this is exactly what I'm driving at. I think I recognise that you've got a service that you have to keep running. You've made that point very clear and I can absolutely see that. You also, I think, are saying that you recognised at the time that there are these dysfunctional relationship, competence issues underlying it. I don't see how a clinical governance system is going to sort that out. Don't you have to change the underlying culture in that –

MR HALSALL: Well, you do, but how do you go about changing the underlying culture?

DR KIRKUP: Exactly.

MR HALSALL: The issue I'm saying, some of that is about changing people, and I we should have said, 'Change some of the more senior people' quicker than

we did. I think that's an absolute key. But I don't think, not knowing those people – I think we believed that actually they were able to make some of the changes that needed to be changed, but that subsequently didn't end up, so we changed again and did some work around that. Trying to get somebody to come in and give us an expert view, was another way of saying, 'How would you go about starting to try to change some of those underlying values of the organisation?'

DR KIRKUP: Yes.

MR HALSALL: I do remember meeting with the LSA and talking about midwifery supervision and the trust, and how do we go about that? Bringing in a new Director of Nursing was another big key around the amount of time that she spent in terms of trying to work on that. We had some structural stuff like, pushing in terms of clinical governance at the clinical risk strategy in terms of trying to move the organisation around CNST standards around level one and level two. So I think there are a bunch of things that we were trying to do at that time.

DR KIRKUP: Yes. Those kinds of changes take a long time to have an effect, and I'm not criticising it. I'm just saying, you would've recognised as well as anybody I would've thought that those things take a long time?

MR HALSALL: Yes, they do. But the –

DR KIRKUP: But the external signals that the Trust was giving throughout all of this period is, 'Maternity is safe here and everything is okay'.

MR HALSALL: I wouldn't have said everything was okay –

DR KIRKUP: I think the press releases are pretty –

MR HALSALL: I think the issues we were trying to do was to keep public confidence in terms of the fact the maternity unit is – so I don't know how that unit compared to other maternity units in terms of rotas and all the rest of it. I do know that we did our best to take a view in terms of safety, and we did things and we told people what we'd done. I don't think we – I don't think we got – every time we thought we'd got somewhere, you'd find something that happened, and you'd find that slip-back. So there's that bit about people finding a way to deal with something that actually you don't know they've found a way to deal with it, that's the problem – you found out that they've

dealt with stuff. So I think there was a fair bit of positive progress and slip-back.

DR KIRKUP: Was it positive progress or was there an element, perhaps, of people wanting to be persuaded that things were improving?

MR HALSALL: I don't know. It could be a combination of both.

DR KIRKUP: It's a difficult question, I appreciate that.

MR HALSALL: I think there can be a combination of both.

DR KIRKUP: No, I mean, generally – inherently, I think it's a difficult question. Okay, I do want to follow up some of the other specific points, but they relate to individual cases, so can we have a brief pause while I ask people to leave the room, thank you?

(The meeting went into private session at 12.06)

THE MORECAMBE BAY INVESTIGATION

Tuesday, 14 October 2014

Held at:
Park Hotel
East Cliff
Preston PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser, on Governance
Professor Stewart Forsyth – Expert Adviser on Paediatrics

KATHRYN HAMPSON

Transcript produced by Ubiqus
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(At 3.28 p.m.)

DR KIRKUP: Hello please take a seat. Hello I'm Bill Kirkup, I'm chairing the Panel.

MRS HAMPSON: Hello.

DR KIRKUP: I will ask my two colleagues to introduce themselves to you.

PROF FORSYTH: Hello.

MRS HAMPSON: Hi there.

PROF FORSYTH: Stewart Forsyth, I'm a paediatrician, and I am a director from Dundee and Teesside.

MRS HAMPSON: Hello Stewart.

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

DR KIRKUP: You will have seen that we are recording the proceedings.

MRS HAMPSON: Yes.

DR KIRKUP: And we will produce an agreed record at the end. You will also know that we've invited families to be present, observing us. As it happens we don't have any families with us this afternoon.

MRS HAMPSON: Yes.

DR KIRKUP: But they may listen to the recording at a subsequent date.

MRS HAMPSON: Yes.

DR KIRKUP: And you will also know that we've asked you hand in any mobile telephones, laptops, recording devices just to emphasise that we don't want anything to go outside the room, until we're ready to report with the findings.

MRS HAMPSON: Yes.

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

MRS HAMPSON: No.

DR KIRKUP: Okay, in that case I will start off with a very general question and then hand over to colleagues initially; and that is can you tell me when you started at the Trust, and what you've done there?

MRS HAMPSON: How far back do you want to go?

DR KIRKUP: When did you start at the Trust?

MRS HAMPSON: So, I started my nurse training – can you hear me okay? I started my nurse training in 1980.

DR KIRKUP: Yes.

MRS HAMPSON: I actually was initially was doing combined nursing, adult and children nursing at Alder Hay. But, for family reasons, transferred to what was then South Cumbria School of Nursing, if I recall. I qualified as a staff nurse in 1983, worked in male surgery for 18 months or so and then went to Lancaster School of Midwifery, as it was then. This was before the Trust was a Trust, just a hospital.

DR KIRKUP: Yes.

MRS HAMPSON: And qualified as a midwife in 1986 and came to Furness General hospital at about the November of 1986.

DR KIRKUP: As a midwife?

MRS HAMPSON: As a – in those days it was staff midwife.

DR KIRKUP: Staff, yes. Okay, when did you become a supervisor?

MRS HAMPSON: 2005-ish, so I worked as a rotational midwife until around 1991, and was a labour ward sister, as we called them then, for a while, before I moved onto the community, as a community midwife in 1994. When I trained it was just the usual registered nurse, registered general nurse it is actually, when I trained, a registered nurse; and then I did a post registration degree. And midwifery supervision, which I'm sure you understand, was one of the modules that I did.

DR KIRKUP: Sure, so you started as a supervisor in 2005?

MRS HAMPSON: Around about then.

DR KIRKUP: Did that continue? Are you still doing that?

MRS HAMPSON: I'm a qualified supervisor of midwives, but I resigned from my position as supervisor in 2012.

DR KIRKUP: Okay.

MRS HAMPSON: I'm sure you understand that, as a supervisor, you're appointed by the local supervising authority, not employed by them, and some areas of the country, midwifery supervision is given time, or payments, or – and at the time, when I was initially practising, and until relatively recently, you got neither of those.

DR KIRKUP: Okay is that what prompted you to resign?

MRS HAMPSON: I think – well, all the incidents that have happened, and my extreme dissatisfaction with the way that the senior management team, the Trust board and the then LSA senior officers handled it.

DR KIRKUP: Okay.

MRS HAMPSON: I was completely and utterly dissatisfied with their fundamental lack of support.

DR KIRKUP: Okay, that's a very important point. I would like to come back to that.

MRS HAMPSON: Yes.

DR KIRKUP: I would like to ask you some general questions and then return to that please.

MRS HAMPSON: I'm sure you will.

DR KIRKUP: Okay.

MR BROOKES: Okay, yes that is important. So, again just starting off generally if we could?

MRS HAMPSON: Yes.

MR BROOKES: I would just like you to describe for me your role as a supervisor of midwives.

MRS HAMPSON: Well, I was a clinically based community midwife with a traditional caseload and as a clinically based midwife I was already a G grade and when we had 'Agenda for Change' the jobs were assimilated, so I was about a 7, oh right, using my hands. And so I had a caseload, the busiest single handed caseload in the area, and I ran an outlying consultant clinic as well.

So, midwifery supervision was in addition to that and I've got to say, at the time, the decision making process and the presence of supervision in the senior management arena was organised by the senior supervisors midwives; I wasn't party to any management discussions, management forums.

MR BROOKES: Sorry, I just want to make sure I understand that.

MRS HAMPSON: Yes.

MR BROOKES: So, you were a supervisor of midwives.

MRS HAMPSON: Yes.

MR BROOKES: But obviously the context of that supervising would -?

MRS HAMPSON: So, the context of that would be that from a clinical perspective I was responsible for a small group of midwives; I was their main supervisor of midwives, they were my supervisees and so within that role I was responsible, for example, for their annual supervisory reviews for collecting the notifications of intention to practise, which in those days they would have

sent off in the post. Any supervisory activities that went on within the unit, I was – obviously we had meetings, although those meetings weren't regular, and they weren't cross-bay, you'll have heard that term. They were just local supervising midwives, where we met and discussed issues; but I wasn't involved in the, for example, guideline groups, labour ward forums, anything like that. Mine was very much clinically based within the community.

MR BROOKES: So you were responsible, as the supervisor, of a certain number of midwives?

MRS HAMPSON: Yes.

MR BROOKES: Okay, and how was that role fulfilled after, as you say, there were things about registration etc. but in terms of their continued ability to practise, their competency, what would -?

MRS HAMPSON: Well, in addition to that obviously I'm sure you know that the supervisor is responsible for investigating poor practice and addressing any issues, and because I had, I suppose, looking back, a very junior position at that time, wasn't involved in any investigations or reviews of any particular midwife's practice. This is pre 2008 I'm talking about. I do know that there were investigations, and there were suspensions, but I wasn't involved with that.

MR BROOKES: And 2008 onwards?

MRS HAMPSON: From 2008 onwards I became more involved.

MR BROOKES: Okay; and what training were you given?

MRS HAMPSON: As a supervisory midwife you undergo – it's – at that point it was at diploma level, the module, which is an accredited module at Manchester University. You have to have been a midwife for a period of time; you have to submit a paper for evaluation before you're taken onto the course, and it's an accredited course, there are assignments, so that's – you then obviously have to pass and then you're appointed by the LSA MO, the local supervision authority midwifery officer.

MR BROOKES: That is general training to be a supervisor.

MRS HAMPSON: Yes.

MR BROOKES: But in terms of doing investigations, were you given any specific training?

MRS HAMPSON: Oh right, if I use the term – by the time we get to 2008, and in the

case of the first incident, by that time the more experienced supervisors of midwives, two of them had resigned, three of them had resigned and the other two or three were based in the unit, one of whom was the risk manager, and the Head of Midwifery was a supervisor of midwives. But in her words, she wasn't a supervisor of midwives in our hospital, which I found difficult to understand, when you're the Head of Midwifery.

So, it was very little support, no time, very little support given to undertaking, for example, a supervisory review of an incident before you progressed to an investigation. And at that point there was paper guidance, there was nothing electronic, there was no tool kit, there was no performer or anything; it was basically 'This is the guidance, look through it and ask somebody else to help you'.

MR BROOKES: So, just to be clear, you weren't given any specific training?

MRS HAMPSON: No, other than what you do within your – the module that -.

MR BROOKES: The module.

MRS HAMPSON: Yes and you -.

MR BROOKES: Which had been a number of years before?

MS AMPSON: Yes.

MR BROOKES: Was there any continuous support or training?

MRS HAMPSON: Every three years you, at that point, were required to – as part of your professional development within supervision, present a clinical incident and it was a forum with supervisor of midwives from the north-west.

MR BROOKES: Okay, so 2008, you're now getting involved in doing some investigations.

MRS HAMPSON: Yes.

MR BROOKES: Before we go into the actual investigation side of things, I'm just interested how was that process of investigation linked into the governance arrangements for the Trust?

MRS HAMPSON: Well, my recollection is that there was a complete absence of a robust clinical governance structure. The predominant objective was to achieve CNST; this is my recollection. And all the focus was on money saving, to get to level 2 at CNST. The actual, on the ground clinical governance structures, for example there was no robust multi-disciplinary guideline group. It was in a room with senior people and there were, to the

best of my knowledge, no clinically based supervisors, midwives were invited to contribute to that.

MR BROOKES: Okay, so you've got an investigation.

MRS HAMPSON: Yes.

MR BROOKES: And you're conducting it; how would the outcomes of that investigation get into the system, the hospital system?

MRS HAMPSON: Okay, so even before we get to the investigation, the first investigation that I conducted, and again this was prior to any electronic guidance tool kit, performer, anything with no help from the LSA midwifery officer at all; no experienced supervisors of midwives that had previously undertaken an investigation to assist me. And with outright obstruction from the senior management team, who were also supervisors of midwives and the board.

MR BROOKES: So, how did that obstruction show itself?

MRS HAMPSON: I was basically told this was -- do I need to mention an incident at this stage or shall I just be broad about it?

DR KIRKUP: If it involves clinical details of an incident we'll have to take in the second part of the session, where we ask -.

MRS HAMPSON: Yes, so I'll be broad then at this point. So, there was - because there had been an incident I wasn't involved in reviewing or investigating that, but then there had been a second incident which I was made aware of a couple of weeks later, and asked the question, so "Who's looking at this? Who's going to be doing this investigation?" Was basically told there's not going to be any more investigations, you cannot conduct an investigation about this.

MR BROOKES: Who said that?

MRS HAMPSON: Chairman and the Head of Midwifery.

MR BROOKES: Chairman of the Trust?

MRS HAMPSON: Yes.

DR KIRKUP: Who was Chairman of the Trust at that time?

MRS HAMPSON: You want me to say names?

DR KIRKUP: Yes.

MRS HAMPSON: Tony Halsall .

DR KIRKUP: He's the Chief Executive.

MR BROOKES: He's the Chief Executive.

MRS HAMPSON: Oh, I do beg your pardon, sorry that's, yes.

DR KIRKUP: It's okay, no problem.

MRS HAMPSON: Yes, the Chief Executive.

MR BROOKES: And what reason did he give that there was not to be an investigation?

MRS HAMPSON: Because until the management investigation – this was the rationale, until the management investigation of the incident that had occurred the previous month had been completed, there were to be no further investigations. Now, I'm a reasonably inexperienced, well, I've never conducted an investigation before, supervisor of midwives; so I approached the Head of Midwifery on two separate occasions.

MR BROOKES: And who was that?

MRS HAMPSON: That was Angela Oxley.

MR BROOKES: Thank you.

MRS HAMPSON: I also discussed it with the risk manager and that was Jeanette Parkinson, who I'm certain had been basically told the same as I.

MR BROOKES: Did you talk to the LSA about it?

MRS HAMPSON: I did.

MR BROOKES: And what did they say?

MRS HAMPSON: I eventually, having tried to get the – it was Marion Drysack at the time, I don't recall whether she was off work – bless you (someone sneezed) , I don't recall whether she was off work, you know, the time scale, I can't recollect.

MR BROOKES: Sure.

MRS HAMPSON: But eventually I managed to talk to Judith Curitak, who was the supervisor of midwives, who said to me, "Well you don't need the Trust's permission to undertake an investigation", in my naivety I knew that, but you're a clinically based midwife being told "You're not doing this." You've no time to do it. You've no protective supervisory time to undertake this. You know that this is a serious incident that needs the proper investigation. You've got the written guidance, which the 2005 guidance had just been superseded by the 2008. Now, the 2008 guidance, I can't recollect at what point in the year that that was released. I do recall that there was a delay

and it would have been because of funding; but it arrived at what point? Well, when you compared to two, the 2005 guidance was actually more useful because it was, you know, supervisory investigation by numbers, which for a novice that's what you need to have.

So, having had the conversation with Judith; went back again to Angela Oxley, who said, "No, you are not to do it". And Tony Halsall's words to me, in the corridor, were, and I am absolutely certain that he used this phrase to other of my colleagues, "You're lucky you have a job."

MR BROOKES: Okay. So, you were employed by LSA?

MRS HAMPSON: No, no, no, no, I'm employed by the Trust, but you're appointed by the LSA.

MR BROOKES: I apologise.

MRS HAMPSON: So, you don't – at that time you weren't given any protected time to undertake supervision, so I banged on and banged on about it, I also spoke with the – I can't recall whether Mr Hussain was a clinical director then, or a deputy clinical director; I can't recall, but anyway he was the senior obstetrician at the time, and I worked with him on his satellite clinics, and I'm using that term loosely, it was a clinic that wasn't in the main part of the hospital.

MR BROOKES: Sure.

MRS HAMPSON: And I said to him, "This is absolutely the wrong thing, we need to be doing an investigation here." He supported me in that yes, he agreed that there should be an investigation because there were both, taking a step back, you've probably heard this before that at that point, what you did, you did a review of the case by looking at the notes basically. I wasn't at the point where I was interviewing the people involved, because that's part of the process when you get to the investigation. So you have a look at the case, realise that there were definitely some issues there; and not just midwifery but medical clinical governance issues as well. So, eventually I was allowed, in my naivety, allowed.

MR BROOKES: So, what changed; what changed?

MRS HAMPSON: They had completed the management RCA.

MR BROOKES: Okay, so they had done a root cause analysis through their own process?

MRS HAMPSON: Yes, so that was completed the February, the March of the next year, which was 2009.

MR BROOKES: Were you made aware of that?

MRS HAMPSON: Yes.

DR KIRKUP: When you say "next year", sorry Julian, I just need to keep track of when we're talking about.

MRS HAMPSON: So, we're talking about September 2008, the second incident.

DR KIRKUP: Yes.

MRS HAMPSON: That's the one that I was concerned about.

DR KIRKUP: Yes.

MRS HAMPSON: And then the - my commencing the supervisory investigation into what happened was delayed until about the management RCA was completed about the March.

DR KIRKUP: Of 2009.

MRS HAMPSON: Of 2009, February, March and once I'd commenced the investigation I completed it within the 28 days that it was, at that point, and still is, the requirement.

MR BROOKES: Okay, but before you started that investigation you'd been made aware of the RCA management investigation's results?

MRS HAMPSON: I can't recall that. I can't recall.

MR BROOKES: I thought that's what you'd said; if it's not clear that's absolutely fine.

MRS HAMPSON: I can't recall that I -.

MR BROOKES: It's just that I'm quite interested on whether or not that information was available to you afterwards.

MRS HAMPSON: Right, okay, I can't recall that I was shown that; but what I'm going to tell you now is that the result of my investigation and my recommendation for one of the midwives involved move things on a little bit, and an external auditor was brought in. So I disagreed with some of the information.

MR BROOKES: That is why I was asking because I want to know whether or not your findings were consistent with the management's investigation.

MRS HAMPSON: No, no, I was concerned that there were issues that had not been either identified or acknowledged in the management investigation. But that was just through conversation, I wasn't given the RCA to look at, the time

line or anything like that. All I had were the notes and then the interviews I had with the midwives involved.

MR BROOKES: Okay, so you've completed your review.

MRS HAMPSON: Yes.

MR BROOKES: You've made some recommendations.

MRS HAMPSON: Yes.

MR BROOKES: Those recommendations go where?

MRS HAMPSON: They go - you send a management summary report, in this case it was to the Head of Midwifery, Angela Oxley, but then you're supervisory investigation report goes to the LSA MO, which was Marion Drysack.

MR BROOKES: And what was the response from the LSA?

MRS HAMPSON: With regard to my recommendations for one of the midwives, she just wanted some addition – an additional reflective piece of work and otherwise it was described as 'robust'.

MR BROOKES: Right.

MRS HAMPSON: And she agreed with my recommendations.

MR BROOKES: And other one? Sorry, I've lost it there; did you say that was you made recommendations on one?

MRS HAMPSON: She agreed with both sets of recommendations, for both midwives, but on one of them she had some additional -.

MR BROOKES: She added something, okay.

MRS HAMPSON: - suggestion.

MR BROOKES: So, is the expectation there that the Trust then takes forward those actions? How does it work?

MRS HAMPSON: At that point, and again, I hope my memory serves me right, we had two, options; you have an option – the only option you have now is called 'supervised practice', so as an employer you are not bound to find a placement for a midwife who needs a period of supervised practice; that is up to the LSA. In 2008 you could also opt for – you may see it written as 'supportive practice' or 'developmental practice'. So, at that point that's the option that I was suggesting and the terminology 'supportive and developmental' basically means the same thing and there were certain recommendations that I had made within that framework.

So, that would be the recommendation of who would manage that, for

one particular midwife was that it would be the administrator of something called the K2 package. Now, the K2 package is an online foetal monitoring -.

MR BROOKES: Yes.

MRS HAMPSON: Yes, so you understand.

MR BROOKES: Yes.

MRS HAMPSON: So that was how that worked. So it wasn't that at that point was recommending supervised practice, it was this developmental/support practice.

MR BROOKES: Now, I understand that your role as a supervisory midwife is to look at the practice of individual.

MRS HAMPSON: Yes.

MR BROOKES: But, as part of your investigation, did you feel that it was problems with an individual or more systemic than that?

MRS HAMPSON: At that point, for that particular investigation, I raised concerns, the evidence at the time, and I'm sure you understand that, you know, we're looking at supervisory issues, we're looking – we're using the code of professional conduct, we're using the midwifery standards and we're using evidence from NICE, from wherever.

MR BROOKES: Yes.

MRS HAMPSON: So, the evidence at that point, about I'm sort of going to get to specifics here, but am I okay again, because I'm not talking about an individual, I'm talking about specific events?

DR KIRKUP: Yes, that's absolutely fine so long as we don't talk about clinical detail.

MRS HAMPSON: Okay, so the evidence around, for example, foetal monitoring in a prolonged second stage of labour was very, very woolly, it wasn't robust. The local guidelines didn't reflect that, and nor did national guidance and I'm certain you've got copies of these reports from the LSA, so you can look at the references that were used at the time. Jumping ahead, a later investigation that I undertook, in 2010 expanded on that and that was – by that time we were using the tool kit performer, it's much more robust and all the rest of it.

MR BROOKES: At what stage did you, as a professional working in the midwifery unit become aware of more wider concerns?

MRS HAMPSON: I would say in 2008; this was before the first incident in July.

Those of us who were clinically based midwives, bearing in mind several of us had worked there for a long time, were becoming increasingly concerned on the run up to these incidents, about the not just the management culture, but the management actions of reducing staffing levels, for example, on night duty. And one of my senior colleagues, who had been an experienced supervisor of midwives resigned over this, she was very, very unhappy; so on the run up to events, myself and my senior colleagues included, were becoming increasingly concerned that staffing levels were being reduced, we felt patient safety was being compromised. They had downgraded the special care baby unit, and at this point the women and children's section, division, had been lumped in with surgery, so no offence to you medical guys but, you know, put women and children in the surgery and you're the poor relations before you even start.

So, we were concerned that there was this – the overriding objective, and this is my recollection as well as my sort of feelings at the time, were that it was all about money, all about achieving CNST because foundations, it was sort of foundation status or bust and patient safety was – I'll use the term, I've used the term on the telephone with Nick that I believe there was a systemic disregard for risk. We had no incident reporting system. The clinically based, senior clinically based midwives had no access to the incident reporting system, neither to report, nor to respond feedback to anything. So all of this was building up and building up and building up.

They downgraded the special care baby unit, for example, moved transitional care babies onto a maternity ward with no additional resources in terms of midwives, no neo natal outreach, and certainly no additional training for midwives. Now this guy will know what havoc that can wreak.

And you know, if you're familiar now with the demographics of Barrow, in particular, because I can only talk about what happened at Furness; there's massive social deprivation in the Barrow area, and all the health inequalities that come with that; and so that impacts on the obstetric health. And even though we only have 1100 deliveries plus a year, you know, we've got our fair share of small babies, babies that are born who are compromised within that, so you have got a consultant unit that has been proven that it's an absolute need for and yet, there's this systemic disregard.

Just this focus on money and a fractured clinical governance situation/structure, because I didn't – I cannot recall that there was a very clear, or cohesive multi-disciplinary approach to clinical governance.

MR BROOKES: Was that just for clinical governance or was it to clinical practice?

MRS HAMPSON: Both.

MR BROOKES: So, how would you describe the relationship between midwives and obstetrics, paediatrics?

MRS HAMPSON: When you're working in a high-stress environment there are always disagreements and I think that working in the high-stress environment we were at the time, obstetrics is stressful enough, and then you're working in an environment when your resources are reduced, your staffing is reduced, there are bound to be disagreements, because everybody's stretched.

MR BROOKES: But a difference between disagreements and a system which doesn't communicate effectively, for example. Are you saying it was just -?

MRS HAMPSON: At my level, at that point, at my level, I felt that I could not see any clear and cohesive multi-disciplinary teamwork within that senior level of medics and midwives, and by that I mean midwifery management, it wasn't clear to me. Maybe I was blind, I don't know, but that manifested itself by -.

MR BROOKES: You've just demonstrated – you've talked about this senior midwifery management level.

MRS HAMPSON: Yes.

MR BROOKES: What do you mean that? Who was that?

MRS HAMPSON: Well, I'm talking about the Head of Midwifery, the matrons, the risk management team; not pointing the finger at anybody here; but it didn't seem to me that there was a healthy multi-disciplinary team approach. And I'm absolutely certain that the pressure on everybody, in terms of resources and being this little tiny division within surgery just was an additional factor.

MR BROOKES: Okay, I understand what you've described in terms of management structures, I understand that; I am complimentary, or in addition to that, through your role as a supervisory midwife, were you aware of any clinical concerns about the practice of midwives?

MRS HAMPSON: There had been previous investigations into other midwives that I hadn't been party to.

MR BROOKES: Sure.

MRS HAMPSON: And was aware that there had been other midwives that had been suspended, undergone supervised practice, dismissed from the Trust in the past; but as we, moving into 2008 now, and we came to the first supervisory investigation that I conducted, I think the only answer I can give you is that I disagreed with – or my findings from the investigation showed there were concerns about a particular midwife, and it wasn't until, you know, you look back to see whether or not a midwife that you're investigating has been involved, for example, in any similar incidents. And the files, as it were, the documents, were just a bit haphazard, but again I'm not criticising my predecessor, they didn't have a clear structure, standard tool kit to use then. So, I had become concerned about one particular midwife and I'm repeating myself, but the concerns I raised in my recommendations, weren't well received.

MR BROOKES: Were you concerned about any of the midwives that you were supervising?

MRS HAMPSON: I don't recall that and I wasn't this midwife's named supervisor.

MR BROOKES: Are you aware of any investigations that were taken by other supervisory midwives into your care roles? Because I assume that's how it worked, you wouldn't have done your own.

MRS HAMPSON: No, you didn't and there were investigations into other midwives' practice and I can't clearly recall that I was their named supervisor; if I had been my usual practice would have been to give them additional support, and I can't recall that happening. We were such a small team and it was difficult to divide up, which is why now, this cross bay working is much more robust.

MR BROOKES: I accept it was a small team, and in that context were there ever occasions where one supervisory midwife would be investigating another supervisory midwife?

MRS HAMPSON: I'm not quite clear what you're asking me there.

MR BROOKES: It may be that, as you say, you had a caseload as well, and there may have been an incident that happened to one of your cases; how would that be handled, who would have done the investigation?

MRS HAMPSON: Right, so, well I'll give you an example and I'm not absolutely

certain what you're asking me, so I will -.

MR BROOKES: I'll say it again, you know, so supervisory midwives also have their own caseloads wouldn't they; they would also be dealing with -.

MRS HAMPSON: The supervisory midwives have their – do you mean their own -?

MR BROOKES: Mothers and babies.

MRS HAMPSON: Yes, well it depends because if it's a community midwife, such as me, you have a caseload, of you're a labour ward coordinator then you have what comes through the door.

MR BROOKES: Yes, but that point is that -.

MRS HAMPSON: I understand what you mean, no.

MR BROOKES: So there may have been something that had gone wrong, but in the -.

MRS HAMPSON: Yes, that would have been conflict and I myself was in that position at a later date and had to say, "Look, I'm this lady's named community midwife so it's completely unethical of me then to –" and that was documented at the time.

MR BROOKES: So that is what I was checking there that you are not aware -.

MRS HAMPSON: Right, I understand, I thought you were talking about the midwives.

MR BROOKES: And you're not aware of any cases in Barrow where that was the case where -?

MRS HAMPSON: There was the case where I was the named community midwife.

MR BROOKES: Yes, I understand that, but you're not aware of a case where the actual investigation was conducted by another supervisor of a supervisor? Maybe the answer's no, I'm just trying to ascertain.

MRS HAMPSON: Well yes, because later in 2010, when I undertook my last supervisory investigation, one of the midwives involved in, you know, you're looking at the timeline, you're looking at the chronology of an event, one of the midwives was a supervisor of midwives, so yes, so does that answer your question?

MR BROOKES: Yes, that's absolutely fine; I was just trying to get to the bottom of it.

MRS HAMPSON: Establish, yes. Regardless of who it would be, I would be looking at their practice as long as there wasn't conflict involved.

MR BROOKES: Okay.

MRS HAMPSON: I'm not her named supervisor of midwives and I'm not the lady's named midwife, community midwife.

DR KIRKUP: Just before you move on, you mentioned there that your recommendations for a particular midwife who you had concerns about.

MRS HAMPSON: Yes.

MR BROOKES: Were not well received.

MRS HAMPSON: Yes.

MR BROOKES: Who by and why not?

MRS HAMPSON: Both the Head of Midwifery and the risk manager were not comfortable with my concerns. They didn't share them and then, once I had completed the investigation and submitted the evidence, it then became quite clear that there were valid concerns, or I had valid concerns that needed addressing and that's when the Trust then stepped in from the management perspective and they commissioned an audit into the particular midwife's record keeping and then there was an additional – there was another investigation that followed, but I again it would have been conflict for me to have been involved with that. I did give the investigating midwife a little bit of just, I'm saying support, but from an administrative perspective, pointing her in the right direction because I've a feeling that by then, the tool kit might have been available, but I can't remember the absolute date; I'm sorry.

DR KIRKUP: Okay, that's absolutely clear.

MR BROOKES: No, that's fine. So, just back to the point so within your cohort of midwives that you were acting as supervisory midwife, you had no concerns about the quality of the clinical care of -?

MRS HAMPSON: Not that I can recall, and I wasn't the named supervisor for either of the midwives that I was investigating.

MR BROOKES: So, changing to something slightly different; can you just explain to me the training, the professional development regime in the unit at the time; what were you expected to do, what opportunities were made available?

MRS HAMPSON: Well, there were general things like midwifery mentorship, which is about assessing student midwives in practice, so that was an ongoing opportunity. There were, from a supervisory perspective, there were statutory study days, for example, so statutory requirements, similar to that

of midwives. There were the developed, as time went on, what we at that point called obstetric study days; now these were supposed to be multi-disciplinary study days and it was one every six months, and within that – this was on the back of, do you know what ALSO is, I don't want to patronise you, I'm sure you do.

MR BROOKES: ALSO, yes.

MRS HAMPSON: So that was sort of one of the early obstetric study days, courses that we were all funded to go on. That was then superseded by the obstetric, in house obstetric study days, which were supposed to be multi-disciplinary, but it was predominantly for midwives; and that was covering similar things to in ALSO, neonatal life support, basic life support.

MR BROOKES: So, could you help me with this because I am not clear on how this works, so you go through your annual appraisal and there may be some identified training needs.

MRS HAMPSON: I really cannot clearly recall that there was a robust management appraisal calendar.

MR BROOKES: Well I'm not just thinking management appraisal, I'm thinking clinical appraisal as well.

MRS HAMPSON: So, your supervisory, annual supervisor review would incorporate that, looking at what your professional development needs; looking at if there are any concerns that you wanted to raise as well as any practice concerns that might have been raised. And it can be anything from record keeping, you know, to whether or not you were given the opportunity to undertake additional professional development.

It wasn't until around 2005ish that the Trust even funded post registration higher education. Anyone who wanted – anyone who trained in the dark ages, like I did, and wanted to, you know, develop their career and gain a degree, you funded it yourself. They did give you some time but then gradually that was brought in, but there was a cap on it, like there is with anything. The fund isn't bottomless.

MR BROOKES: Yes sure, and that is what I am trying to get to understand; so you've been through the appraisal system.

MRS HAMPSON: Yes.

MR BROOKES: There's been some identified professional needs for training.

MRS HAMPSON: Yes.

MR BROOKES: How would that then be made real?

MRS HAMPSON: It would be up to the individual to seek out the opportunity; the funding was available within the post grad department, and then you would have to approach your manager who would agree to release you and would agree to the funding, and it was if the funding was in the pot you could go. This is additional to the mandatory six monthly obstetric days.

MR BROOKES: So, I'm just thinking about keeping up-to-date, keeping up to speed with new developments etc.

MRS HAMPSON: Yes.

MR BROOKES: So, in effect there was an opportunity to do that and were people released, were they allowed to do the training that was required?

MRS HAMPSON: My recollection is yes.

MR BROOKES: Okay, that's helpful. If I can change just to something else; are you aware of the Fielding report?

MRS HAMPSON: Yes.

MR BROOKES: Do you know when you became aware of the fielding report?

MRS HAMPSON: Probably on the news; you're going to ask me what year now aren't you.

MR BROOKES: Well, I'm aware you were copied in on an email; you won't remember this, in June 2011 enclosing the Fielding report as part of a preparation for a CQC potential surprise visit.

MRS HAMPSON: Ah yes, yes.

MR BROOKES: Does that ring any bells?

MRS HAMPSON: Vaguely, I was interviewed by the – in my capacity as a supervisor of midwives, interviewed by the CQC and by MONITOR and by the NMC.

MR BROOKES: Okay.

MRS HAMPSON: And that would have been summertime of 2011?

MR BROOKES: yes, June 2011 is when the email is.

MRS HAMPSON: Yes.

MR BROOKES: It is potentially alerting people to the effect that there may be a CQC unannounced visit and you should read the Fielding report.

MRS HAMPSON: And this was all coming on the back of this massive

reorganisation of resources, going back to early 2008 and I think, in fact I know that you've maybe had copies of the minutes of, for example, one of the first Band 7 meetings that we had with the then Head of Midwifery, and it was all about, "Well we're too top heavy with Band 7s" and they're your – you know, your clinical leaders, they're your role models, they're the clinicians that you want to be able to drive your professional development forward, and suddenly its "We've got far too many of these".

So, it was now getting to a point where there was a lot of unrest and dissatisfaction within the unit, not just because of the incidents that had happened, and I'm sure we'll come to the repercussions of that; but also that there were a series of interviews being held to – everybody – the Band 7s had to apply for -.

MR BROOKES: A job.

MRS HAMPSON: So many jobs, and things like that; all that on top of this scrutiny, the public scrutiny and the public – the [*Pause*]

MR BROOKES: It's okay, take your time. Go on. [*Pause as the witness became distressed*]

DR KIRKUP: Would you like some tissues?

MRS HAMPSON: I'm okay. I'm okay; I'm fine, thank you. Thanks very much, I don't want to make a fuss.

DR KIRKUP: No, that's okay we will just take a brief pause.

MRS HAMPSON: All this was in a climate of unprecedented, intolerable levels of harassment, both private and public, of the staff. I have to say I feel quite humble at this point, because I was not targeted at that point; my problems came later. And I did not suffer as many of my colleagues did. So, really I welcomed the CQC, I welcomed their intervention because it felt that nobody -.

MR BROOKES: Sorry, can we go back to the Fielding.

MRS HAMPSON: Oh sorry.

MR BROOKES: The reason that I am interested in the Fielding was published the year before.

MRS HAMPSON: I can't recall the dates and times.

MR BROOKES: That's what I'm trying to understand.

MRS HAMPSON: It was the theme.

MR BROOKES: Yes, but what I'm trying to understand is you'd think something like an independent report has made recommendations around your service.

MRS HAMPSON: Yes.

MR BROOKES: Would be something that you would be aware of.

MRS HAMPSON: And of course it was, but despite that we were – we felt that nobody was listening to us. The Head of Midwifery didn't listen to us. If I tell you at around about that time I had applied for a matron's post because one became available and I felt that I could perhaps make a difference. The LSA weren't interested at all, the LSA MO, by that time I'm fairly certain, was absent for the majority of the time, gave us little or no support; we had no support from the Chief Executive sorry, not DR KIRKUP. And we just – I know that both myself and my senior colleagues felt that how many more disasters have got to happen before they realise that this is just a mirror image of what was happening there. And it was still all about money, it was still all about foundation status and CNST.

MR BROOKES: So, just the last thing if I may, I am just interested in your assessment of what was going wrong in the unit.

MRS HAMPSON: Systematic disregard for risk, complete disregard for the impact that the massive reduction in resources; and whilst on one hand yes they said there were opportunities for professional development, but simple things like introducing the new perinatal institute notes, that was just done overnight; there was no additional training given to the staff, it was, "Here's some new notes". Now, record keeping, you know, is absolutely crucial to safe practice, absolutely crucial.

You suddenly present a team with a whole new set of antenatal and post natal notes, they weren't introduced at once, I'm giving you this an example of this disregard for risk. It was a case of "We've got to get it done because we'll achieve CNST, get this done" and left to the midwives to get on with it. And you're working understaffed, in a hostile climate from the public, and not only are you under-resourced in terms of the numbers that were assigned, but also because there was this – people were suffering so terribly, and not being able to come to work because they weren't safe to function; you know, they weren't fit to function safely. And I honestly felt that I was getting to the point where I felt I can't work for this organisation any

longer, and I had a conversation with Angela, in her office, and she said to me that her – and I'll never – I'm saying I can't recall anything, but I can clearly recall her saying to me, "I don't think you're on my side". And I said, "Well, if you mean this is because I'm disagreeing, fundamentally disagreeing with your approach to this unit, and the staffing, and the safety issues that we've got concerns about then yes, I'm not on your side" so I withdrew my application. I couldn't work with a team that had – were so, from my perspective, and from a clinical perspective, that the primary focus, I feel, was saving money.

MR BROOKES: Okay, and just get the other side of the coin, get your view but you feel that – what was your feeling about the level and the quality of clinical practice in the unit? Was that safe?

MRS HAMPSON: I think it was – at times not safe because of the staffing situation and we then moved to the clinical governance issues that I had with the medical staff. And I'm not just talking about the multi-disciplinary collaboration in communication; basic things like having access to, and bearing in mind I didn't work in the unit; I had been a labour ward sister several years before; but you're in and out of the unit, because that's where you're based all the time, and as a supervisor these things are brought to you, you've got the labour ward co-ordinator saying they can't get hold of this SPR and valid concerns about specific named SPRs as well. There was an overriding overreliance on verbal instructions from SPRs. And that came out in the investigation I conducted in the 2010.

MR BROOKES: Okay, thank you.

DR KIRKUP: Just before I hand you over to Stewart; I just want to follow up on this – about the Fielding report; can you recall discussions in the immediate aftermath of it being finalised. I will tell you when that was; that was August 2010.

MRS HAMPSON: No, I can't clearly recollect. At that point this is when we were going again through this.

MR BROOKES: Yes, the application.

MRS HAMPSON: Yes, and well simply the focus was on reducing the number of Band 7s and, from the community perspective, setting up new posts for specialist midwives, particularly specialist midwives working within mental

health, drug and alcohol, blood borne viruses ~~bank assisting~~, things like that, that we never had before. And as I've said earlier, the health inequalities in Barrow are such that -.

MR BROOKES: I wanted to focus on the Fielding report for a moment, because I want to get an answer to this; when the Fielding report was circulated in the email that Julian was talking about, in the middle of 2011, does that mean that the whole thing came as a complete surprise to you?

MRS HAMPSON: I don't remember having – I don't remember being involved; I certainly want invited and was not involved in any senior discussions about our local response to the issues that were raised in the Fielding report.

MR BROOKES: Yes, I will refresh your memory ever so slightly, you were involved in a discussion about it, but I have to agree with you that it was pretty high level summary and it didn't go into details about recommendations.

MRS HAMPSON: Absolutely, I don't recall being -.

MR BROOKES: Was there a supervisor and midwives meeting?

MRS HAMPSON: It was a general discussion.

MR BROOKES: Supervisory midwives meeting in September 2010. Jennifer Bounds, Kath Hampson, Selma Windell, Jeanette Parkins and Karen Burns and it appears to have been Angela Oxley.

MRS HAMPSON: Yes.

MR BROOKES: Taking you through very, very summary things as to recommendations.

MRS HAMPSON: Yes.

MR BROOKES: But what I'm trying to get at is, was the start of a process where you all started discussing it and talking about the action plan and the response or not?

MRS HAMPSON: Again, even at that point, everything was handled by that senior management team and us, being on the ground, supervisors, midwives, got on with your, in my case, my clinical case load and were only involved at a clinically based level with decisions or issues, day to day issues. We were not involved with management. We certainly had no, that I can recollect, influence on management decisions, which I think is very clearly demonstrated by my concerns that I've already raised about this actively obstructing valid concerns.

DR KIRKUP: Okay, Stewart.

PROF FORSYTH: Just a couple of things; can you just - you are a community midwife, do you work in labour suites as well?

MRS HAMPSON: No.

PROF FORSYTH: Not at all? From start to finish you didn't have any sessions in the labour suite?

MRS HAMPSON: I may have gone in periodically, and I did go in to look after maybe ladies, as their named midwife. Because of the staffing issues I couldn't work 24/7.Obviously we provided intrapartum service for women having home births.

PROF FORSYTH: Yes, quite.

MRS HAMPSON: So that's where I would keep my intrapartum skills up to date, but I did periodically work in an ad hoc basis on the delivery suite, helping out and indeed, was quite closely involved with one of the families in a subsequent pregnancy, labour and birth and that was primarily because nobody else would.

PROF FORSYTH: Okay, well that was through your supervisory role; were there discussions about maybe some of the women who had been delivered in Barrow, were too high-risk for Barrow and should be transferred?

MRS HAMPSON: Again, I don't recall being involved in those decisions. If we're talking about preterm labour, for example, I don't recall that there was a gestational, a lower gestational age at which a decision would have been made to transfer in – I don't recall there being a standard gestational age for that. But I was not involved in, again, those multi-disciplinary meetings, decisions, I don't know who was; certainly the midwives, to the best of my knowledge, weren't.

PROF FORSYTH: Right, were the midwives involved in discussions about the transitional care area and transferring -?

MRS HAMPSON: I can't answer that question because I wasn't and we didn't have any midwives working on the special care baby unit I think at the time; I might be wrong. But they were either children's nurses or there was definitely a neonatal practitioner working there.

PROF FORSYTH: This is the special baby unit or just a Level 1 unit and wasn't obviously resourced to look after the babies.

MRS HAMPSON: And it was in a different - if you're familiar with the unit now.

PROF FORSYTH: Yes.

MRS HAMPSON: You know.

PROF FORSYTH: Yes, it has been changed quite a bit.

MRS HAMPSON: Yes.

PROF FORSYTH: This is the last point and in terms of this Fielding report; the inference was that the financing at that time were unconnected. Do you think, looking back, that when you're talking about where issues of risk management etc. etc. do you think that there were some common issues across these cases that needed to be addressed?

MRS HAMPSON: As I said before there was an overreliance on verbal instruction from SPRs, there wasn't, to me, a very clear and cohesive evidence of multi-disciplinary collaboration and now I don't just mean at the decision making level, I mean at the guideline level. So yes, I had concerns and I think that there are some – there's not one common theme, but there are similar issues with several of the cases.

PROF FORSYTH: Okay, thank you.

MRS HAMPSON: And not just midwifery practice issues.

DR KIRKUP: A couple of questions and then I want move into a session where we talk about the confidential issues in a little bit more detail. But in the general questions you've referred, a couple of times, to labour ward staffing changes.

MRS HAMPSON: Yes.

DR KIRKUP: Can you just take me through the numbers on that? What was the difference before and after for you to say it's a drastic reduction?

MRS HAMPSON: They reduced the numbers of midwives on night duty and they took one member of staff off night duty, they took a midwife, should I say, off of night duty. And they set up an on call system, if I recall, which was very, very unpopular, shall we say. The community midwives, our on call system was for the Homebirths.~~homeless~~. We weren't required to be on call for the unit, but occasionally some of us did, with the understanding that we were, if we were called into the unit, it wasn't to deliver care to – for a high risk, that would be the labour ward co-ordinator's responsibility, because with the very best of intentions, you cannot maintain your skills in high risk.

DR KIRKUP: Sure.

MRS HAMPSON: But they'd reduced the numbers of midwives on nights, and you're going to ask me, by one, you're going to ask me what numbers, but it's by one and similar during the day as well.

DR KIRKUP: Okay, you've mentioned that it was highly unpopular with the staff in particular, why was it unpopular?

MRS HAMPSON: Again, this is just my personal view that people don't like being on call when they've never had to be on call before. As community midwives we're used to it, we moan about it, but we're used to it but it was unpopular and I believe that the Unions were involved and they did have difficulty at times covering the on call.

DR KIRKUP: Yes, I can see that that would cause anguish amongst the staff, yes.

MRS HAMPSON: Well, they were already anxious about the reduction of numbers of staff, and the downgrading of the special care and the additional – potential additional risks that that faced. And you know what the A590s like, I mean, only going back to was it, when were they had the crisis within the neonatal staffing, and there was a discussion about downgrading our unit to midwifery led. And I immediately, my first response to the then deputy Head of Midwifery, was that whilst the ambulance service, they haven't got the capacity to transfer 40 odd women.

DR KIRKUP: You felt the same about the change of the transitional care – you felt that -?

MRS HAMPSON: My concerns were that they had downgraded the special care, moved transitional care babies into a maternity ward setting that had had its staffing reduced, there was no robust outreach system set up and no additional training for the staff.

DR KIRKUP: Okay, I want to come back, and the last question of this part of the interview, to what I said when we started, and that was the fact that you stood down in 2012.

MRS HAMPSON: Yes.

DR KIRKUP: And you said that was because of the lack of support from Trust management and overriding of decisions. The account that you've given us places all of that round about 2009, 2010. Why was it 2012 before you stood down?

MRS HAMPSON: Well, you have probably got a copy of the email that I sent to Lisa Bacon, and I had just got to the point where I felt I couldn't carry on any longer with supervision, and there was a member of our team on the community who we had had some concerns about, and I was asked by our matron to, at that point we – they'd had the reorganisation and myself and a colleague were – although we were the same band, we were then placed in a role as lead community midwives.

So we had some additional management responsibilities, but I'm talking about in the community, day to day operational stuff, management of sickness and things like that, and appraisals by them and so there were some concerns raised and there had been historical concerns raised about one of my supervisees who was also a community midwife. So, I was asked, myself and my senior colleague were asked by our matron to conduct a management investigation, and that involved looking at the concerns that had been raised in records and things like that.

So, I'd been involved in two investigations, supporting staff, supporting a family and then this was thrown at me, and I just felt that I couldn't believe that they actually thought it was acceptable for me, as her Supervisor of Midwives ~~supervisory midwives~~, to conduct a management investigation into - I couldn't have even conducted a supervisory investigation into – I couldn't even have conducted a supervisory investigation. So, I was very unhappy and voiced my concerns and -.

DR KIRKUP: To the others.

MRS HAMPSON: To the matron at the time, spoke to the LSA about it, who basically said, "Well, you could do it". And I said, "No, it's conflict, how on earth you be somebody's supporting, in a supporting role and conducting an investigation on them?" I felt that it was ethically wrong, and I was completely had no confidence at all in the management team, or the, at that point, the senior supervisory mechanism, and so decided that I would have to resign.

DR KIRKUP: Thank you. For absolute clarity because it's really hard sometimes.

MRS HAMPSON: Yes.

DR KIRKUP: To keep track of who's who and at what time this is, it's becoming quite a complicated saga, the Head of – I've lost track of who was head of

the Trust.

MRS HAMPSON: Sasha Wells, she came in in 2011.

DR KIRKUP: Right, and that was who you took it up with in the Trust?

MRS HAMPSON: No, because it didn't get that far.

DR KIRKUP: It didn't, I know it wasn't -, I'm just trying to -.

MRS HAMPSON: It was Joyce McGullien.

DR KIRKUP: Who was the matron?

MRS HAMPSON: Joyce McGullion.

DR KIRKUP: Say it again?

MRS HAMPSON: Joyce McGullion.

DR KIRKUP: Okay, thank you.

MRS HAMPSON: And I had quite a confrontational meeting with Joyce; but what I want to say, because I haven't answered all of the question, is that in my email to Lisa Bacon at the time, who was, by then, do you I don't know whether she was in post as the LSA MO, or was still a link supervisor, I can't recall, but you'll have that information.

DR KIRKUP: 2012 it was.

MRS HAMPSON: She was in post. She was relatively new to post and in my email, I said to her the one only reason, no, it was prior to this, that in one of conversations, my electronic conversations with her, I said that the only reason I haven't resigned, this was earlier, was because I was committed. I'm a conscientious person and was committed to trying to improve our services for the women.

DR KIRKUP: Okay. Thank you. Anything indeed that you want to say to us at this point, otherwise I'm going to ask for a brief pause while we move in to the confidential part of the meeting? If you wouldn't mind -?

MRS HAMPSON: Can I just look to Jerry for any prompting or not? Is that not acceptable?

DR KIRKUP: It's not part of process no, this is your interview.

MRS HAMPSON: Yes, well I think that's as much as I – they're the important issues that I can comment on.

DR KIRKUP: Okay, well we do have one or two questions about clinical details, so we will ask you to leave the room please? [*Pause*]

[From hereon the hearing went into private session]

THE MORECAMBE BAY INVESTIGATION

Tuesday, 7 October 2014

Held at:
Trinity Enterprise Centre,
Ironworks Road,
Barrow-in-Furness.

Before:

Dr Bill Kirkup - Chairman of the Investigation
Professor James Walker - Expert Adviser on Obstetrics
Professor Stewart Forsyth -- Expert Adviser on Paediatrics

SUSAN HARDING

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

DR KIRKUP: Good afternoon. Take a seat. I am Bill Kirkup, I am the Chair of the investigation panel. I will ask my two colleagues to introduce themselves to you.

PROFESSOR FORSYTH: Stewart Forsyth, Pediatrician, Medical Director from Dundee.

PROFESSOR WALKER: I am Jimmy Walker, a Professor of Obstetrics from Leeds and I used to work for the National Patient Safety Agency.

DR KIRKUP: You will have seen that we are recording and we will make an agreed record of the interview today. You will also know, I think, that family members are able to be present, apart from any part of the session where we deal with individual clinical and confidential matters, so we will reserve a brief period at the end to do that.

You will also know that we have asked you to hand over any mobile phones, recording devices. That is to emphasise that nothing goes out of the room until we are ready to produce a report with all the findings in context.

Do you have any questions for me about the process?

MS HARDING: That is fine.

DR KIRKUP: I will ask you a general question to start with and hand you over. That is: When did you start in Trust and what have you done there since?

MS HARDING: I am Susan Harding, I am a consultant anaesthetist and I was appointed to Lancaster Acute Hospitals NHS Trust in 1996 and I have been with the Trust ever since.

DR KIRKUP: You have had a role as clinical lead?

MS HARDING: Yes. In fact, from 1997 I was the lead obstetric anaesthetist for Lancaster. That would have been before we merged and became the merged Trust. I held that role until for ten years until 2007 when I became the Cross Bay clinical lead for critical care.

DR KIRKUP: Is that still the role that you have?

MS HARDING: No. From June 2012 I am actually Associate Medical Director with responsibilities for Lancaster and Kendal. So we have the overall Medical Director, George Nasmyth, and then we have some site lead Associate Medical Directors.

DR KIRKUP: How much dealings have you had with Furness since 2012? I guess less?

MS HARDING: Less. When I was cross-bay lead I actually did regular clinical sessions in Furness because I felt it was important to actually work there in my day-to-day job to know what was going on.

DR KIRKUP: Thank you. That is very helpful. Jim.

PROFESSOR WALKER: Good afternoon. So just clarify that you are appointed consultant in 1996 and then you were lead obstetric consultant or anaesthetist in 1997 and it was 2007 you then were made clinical lead for critical care, not for anaesthesia?

MS HARDING: Critical care covers ITU and anaesthesia.

PROFESSOR WALKER: Okay. Overall? Yes?

MS HARDING: Yes.

PROFESSOR WALKER: Then Medical Director in 2012.

Were you clinically actually working at all in Barrow or was it clinically were you always in Lancaster?

MS HARDING: Only when I took up the cross-bay critical care lead then I started to do a regular anaesthetic session in Barrow, so it actually worked out about one day a fortnight I would spend a full day in Barrow doing one theatre list and then spend the other half session doing administrative duties on that site.

PROFESSOR WALKER: That theatre list, could it be anything or a specific thing?

MS HARDING: No. I said put me down to do whatever you need me to do, yes.

PROFESSOR WALKER: One of the things when you join the Trusts together that you have got the problem of

different practices and different levels and different places and so on. When you took on this role, I mean, how did you view the standards of anaesthetic cover, particularly towards obstetrics, in the places where you now had overall responsibility for?

MS HARDING: Yes. I probably knew very little about the anaesthetic covered in Barrow until 2007 and my first contact really with any midwives or obstetrics at Furness came about following a critical incident that had been reported at the beginning of 2007 regarding an epidural infusion that had been connected to the intravenous cannula.

I was asked for some input into the investigation of that incident, I suppose, and that unearthed something that I found surprising, such as actually the anaesthetic cover for obstetrics ~~obstetricians~~ was certainly not dedicated, I had always know that the epidural rate in Barrow was very low, so about 4 or 5 percent, compared with 20 percent in Lancaster and I was not entirely sure of the reason for that but following the incident I actually did some teaching to the midwives in Barrow on one of their obstetric ~~obstetrician~~ study days and asked them, "Why is your rate so low?" and they said, "Well, you know, the anaesthetists are not always available. Quite often if we do ask for an epidural

then they cannot come because they are doing a list in theatre or covering an emergency." So I said, "That does not sound very safe."

They had a practice of syringe driver infusions on their epidurals which, from my personal experience, is not the best way to manage epidurals, because in Lancaster the midwives administered top up on demand. I said, "Why the difference?" "Well, it was thought to be safer because you connect someone to an infusion and you do not have to worry about the side effects of the top up", which is actually not true at all.

So that was why I went to give the teaching about -- because it became apparent that nobody had ever actually taught the midwives about the potential risk and complications of epidurals which can happen whether you are on an infusion or a top up.

They said, "Oh, thank you, so much. It is really nice. None of the anaesthetists in Barrow are interested" and there had been a consultant who had been the obstetric ~~obstetrician~~ anaesthesia lead there when I had started in Lancaster and we met at the Maternity Services Liaison Committees but he unfortunately left and moved to Chorley and since he had left there was not really an anaesthetist with a particular interest in obstetrics ~~obstetricians~~ to resume the role.

PROFESSOR WALKER: That was a sort of baptism of fire, I suppose, when you first came into post and you came across this which unearthed a wider issue than the incident.

MS HARDING: It occurred to me that when I had found this out in 2007 it unearthed a few things. I actually wrote a letter to the Medical Director at the time because I really felt that the cover was not adequate. There are national recommendations that dedicated obstetric anaesthetic cover should be immediately available. We certainly did not have that.

PROFESSOR FORSYTH: What date was that letter?

MS HARDING: July 2007.

PROFESSOR FORSYTH: 2007. Thank you.

PROFESSOR WALKER: You wrote stating that the cover was not appropriate and what else?

MS HARDING: Actually Barrow does not have any anaesthesia trainees. They have a two tier rota where there is essentially a middle grade rota staffed by a very experienced staff grades and associate specialists and then a consultant who is second on-call. The first on-call anaesthetist is covering theatre, the obstetric unit, the ITU and actually at the time, when I took over as clinical lead, several of them were not even resident in the hospital at night. Which, you know, to

me coming from a normal teaching environment seems definitely not an acceptable standard.

PROFESSOR WALKER: There was another case also that someone was more than some distance, away, not only not living but some distance away as well?

PROFESSOR MONTGOMERY: Yes. Because the anaesthetist who lived over the road from the hospital had been allowed to do their on-call from home then the anaesthetist who lived in Dalton had been allowed to do their -- or no-one had ever actually challenged them.

PROFESSOR WALKER: Did you get response from the Medical Director?

MS HARDING: Yes. They were about to have a CNST inspection at that time and I said, "This is not acceptable. I will certainly raise this when we have the CNST inspection." So there was a lot of, "Oh, please don't do that. We will sort it out." I got the impression that when we were filling in the CNST forms we were slightly hiding behind the fact that the cover was -- there was not explicit what the cover was in each place.

In fact, since then the first on-call anaesthetist is resident. It took introduction of the new SAS grade contract for that to be explicitly written into their contracts because obviously they were very comfortable

with their working practices and did not want to change.

We now have, during the daytime, the first on-call is not in theatre, so they are not doing a list, they are available for emergencies wherever they occur in hospital but primarily to cover the obstetric unit.

PROFESSOR WALKER: Do you feel then that these things you flagged up in 2007 to the Medical Director that that has solved all of these problems?

MS HARDING: No. There is still relative under staffing in the hospital in Barrow.

PROFESSOR WALKER: What about the epidural service? Has it improved?

MS HARDING: Yes. I no longer have much to do with the obstetric anaesthesia any more but now we do have similar systems in place on both sites. They have moved on both sites now to a patient controlled epidural analgesia infusion pumps, which are the same on both sites with the same protocols.

PROFESSOR WALKER: That, in fact, would not have solved the problem of the original incident?

MS HARDING: No. I never understood why it had not been the anaesthetist who had not connected the epidural infusion in the first place.

PROFESSOR WALKER: Was that anaesthetist talked to or

tackled?

MS HARDING: I do not know.

PROFESSOR WALKER: Okay. You felt that the care and provision to the labour ward for epidural services was inadequate but you think it has probably improved to a degree, although still under staffing? What about acute's responses in permanent anaesthesia staff to labour ward?

MS HARDING: Another thing which I tried to make them introduce, which they were reluctant to initially but then had to, was a baton bleep.

When I first became clinical lead if the obstetric needed an anaesthetist quickly they had to telephone switchboard, switchboard had to look at the rota, they then had to work out who was covering and then telephone that anaesthetist's mobile telephone. They did not have an on-call bleep. That partly was because they were allowed to go home when they were on-call. So if they had to have handed a bleep over they would have had to have come in the following morning to hand the bleep on.

We do now have a baton bleep. So if the midwives need to call an anaesthetist quickly the first on-call bleep, that is the bleep and they can be fast bleeped or bleeped normally.

PROFESSOR WALKER: As far as you aware that does work, does it? So people do come in in the morning --

MS HARDING: Yes.

PROFESSOR WALKER: -- to hand it back over, do they?

MS HARDING: They don't go home now.

PROFESSOR WALKER: They do not go home. That is much better.

We have heard about certain problems, particularly at night about getting into theatre, for instance. Is that something which is still a problem or has it been -- do you feel it is a problem?

MS HARDING: I know that there ~~they~~ did not used to be a night theatre team in the building, so the nursing staff, theatre the nursing staff. So if there was an emergency caesarean the theatre team would have to be called in from home. So obviously the theatres would be locked.

I have never worked in Barrow out-of-hours, so I do not know who had the keys. There will have been some system for opening the doors.

PROFESSOR WALKER: Was there any situation ever flagged up to you when you were lead for anaesthetics that --

MS HARDING: No.

PROFESSOR WALKER: Delays of opening theatres or people starting without some of the staff there, anything at

all?

MS HARDING: I do not think so, no.

PROFESSOR WALKER: What about the emergency, sort of acute collapse in labour ward? I mean, were the anaesthetists involved in the drills or the training for acute collapse?

MS HARDING: Probably not in 2007 but probably now, yes. The anaesthetists are not on the cardiac arrest team.

PROFFESOR WALKER: Are not?

MS HARDING: Are not and that is historic, it has been the case for a long time and I do not think it is unusual. I think there are hospitals -- there are other hospitals where the anaesthetist is not on the cardiac arrest team but they would then expect to be contacted if the arrest situation was progressing and they would need an anaesthetist. So in an obstetric collapse then the anaesthetist would be called.

PROFESSOR WALKER: That would be fairly automatically, presumably?

MS HARDING: Yes.

PROFESSOR WALKER: Through the crash bleep. Again, had you any incidents reported to you where you felt the responses to be inadequate or you felt that the equipment was notice there when they arrived or the

communication was poor? Anything at all that you were involved with?

MS HARDING: I cannot think of anything specific.

PROFESSOR WALKER: Okay.

MS HARDING: Communication is poor. Has been poor, yes.

PROFESSOR WALKER: Communication where? Between who?

MS HARDING: There are a couple of incidents which did not particularly fit comfortably with me. I have been thinking about coming to give evidence to this inquiry and I made a few notes about things which occurred to me.

PROFESSOR WALKER: Will we be talking about specific cases later or?

DR KIRKUP: Yes, if it involves any clinical situations we should leave it until later.

PROFESSOR WALKER: In general, did you get any feedback from anaesthetists who were covering the labour ward that there was a problem with the communication with the obstetricians or the midwives or they got called at inappropriate times or not called at all?

MS HARDING: No. The practice was not as I would have necessarily expected. Because labour ward is a bit of a distance away from theatres it seemed to be ~~accept~~ accepted practice that when they are called an

emergency Caesarean Section the first time the anaesthetist would meet the patient would be when they had arrived in theatre.

Whereas I would be used to going to the lady's room, taking a full history, you know, seeing what had been going on and planning my anaesthetic there, going through to theatre to get ready but it did seem to be that the anaesthetist was in theatre, the patient would be brought to them and they would then do -- I think that the anaesthetists in Barrow actually were very competent. I was not aware of any deficiencies in anaesthetic practice, there were just little things like that that did not sit comfortably with me.

PROFESSOR WALKER: In Lancaster the obstetric theatre is within the labour suite, is it?

MS HARDING: It is fortuitous. We have this building called the Women's Unit and most of the Caesarean Sections, until very recently, were undertaken in actually the gynaecology theatre but it is on the same floor as labour suite, so you come through the double doors from the labour suite and you are in the Women's Unit theatre.

PROFESSOR WALKER: You said until recently. What has happened now?

MS HARDING: We always had a second theatre, so a

smaller, for the emergency Caesareans should the main theatre be busy but we have actually refurbished that second theatre, that has now become the obstetrician theatre. So we do our elective sections in there as well so that people are used to working in that environment and all the drugs and everything else.

PROFESSOR WALKER: Was there ever any move to try and produce an obstetrician theatre in Barrow?

MS HARDING: It was talked about. It was not particularly it was not very popular with the anaesthetists who felt that they needed to be comfortable in their environment and their environment was the main operating theatres. I think they felt that if there was a theatre in Women's Unit which was only used occasionally it would have problems with just stock and checking machines and it physically was not there at the time.

PROFESSOR WALKER: What do you feel about that as the lead for the service?

MS HARDING: I have worked in hospitals where they have got dispersed operating theatres, so small -- orthopaedic have a separate operating theatre, eyes have a separate operating theatre and you certainly do lose something in having the lack of support.

Having said that, in Barrow the anaesthetists all

worked single-handedly all the time and out of hours there would only be one anaesthetist in the building anyway. So I think that I understand the concerns about transferring patient from labour ward quite a distance across the main corridor into the main theatre block.

PROFESSOR WALKER: Sometimes the door is locked?

MS HARDING: And possibly the door is locked.

PROFESSOR WALKER: I am interested, did anyone look at the number of times that this was required to be done, risk assessed it against alternatives?

MS HARDING: I understood that there were some plans being drawn up to re-instate a theatre into the labour ward area but these things sort of evolve and then, oh, you know, we will have a different plan and then, oh well, we might be merging the obstetrician unit, so we are not going to progress with that for the moment and I don't think that it has actually happened.

PROFESSOR WALKER: I think that one of the things is that if you look back through the some of the reports that the problems of the obstetric theatre has been brought up before, including ** poor(?) particularly in others, but nothing really has been done apart from, I think, the changed the route they take the patient. That is about the limit of it.

MS HARDING: Yes.

PROFESSOR WALKER: Are you comfortable with that as an end point that that is as far as we can go in current circumstances?

MS HARDING: No, because I think that there are -- well, we are still currently having to discussion about reconfiguration of the whole of the Barrow floor plan and moving, I think the latest is actually labour ward is going to move much closer to the main theatres. It will become a bit like Lancaster; the labour ward will just be a set of double doors through into the main theatre complex which probably keeps both parties happy. I think that means putting the labour ward on paediatrics.

Whilst I was Cross Bay anaesthesia lead there was -- there has always been a site based anaesthesia lead in Barrow and, whilst I would give my opinion, the day-to-day running and team would be involved in those sorts of decisions.

PROFESSOR WALKER: I appreciate that but also the feeling I get is that this is one of the risks which had been highlighted in the unit several times by the different people, individuals and reports and not an awful lot has been done about it, even changing the system of the lock on the door to actually a

combination lot or a swipe card lock or something which could be easily overridden if need be because, you know, a locked door is actually quite a for formidable thing to overcome for someone to wait for someone to come and open it.

MS HARDING: I think it is a combination lock.

PROFESSOR WALKER: Is it? I heard it was a key. That was the impression we got.

PROFESSOR FORSYTH: There are two doors. One door you needed a key.

MS HARDING: Okay. But now there are staff there all the time.

PROFESSOR WALKER: All the time. Yes.

MS HARDING: Yes.

PROFESSOR WALKER: Okay.

PROFESSOR FORSYTH: Do you think that if a mother or the lady collapses in perinatal period in Barrow her risks are greater than that if she collapsed in Lancaster?

MS HARDING: I think actually resuscitation training for the staff on the ground has been good in both places. Now there is a anaesthetist in the building so I think that if a mother collapses, you know, it is pretty serious wherever it happens.

PROFESSOR FORSYTH: Certainly prior to the

anaesthetists being resident in the building, that would be increased risk?

MS HARDING: It would. Having said that --

PROFESSOR FORSYTH: When was the changed made again in the --

MS HARDING: 2008? Yes. I can't remember -- the new SAS contract I think it was 2008. If a mother collapsed in Lancaster in the small hours it is possible that the anaesthesia response would be a relatively junior Registrar who is also covering ITU at the same time. So neither of our sites have got dedicated resident cover.

PROFESSOR FORSYTHE: What about in terms of resuscitation? You mentioned, for example, the cardiac arrest team not having a anaesthetist. Again, in somewhere like Barrow, does that make sense, not to have the anaesthetist on the cardiac arrest team when you have got morbidity, the skills are there?

MS HARDING: Yes. I queried was the anaesthetist was on the -- they said, "Well, we could be stuck in theatre, there is only one anaesthetist on site, therefore, we are not on the crash team", despite the fact that out-of-hours actually they do not do that much operating.

PROFESSOR FORSYTH: Yes. I mean, who is pulling the

strings here? I mean, it does seem to me that the anaesthetists are quite clear what they do and what they do not do in Barrow but maybe not with the patients' interests at heart.

MS HARDING: Yes. The anaesthetic department suffers from being a non-training department and relatively isolated. Their unconventional practises can go unchallenged because you have registrars rotating through the regularly and then your practises will be queried if you seem to be doing something – and, you know, our trainees expect to be on cardiac arrest team. So whilst I said other hospitals do not necessarily have anaesthetists on the cardiac arrest team, it was more, I think, the fact that there is only one anaesthetist.

PROFESSOR FORSYTH: Yes, but it does seem rather strange that because if you are in a smaller hospital then the skills of the other people in the cardiac arrest team are probably more limited than in a larger unit.

In terms of neonatal care, are the anaesthetists involved at all?

MS HARDING: No, I don't think so, apart from there may be the odd, "Can you intubate this baby at Caesarean section?"

PROFESSOR FORSYTH: But there is no direct involvement?

MS HARDING: No.

PROFESSOR FORSYTH: How many consultant anaesthetists are there in Barrow, do you know?

MS HARDING: Eight and one part-time.

PROFESSOR FORSYTH: How many are in Lancaster?

MS HARDING: 23.

PROFESSOR FORSYTH: 23?

MS HARDING: We have a split ITU and anaesthetic rota in Lancaster we have a consultant -- on the ITU, the ITU is covered by a consultant anaesthetist, apart from one of the intensive care anaesthetist consultants who is a respiratory physician. So there are seven of them and then the other -- so we have two consultants on-call every night, one who is covering theatres and obstetrics ~~obstetricians~~ and one who is covering intensive care.

PROFESSOR FORSYTH: Do you think there should be more? Are you aware of, particularly when you are clinical lead, high risk women not building transferred to Lancaster or at another larger centre?

MS HARDING: Yes, I was aware of specific cases.

PROFESSOR FORSYTH: Clinical lead, what do you do about that?

MS HARDING: It was an ~~I was on~~ obstetric decision. I felt that the obstetricians did not feel that there would be

anything to be gained from transferring a patient to Lancaster. So they might transfer a patient to Manchester for cardiac intervention or something, but they did not feel that Lancaster would offer any advantage to their patients.

PROFESSOR FORSYTH: Were you aware that the neonatal level in Barrow was very much a level one unit? It was not meant to have something close to high dependency care, never mind intensive care.

MS HARDING: Yes, yes, and I would assume that if they needed to deliver somebody at a very early gestation that the neonatal circumstances would dictate transfer, you know, transfer your patient.

PROFESSOR FORSYTH: Was there a forum? You say very much an obstetrician decision but was there a meeting of key people, obstetric anaesthetists, paediatricians to thrash out some of these things because they were dealing with literally life and death situations and getting the policy right in the interests of the patients, both mother and baby in many cases, would be the right way forward?

MS HARDING: Yes, I don't think there was. Lancaster had labour ward forum but it very specifically was looking at Lancaster's labour ward issues. Likewise I think Barrow had a similar.

PROFESSOR FORSYTH: There was not really Trust wide proper discussion around that?

MS HARDING: No.

PROFESSOR FORSYTH: Is that because of geography or was there more sort of culture and behaviours around that as well?

MS HARDING: Both, I think.

PROFESSOR FORSYTH: Has that got any better in recent time?

MS HARDING: Yes, Yes, and certainly, I think, in the women's and children's division there has been a lot more emphasis on Cross Bay working organisation, rationalisation of all the policies and, you know, the governance in the women's and children's division probably has led the rest of the organisation because of the spotlight that they have been under. In terms of critical incident, trigger lists, more robust investigations, incidents.

PROFESSOR FORSYTH: The wider view on this issue is how does Lancaster see Barrow? How does Barrow see Lancaster, to balance that up?

MS HARDING: Okay. Barrow people, some people in Barrow refer to the merger of the Trusts as "the takeover". Lancaster took us over. Staff I have spoken to have often felt quite

insecure for their jobs, you know. Lancaster is taking all the services away, we are not going to have a hospital. I have tried to reassure them that actually I think that Lancaster is more vulnerable than Barrow because being so geographically isolated you could not take the hospital away from Barrow. Whereas we are 20 minutes away from Preston, so actually if our Trust is non-viable, Lancaster is definitely very vulnerable. How does Lancaster see Barrow? There is not that much until you get up to more senior management, there is not a lot of people going to work on the other site because of geography.

PROFESSOR FORSYTH: So there is not a real sort of feeling, for example, in Lancaster what can we do to help to strengthen some of the services in Barrow?

MS HARDING: I think there is. Some of the specialties have decided that the only way to solve some of the problems is for all the consultants to be cross bay. Usually that means that you recruit to Lancaster and the job is a cross bay job and I know from being clinical lead sometimes it is very difficult to recruit to a job in Barrow. So, yes.

Obviously when we first merged there was a Barrow department and a Lancaster department in most of the specialties and it is slowly evolving that somebody

appointed to the Trust is appointed to the Trust.

PROFESSOR FORSYTH: Okay. Thank you.

DR KIRKUP: If somebody is appointed to the Trust is it expected that they will work across two sites or sometimes on one site, sometimes on the other site?

MS HARDING: It is not expected. That is written in the contract but it is not expected and then when circumstances changed and people are asked, "Will you go and work in Barrow one day a week?" It has caused quite significant problems.

DR KIRKUP: Have they ended up going to work in Barrow one day a week or not?

MS HARDING: No. I only know of one specific instance [redacted].

DR KIRKUP: Right. The employment tribunal rule was?

MS HARDING: [redacted].

DR KIRKUP: Anything else?

PROFESSOR WALKER: Yes. Can I just briefly pick up on something? You mentioned that the midwives have found in the past that epidural essentially is low because

they could not get anaesthetists to do epidurals?

MS HARDING: That is what they told me, yes. So they would not like to raise a woman's expectations, call the anaesthetist who says, "I am going to be tied up for an hour" and then obviously the woman would be disappointed.

PROFESSOR WALKER: In fact, it was beyond the fact that they called and they did not come, they actually were not even called ...

MS HARDING: Yes.

PROFESSOR WALKER: ... or introduce the prospect of it because the assumption that they may not come. The next thing is the anaesthetists are not on the cardiac arrest team. You made that comment.

To some extent it is anaesthetists downplaying their job. They seem to be being involved in less than they might be expected to. That could be to the detriment of the anaesthetic numbers?

MS HARDING: I think they would get called fairly quickly in a cardiac arrest if they were needed but it would not be automatic part of the cardiac arrest team.

PROFESSOR WALKER: Sure. But if they had the facilities to provide an epidural service, for instance, and that was requested, plus providing support for the cardiac arrest team, then there is an

argument for more anaesthetists and would you be able to fill these posts?

MS HARDING: I mean, we are already looking at providing a consultant based service and we did put forward a proposal that there should be two resident anaesthetists, one covering ITU and one covering obstetric and, you know, other emergencies. That came in at quite a few million pounds.

PROFESSOR WALKER: And?

MS HARDING: They fudged it by having a third on-call anaesthetist available who is not resident. So we now have three anaesthetists who are actually officially on the rota and available but we still only have one resident who is in the hospital.

PROFESSOR WALKER: Right. That is not a great improvement though, is it?

MS HARDING: No. I didn't really have anything to do with that because that has been a more recent development since I moved away from anaesthetic lead.

PROFESSOR WALKER: There does appear to be a lack of cohesion in the obstetric service, from the point of view that anaesthetists being involved with obstetricians and midwives and neonatologists trying to design the service for Barrow. Is that true?

MS HARDING: Yes. Unfortunately, we made a very good

consultant anaesthetic appointment to Barrow about three-years ago [redacted] She had an interest in obstetric anaesthesia so we thought fantastic. Unfortunately she has [redacted] and has moved [redacted] It is disappointing because one person can make quite a difference. You have got to want to be involved in making a difference.

DR KIRKUP: What's the perception of the reason for the exit? Was it push or pull?

MS HARDING: Pull, I think. Her husband is from the Isle of Man.

PROFESSOR WALKER: Okay.

PROFESSOR FORSYTH: Yes.

DR KIRKUP: We have one or two clinical issues that I want to pick up with you, so I will have a brief pause now while we ask people from the public to leave the room.

Private session

THE MORECAMBE BAY INVESTIGATION

Wednesday, 15 October 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

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

VANESSA HARRIS

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7th Floor, 61 Southwark Street, London, SE1 0HL
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(at 3.13 p.m.)

DR KIRKUP: I am Bill Kirkup. I will ask my colleagues to introduce themselves to you.

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

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

DR KIRKUP: When we get the buttons pushed we are recording the proceedings and we will make an agreed record at the end. You will also probably know that we have invited families to be present at the interviews as observers. As it happens, we don't have any but they may listen to the recording subsequently, and you also know that we have asked you to hand over any mobile phones, laptops, recording devices just to emphasise that we don't want anything to go outside the room until we are ready to report the findings in context.

MS HARRIS: Okay.

DR KIRKUP: Do you have any questions on the process?

MS HARRIS: No, I am fine, thank you.

DR KIRKUP: In that case I will start off with one general question, which is when you were first associated with the trust, what did you do and for how long?

MS HARRIS: It was over five years ago so my recollection might be not quite as accurate as I would like.

DR KIRKUP: Understood.

MS HARRIS: I left the trust in December 2009 and went to Liverpool Women's Foundation Trust where I am at the moment, and my recollection is that I was at Morecambe Bay for five years. I am not quite sure of the exact start date.

DR KIRKUP: Roundabout 2004 though?

MS HARRIS: Yes.

DR KIRKUP: Yes, okay.

MS HARRIS: So, I started in the finance department. I was preparing the five-year financial plans that went towards the FT application that they were doing at the time, and I think that was about 18 months to two years, and then I applied for a post within the trust, which was one of the divisional manager posts – there

were three of those at the time – and I was appointed as the Divisional Manager for Surgery, Critical Care, Women and Children's Services.

DR KIRKUP: And you did that until you left in September 2009?

MS HARRIS: I did, yes.

DR KIRKUP: Okay, thank you for that. Julian?

MR BROOKES: When did you start at that divisional job?

MS HARRIS: I am not entirely sure. I am sure they would have records. I think it was about three years, but there was very –

MR BROOKES: So, about 2006?

DR KIRKUP: 2006.

MR BROOKES: Yes.

MS HARRIS: Yes, there was a process in the organisation so they should have records of that.

MR BROOKES: Okay. I would be interested if you could just describe how the divisional management structures worked and how they related to the Board.

MS HARRIS: Okay. Well, there were three in total. As Divisional Manager I was the accountable officer. The way in which the governance structures worked, I think they were different for clinical governance than they were for the corporate governance, so I didn't attend any of the boards or committees at all as a divisional manager. I think there were committees which reported into board sub-committees and one of the critical ones of those, I think, was the clinical governance sub-committee, but my Associate Medical Director and Divisional Head of Nursing went to that meeting. And then we had something which I think – I can't remember the name – hospital management team, it might have been – which is where all the divisional teams met with the exec directors once a month and that's when more of the corporate issues were dealt with, although some clinical issues were dealt with there as well.

The way I fed back through the division is that we had a divisional meeting once a month and that alternated between business issues around finance, HR, performance and then alternately we had a clinical quality meeting, which was more focused on serious incidents, looking at NICE guidance and those kinds of things, patient feedback.

MR BROOKES: So, what would have been on your to-do list as a divisional manager?

MS HARRIS: Looking at the whole of the corporate objectives of the organisation, so it was the whole remit of the role, really. So, looking at making sure that we delivered against our financial targets, our performance targets, that we met the relevant HR responsibilities and that we had a good handle on what the clinical quality was like in the organisation in the part of the division that we managed.

MR BROOKES: So, you did have responsibility for keeping an eye on clinical quality of service?

MS HARRIS: I did.

MR BROOKES: So, how did you do that part of the job? What was the information you used? How was that coming into you?

MS HARRIS: That came into me through the divisional meetings that I just mentioned, so bi-monthly we would have a meeting in respect of that. That tended to be led by the Associate Medical Director rather than by myself, but the kind of information that would go there were summaries of things that had been reported through the accident/incident system; serious incidents; any feedback from patients that we had had, and we would look at things that had come up through the maternity risk meeting that they had in the maternity division as well.

MR BROOKES: I am just trying to make sure I've got that right in my head. So, there's a management meeting, which you lead?

MS HARRIS: Mm hmm.

MR BROOKES: And then there is a clinical meeting separately, in parallel to that?

MS HARRIS: Yes.

MR BROOKES: So, where do the two come together?

MS HARRIS: The attendance was the same, so it was all the same people at both, and at one stage we did everything altogether in one meeting. What I found as Divisional Manager, though, it was a pressurised, acute trust environment and we were tending to focus on money, 18 weeks cancer targets and neglecting the clinical aspects of the role and that is why I made one of the meetings purely about the clinical governance so that it got much more airtime in the overall divisional meeting but it was the same people, and sat around that table as well as myself, Associate Medical Director and our Head of Nursing would have been all the Clinical Directors and the Head of Midwifery

and the two Deputy Divisional Managers that worked for me as well.

MR BROOKES: So, a clinical incident in maternity, for example, would have gone into that process?

MS HARRIS: Yes.

MR BROOKES: So, can you tell me about the incidents that happened while you were there?

MS HARRIS: I can't tell you the detail of those. I don't think there were as many, now I look back, as there should have been reported through that process, now that I work at a specialist women's hospital and see how many serious incidents there are reported through that system, and the one that was particularly an issue in the trust at the time which related to the baby that died, that particular incident didn't go through that divisional process; it was managed by the Executive Directors at that time.

MR BROOKES: And why do you think that was?

MS HARRIS: I think given the seriousness of the incident.

MR BROOKES: Okay, so you have SUIs coming into you; you're looking at those. What kind of actions – what's the kind of way of making sure that something happens around those particular incidents?

MS HARRIS: What we also looked at – each one of those had an action plan that was related to it and we brought all the action plans back through that divisional management team meeting to make sure that they were being actioned.

MR BROOKES: Okay. So, would that be where the Fielding Report came to for action?

MS HARRIS: I can't remember the details of those individual meetings.

MR BROOKES: It would be just before you would have left. It would have been the report done by Dame Fielding into Maternity Services.

MS HARRIS: No.

MR BROOKES: So, that did not come to you at all?

MS HARRIS: No.

MR BROOKES: You weren't engaged in the establishment of that review. Were you aware that that review was going on?

MS HARRIS: No.

MR BROOKES: So, a review into a service that is a key part of yours which is under

scrutiny was not ever talked, discussed with you as the Divisional Manager?

MS HARRIS: No.

MR BROOKES: Do you know whether there was any discussion with your corporate colleagues in the division?

MS HARRIS: I don't know, no.

MR BROOKES: That is what I find hard, you see. This is a significant focus on this. You described a process which seemed very sensible in terms of reviewing this.

MS HARRIS: Mm hmm.

MR BROOKES: And yet both the case of the baby who died and a wider review of maternity seem to have completely missed the processes that you described.

MS HARRIS: Mm hmm.

MR BROOKES: I just don't understand why that is.

MS HARRIS: I can't answer that question. I wasn't aware of that particular review. I think in terms of the one incident that you talked to, then there were meetings in the organisation about how that was going to be managed, which were outside what was the normal process, which is why that one wouldn't have been known.

MR BROOKES: Yes.

DR KIRKUP: I think just to be clear, your question is absolutely right about the incident. We need to be mindful that the Fielding Report was not finalised until the middle of 2010, so you would have left by then.

MS HARRIS: Yes.

MR BROOKES: I apologise, but it had been commissioned.

DR KIRKUP: You would have been there during the time that it was being commissioned.

MS HARRIS: Yes, and no, I am sorry that was not brought to my attention and I did not instigate that.

MR BROOKES: Okay, so in terms of issues within obstetrics and gynaecology and paediatrics, were you aware of any particular issues for those services while you were there?

MS HARRIS: Yes. The main issue, I think, is overall safety of the service which we talked about on a number of occasions. Running services at Barrow had been a challenge for quite a long period of time because it is a very small hospital

which is geographically out on a limb and we went through several discussions during our FT application about whether those services were safe or not and my Clinical Directors raised their concerns during that process, and I think what the issue was for me is how adequate the staffing was in that service, and I didn't particularly at that time have concerns about midwifery staffing at Barrow.

If I was concerned about midwifery staffing, it was more at Lancaster and that was a case that we put to the executive team and we obtained additional funding, more midwives at the Lancaster service. The trouble more around medical staffing was following implications from the European Working Time Directive that had been – well, was a national issue, and also, which I don't know if it affected other people but for a long time Barrow had used lots of overseas doctors from the Indian subcontinent and also from South Africa and I think something changed in the immigration laws roundabout the same time as the European Working Time Directive, which prevented us from accessing those doctors. So, it became really difficult to carry on running what were safe rotas at Barrow and that was not just in maternity and paediatrics; that was also in general surgery, orthopaedics and anaesethetics.

MR BROOKES: So, you were aware of the staffing issues; you were aware and you put a case in for strengthening that within Lancaster –

MS HARRIS: Yes.

MR BROOKES: – but not at Barrow?

MS HARRIS: No, it wasn't highlighted to me that there was a problem in terms of midwifery staffing at Barrow.

MR BROOKES: Okay. Were you aware of any difficulties between cross-specialities?

MS HARRIS: I was aware of a difficulty between paediatrics and obstetric staffing at Barrow but generally it was anecdote rather than anything anybody would put through a grievance process or any kind of whistle blowing – with the benefit of hindsight what I know about whistle blowing now, so it was quite hard to pin that down.

MR BROOKES: Okay, and were you aware of any concerns being raised by midwives at Barrow through to you, concerns about services, concerns around regrading, for example, and also staffing on the wards?

MS HARRIS: No.

MR BROOKES: Okay. You mentioned that you were involved in the FT application in your previous role.

MS HARRIS: Mm hmm.

MR BROOKES: How much of your work was linked, or how aware were you of the FT application as part of your day-to-day work?

MS HARRIS: As a divisional manager?

MR BROOKES: As a divisional manager.

MS HARRIS: Reasonably aware. I had to be interviewed as part of that original FT application. I had to understand my budget and staffing budget and also the clinical issues, so with the accident and incident reports, etc. And again I was interviewed about that as part of the FT application and again the serious incident was brought up in that and I made a comment in that meeting that that had been taken control of by the exec team.

MR BROOKES: Okay. What were the main and the significant things that you were dealing with in your day-to-day work?

MS HARRIS: On a day-to-day basis, I spent one day a week as escalation ~~aspiration~~ manager of the day, which meant managing the A&E targets and departments, and I spent a significant amount of my time making sure that we achieved the 18-week cancer targets and a significant amount managing the finances of the division.

MR BROOKES: And how much of your time was based around children's services, or focused on children's services? This is a large division you're looking at with a variety of different challenges.

MS HARRIS: A relatively small amount of time, I have to say, so I attend – they have a number of workshops, time outs, etc., which I attended and that seemed to be that they had a number of challenges there that they were looking to find solutions for, which a lot of the time went back to their staffing issues, but they were represented on that divisional team meeting and they certainly raised their issues at that meeting for a wider audience as well as myself to help with.

MR BROOKES: And just for clarification, who was actually doing the day-to-day management of the unit as far as you were concerned?

MS HARRIS: There was a Deputy Divisional Manager, whose responsibility was paediatrics and obstetrics and then there were, as I recall, a Head of Midwifery

and five matrons in obstetrics and two in paediatrics.

MR BROOKES: And who was that deputy at the time?

MS HARRIS: I forget his name. Honestly, I can't remember his name.

MR BROOKES: It does not matter. It's just helpful for us to make sure that we actually get it right in our heads because this gets complicated.

MS HARRIS: Mm hmm.

MR BROOKES: So, you had a deputy who was responsible effectively for the day-to-day. Did they ever bring any concerns to you about midwifery services?

MS HARRIS: Other than the issues at Lancaster – they were very, very stretched there and that's when we had a look at those staffing levels. They didn't generally bring issues to me about Barrow or Kendal.

MR BROOKES: Was there any focus on cross-bay working in terms of the direction of travel for the trust?

MS HARRIS: I can't answer at an executive level because I think they were looking at ways to try and make Lancaster and Barrow work in that fashion, but certainly at a divisional level we found it quite difficult to get some cross-bay working between the different teams in those two different sites.

MR BROOKES: Okay, thank you very much.

DR KIRKUP: Just a couple of follow-up questions. Were you directly involved in any incident investigations yourself?

MS HARRIS: Not directly, no.

DR KIRKUP: Not at all, no. Were you involved in any investigations of doctors' conduct or competence?

MS HARRIS: No, but I am aware that there were a number of those whilst I was there and I was kept informed of them but I wasn't involved in the day-to-day running of them.

DR KIRKUP: Who was normally involved in investigating those?

MS HARRIS: The Associate Medical Director and the HR team.

DR KIRKUP: Okay. To your knowledge were management staff ever involved in those?

MS HARRIS: Yes, the deputy divisional managers and the service managers were involved in those as well.

DR KIRKUP: In what capacity? Were they interviewed as witnesses or were they carrying out investigations?

MS HARRIS: In my division they would be interviewed as witnesses. In somebody else's division they would probably be investigating.

DR KIRKUP: Okay, and which division would that be where they were investigating?

MS HARRIS: Whether it was in medicine, which was one of the others, or core clinical services – I think what we generally tried to do is not investigate your own division because you would have potentially a conflict of interest.

DR KIRKUP: Yes, but are you telling me that it was reasonably routine for managers to be investigating those kind of issues in the trust?

MS HARRIS: Not routine, no.

DR KIRKUP: What were the quantity? when it did happen?

MS HARRIS: [redacted]

DR KIRKUP: Okay.

MS HARRIS: But I wouldn't say in three years that they were routine. They were unusual. And then there was a usual list of ongoing disciplinary investigations which we would have undertaken, which weren't around those kind of levels of seriousness but were more around capability and performance and general behaviour.

DR KIRKUP: What was the role of the Clinical Director and the Medical Director in those and indeed the two relevant nurses for the nursing ones you mentioned?

MS HARRIS: That's why I wouldn't have been directly involved. It would have been more their remit to do that, but given that that was in our division, it probably would have been the Head of Nursing from medicine or somebody from core clinical services who would have actually done the investigation.

DR KIRKUP: That's why I am slightly puzzled that in some cases there seem to

have been managerial staff who were leading those processes – not all the time, I realise. Is that usual in your experience? Does it happen in Liverpool?

MS HARRIS: Yes, we appoint an investigating officer who can be a managerial person and what we have done at Morecambe Bay, now you remind me, is we had a series of three HR development sessions, which managers, both clinical and non-clinical, had attended and one of those was how to conduct an investigation. So, we tried to use people who had had that training, whether they were clinical or not.

DR KIRKUP: Okay. It is not that I think that it requires a particular specialist knowledge or anything but isn't clinical leadership one of the key roles of probably the Nurse Director and the Medical Director and wouldn't you naturally expect them to be primarily involved in those sort of investigations?

MS HARRIS: Yes, I would and I think it may be the difference between involved and investigating because the processes that we routinely use is that they wouldn't investigate a process where I am now, for example, if there was something that then would lead to disciplinary investigation. They would be people who would hear that investigation and they would lead the general professional development within the organisation within the division and that's what they did. One of the things that we did around that, we had some concern around nursing standards on the wards. They did a kind of peer review from other places across that and that was led by the Head of Nursing.

DR KIRKUP: Okay.

DR WALTERS: Had you managed obstetric services before?

MS HARRIS: No, I hadn't.

DR WALTERS: How did you find the interdisciplinary relationships?

MS HARRIS: In what respect?

DR WALTERS: Obstetricians, midwives, neonatology.

MS HARRIS: I thought they were – we had a site difference so sometimes there's not much cross cover between Barrow and Lancaster but I think we had the usual issues around midwifery care. We had a stand-alone midwifery-led unit. I think the Head of Midwifery was keen to see midwives having a leading role in that sort of area. I thought they worked reasonably well together, the obstetricians and the midwives.

DR WALTERS: So, nothing came out in terms of incidents or grievances or anything

like that around relationships, whistle blowing, anything like that to you as the Divisional Manager?

MS HARRIS: Not that I was aware of, no.

DR WALTERS: Did you have any external assurance of the quality of a service at all while you were managing the service?

MS HARRIS: Not when I was a divisional manager, apart from – I know once we'd had an incident, then an external clinical advisor was brought in to look at that.

DR WALTERS: Was that the Manchester review or –

MS HARRIS: It was the first one that took place. That was when I was there.

DR WALTERS: Right.

DR WALTERS: CNST ~~CST~~ – did that happen while you were there?

MS HARRIS: It did, yes.

DR WALTERS: Which level was that at?

MS HARRIS: We were at level one, but we were aiming for level two and they went through that process and they had an action plan about how far away from that they were. The key thing that held it back, really, was the fact that the wider service wasn't at a level two.

DR WALTERS: Right, so the Lancaster service or the service – the trust?

MS HARRIS: The trust.

DR WALTERS: Right. And were you there when the CQC visits took place?

MS HARRIS: No.

DR WALTERS: Were you there when the five SUIs, which we have all focused on, came to light? Was that after your time?

MS HARRIS: After my time, yes.

DR WALTERS: In terms of your relationship with the executive level, did you ever have to escalate anything in terms of clinical risks or concerns that you would really need help to sort out?

MS HARRIS: The main one, as I have already referred to, was around the European Working Time Directive, yes, and again the midwifery staffing at Lancaster, which we escalated and there were others in terms of other clinical services, but those are the ones that relate to maternity and paediatrics.

DR WALTERS: And what was the outcome of the issues of medical staffing?

MS HARRIS: I think as an exec team they were looking at different ways in which you could manage and organise the service, so a lot of focus actually went on

to the medical and surgical specialities, because actually in terms of levels of concern I think they were higher than paediatrics and obstetrics and they were looking at how you could try and manage that with more of an acute assessment service rather than a surgical or medical assessment service, so you didn't have split rotas, but we weren't making a great deal of progress with that and one of my main reasons for leaving was I couldn't see a solution to operating those two sites. There was basically funding that would support one and even if funding had not been an issue, recruitment was.

DR WALTERS: Yes, so, therefore the reason for you leaving, was that because you felt that the service wasn't safe or that there was not really a solution, or –

MS HARRIS: That there was not really a solution that I could see in the short term.

DR WALTERS: Did you have any conversations with the CCG at your level or the PCT as it was?

MS HARRIS: No, I didn't go to those meetings.

DR WALTERS: What about the neonatal service? First, it was a level one unit.

MS HARRIS: Mm hmm.

DR WALTERS: How did that work given that there is always going to be a proportion of more high risk births? Was that a topic of discussion at all?

MS HARRIS: No, it was only part of the overall paediatric service, but we were very short of medical staff at Barrow to run a paediatric and a neonatal service.

DR WALTERS: And was there ever any discussion about the sort of risk assessment of women given that there was only a level one service?

MS HARRIS: Not to my knowledge.

DR WALTERS: So that wasn't coming out in any of the clinical risk meetings or the governance meetings?

MS HARRIS: No.

DR WALTERS: Okay, thank you very much.

DR KIRKUP: Okay. Anything else?

MR BROOKES: No.

DR KIRKUP: Is there anything else you would like to say to us?

MS HARRIS: Not that I haven't already said.

DR KIRKUP: That's fine. Thank you very much for coming. Thanks for your help.

DR WALTERS: Thank you.

MR BROOKES: Thank you.

THE MORECAMBE BAY INVESTIGATION

Thursday, 18 September 2014

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

Before:

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

SIR DAVID HENSHAW

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

MR BROOKES: Welcome. Good to see you. As you know, I am Julian Brookes. First of all apologies from Bill Kirkup, who, unfortunately, cannot be with us today. He has asked me to Chair this session. We will start with saying who we are. I will ask you for the record to say who you are. There is a little bit of housekeeping and then we will start.

(Following introductions by the Panel and housekeeping)

MR BROOKES: There may be a time when we want to refer to particular cases. We will not do that in open session. If there are particular questions about particular cases, we will do that in a closed session at the end. So if you stray, we will try to bring back that. So there will not be any intention to close that down, it is just about making sure we keep separate what is an open session for anything that might require information about particular patients or relatives. Okay.

MR HENSHAW: One clarification, if I may? I suspect we may stray into comments on individuals. Where do we stand on that? Because that would be an issue that was referred to in guidance but I need to be clear about the lines we are operating within.

MR BROOKES: I think we will always err on the side of caution. If we are going to discuss anything that relates to a specific case or specific individual or set of individuals, we will note that we would have a conversation about that and we will do that in closed session at the end.

PROF MONTGOMERY: Just to clarify, that is individual families as opposed to members of staff.

MR BROOKES: Yes, yes. Particularly at their request.

MS McINTOSH: Sorry, unless it was in respect of performance or discipline, that will be considered closed-session material.

MR HENSHAW: It was not so much the families, more about the individuals in the Trust, employees of the Trust or members of the Board.

MR BROOKES: We would expect to speak about those openly unless, as I say, there are any issues that relate to ongoing disciplinary issues or whatever of that nature.

MR HENSHAW: I am bound by the compromise agreement signed in the case of a number of people who departed the Trust.

MR BROOKES: Okay. If that becomes something that is relevant to a particular question, please, let us know and we will note that. Thank you.

PROF MONTGOMERY: Okay. Thank you.

We thought if I started with time of the SHA and then

broadly, I think I'll hand off with time you spent with the Trust to Geraldine.

I would like to ask you to tell us a bit about what the -- what your induction was in 2006 and what were the highest priorities for the SHA so we can get a sense of where the Morecambe Bay issues or may not have fitted into that.

MR HENSHAW: Yes. It is quite tricky to think back now to that time. But, of course, these were the ~~successive~~ successor bodies to the previous health authorities which ran a very much more direct line management control. I think the ~~matrix~~ metrics are very important. A £9 billion turnover for the North West, and 150 staff in the SHA. So this was strategical leadership of the system. That was the description effectively, in simple terms.

As ever with these things, I think in the concept ~~and~~ in the bounds of Whitehall and the actual reality, there is actually quite a difference because you could have sat there in Whitehall in theoretical purity and thought about how the SHAs would operate. The reality was that you got into difficult situations on a number of wide range of issues.

I think that the system, culturally, still operated in the previous architecture to some degree. It changed and morphed over time.

As an SHA -- you have probably seen the documentation

unless you want me to repeat it all, but, essentially, the focus for the SHA was performance management of the system and their relationships between the various bodies.

Essentially, our vision was about the fundamentally poor ill health profile of the region and what we could do, strategically working ~~with them~~ within the infrastructure of the NHS and partners, what we could do to address that.

PROF MONTGOMERY: I think, if I have I have understood right, the focus of that then takes you towards Manchester as the place where there were the first set of big issues that needed to be touched on.

MR HENSHAW: I would not say it was geographically limited ~~based~~, I think it was more -- the North West has pockets of poor health profile all over and they range Preston, The Lakes, the conurbations I mean, everywhere. I don't think you would say that at all actually. The very reverse actually. We have often been persuaded that the pockets of ~~depravation~~ deprivation in the big cities are the problem, they are not ~~actually~~ the only ones.

PROF MONTGOMERY: Okay, thank you. In terms of the performance hot spots then, as you came in -- what we have been told --

MR HENSHAW: I think the briefing was very interesting. I mean, we had these letters and guidance notes and all the rest of it. I remember the politics of the time or the Government at the time was anxious to get as

many Provider Trusts into FT status.

I am ~~closely-tied~~ linked up with Monitor, as you know. If I look now at the bar and look at the bar then, the bar has risen dramatically in what you have to do to become a Foundation Trust. So there was a political, I think imperative to try to get as many Provider Trusts into FT status.

I think we -- if you want judgment on it, I think my judgment would be I think there were a lot of organisations which had what I would call passive Boards (which were part of the old architecture which often did not actually transform as they should have done) into what I call new boards for Foundation Trust, I suppose.

PCT land was interesting. I think we sought to try to get as much local focus at local level by all those involved in the local health economy working together as stakeholders in a shared mission.

I think we were sometimes criticised by the centre for not doing enough grip and being directive. We saw ourselves as partners in the mission as opposed to continuing the NHS ~~ordinary~~ common control mentality that has been part of the NHS culture for a long time.

That was a deliberate approach. The Board discussed it at great length as part of our building the vision, building the strategy. ~~I am passionate about o~~ Organisations ~~to~~ that perform

the best —are those at local level that have local control and own the problem. We keep issuing orders, well, you know, people will keep on waiting for the orders. So we had a very clear belief around that.

Also about experimentation, in terms of performance, in terms of using evidence. I have always been struck by the evidence and the NHS, which says so much about relying on evidence and when it comes to change, often relies so little on evidence.

So we were using a lot of ~~almost~~ American and other material about performance, about particularly Pathways, about what things were done, using that with the system working collaboratively to try to encourage people to start using that as a basis to see what they were doing clinically actually could they improve that performance. Lots evidence from North America about that, as you probably know, about how things could be improved.

MR BROOKES: Just a clarification here, I am aware of the very different approaches that strategic health authorities took. I know the South West one very well which was quite different.

There is a number of arguments -- what I am interested in was what the focal system was used to because you made the deliberate decision about the kind of approach you were going to take as an SHA. Sometimes if they had been -- if

organisations had been with a department control arrangement and you take that away, it can leave them feeling, you know, without that support system.

MR HENSHAW: You are now empowered without any suggestion of back up.

MR BROOKES: And then there is a development need in terms of changing that kind of culture so how would you have assessed the expectations --

MR HENSHAW: There were different bits in different parts of the region. Manchester, if I can stylise it, Manchester was used to a very tight command control system. ~~Iain would have been applying the North West, a very good friend of man.~~

Merseyside was probably going back to the Donald Wilson days was pretty command control but it shifted a lot. Lancashire was more passive, more laissez faire. So you could actually feel the different ways the system had been run in the past. Cumbria was Cumbria. I mean, I think that there was a sense of --

MR BROOKES: What do you mean by that?

MR HENSHAW: I think there was a sense in the North West SHA in the way the health economies work that Cumbria had its own view of the world, a somewhat siege mentality view. "We are Cumbria. We are different."

That is not being critical. I think, it is descriptive

of how I think the Cumbria health economy saw itself. There were reasons why they required extra resources, et cetera, et cetera.

PROF MONTGOMERY: I'll pick up the bit from that. I will ask you to tell us more about the players in the Cumbria. Was there a difference on the PCT side from the provider's side?

We understand that Sue Page as Chief Executive came from outside of the region and I do not know whether that was a deliberate strategy to move things. Could you say a little bit about -- break up Cumbria a little for us.

MR HENSHAW: I think we were conscious that -- how do I put this -- that we needed to bring some fresh blood into Cumbria, that parts of it perhaps had not had that benefit of bigger professional thinking coming into the economy. Sue was a good example of that.

There were also some very good GP stuff being done up there. I think it was perhaps over described sometimes by those who advocated the GP frame of things, particularly centrally, but they were doing some good things.

PROF MONTGOMERY: Do you think that was the cross the whole of Cumbria?

MR HENSHAW: No, it was in pockets ~~there were some -- sorry, I should have said about that~~.

PROF MONTGOMERY: Was there a -- one thing we have been

asking about is whether there was a north/south divide in Cumbria.

MR HENSHAW: My view of Cumbria -- is it is not pejorative remark -- I think, there is a North Cumbria, South Cumbria, East Cumbria, West Cumbria. There is not one Cumbria. So you need to be really understanding of that when you start dealing with the Cumbrian stakeholders.

PROF MONTGOMERY: If we were asking about the strong GPs, where would they have been?

MR HENSHAW: Mainly in the south, in the Morecambe Bay commissioning areas.

PROF MONTGOMERY: Thank you. We have heard different views of the two PCTs of the Trust. We have heard conflicting views as to whether there was or was not a lead commissioner formally and whether there was a lead commissioner informally. So you had two PCTs principally that were dealing with this Trust.

MR HENSHAW: Yes, it changed over time. It was not static. I think, there was an issue here about trying get clarity around what's actually happening in Cumbria, particularly with the GPs who, in the south, who took -- had a bit or felt they had more of a mandate to operate with more authority.

So, I think, they operated in the way, culturally, that actually suggested -- that they influenced more, they made

things happen more. Whereas in the north it was a bit more passive and the GP context. I mean, it is slightly stylising these sorts of things to try to get a flavour of it.

PROF MONTGOMERY: Lancashire PCTs, so they are not in Cumbria but they --

MR HENSHAW: No, I think there was a real issue around the commissioning. For the Trust, of course, you are dealing with the facing this ambiguity around how the commissioning landscape was operating. North Lancashire perhaps was not as subtle from the GP point of view. I think it was still a bit undeveloped.

PROF MONTGOMERY: Thank you.

If I could pick up another thing that Julian asked about the range of ways in which SHAs operated and Sir David Nicholson and his team had real progress, did they not, going around visiting the SHAs and feeding back what they saw. Can you tell us a bit about what they said to you?

MR HENSHAW: Well, I think -- I mean, one of the issues for us was that -- I will openly admit it was an issue the Board considered right at the start of our life -- were we were going to follow the command control, if you like, model? We saw that as, given the scale we were at and what our role was, we saw that as not appropriate and we could probably get better results by more collaborative

leadership role.

We set the North West academy up, for example, you may have heard of that, leadership academy. We did not do it. We encouraged the system to do it and the system did it itself with our support. So that was the model of operation.

I think David, who is a colleague, would have a view that perhaps we were not directive enough.

PROF MONTGOMERY: Did that view manifest itself in relation to any particular objectives or ...

MR HENSHAW: No, I think -- I mean, we did well on the money. The money was always under control. Performance generally was under control and if you looked at what you were trying to do around innovation, ~~saw the general life we had, I~~ think, that we were doing very well indeed.

Some of the stuff we did before we started using the national benchmarking came in and performance quality and the pathways stuff what actually clinically was being done, I think, led the way in that.

We were in a situation where we started this stuff, the partnering with North American hospitals, organisations and suddenly we were ~~crushed~~ halted with that and had to join nationally and do a national model, which we thought was flawed in a sense that the negotiations had only just started with ~~either~~ Colleges about what would be in what, would be —out we had taken ~~took~~ something that had been gone through that loop in North

America and we got the fastest start on it.

~~It seemed largely~~ clinicians in the North West picked this up. I ~~mean,~~ they seemed to delight in the fact there was evidence and that actually we could use it and demonstrate significant changes in improving outcomes.

PROF MONTGOMERY: We have heard and you pick up on different views about the pressure on the FT pipeline, how much it mattered in the assessment of the performance of the SHA. What proportion of your Trusts got through to FT status?

MR HENSHAW: You have probably seen the pipeline figures. We had generally middle of the pack run rate on the FT issues.

It is fair to say, I mean, I think that goes back my earlier point that there was, you know, the guidance was coming out from the Richmond house about the push to get as many into FT status as fast possible, that was an imperative ~~leading imperative~~. The bar was set pretty low when the whole process ~~this started~~ started.

I think we put a process in place which was as good as it could be, we had to reinforce later on because it was a bit too light touch but, you know. You get a team of people, you would set out in look at the boards, I would see the reports.

Now, I come from a different background where challenge

and the sort of things I am used to is probably more evident around Board tables than I was seeing in the NHS but the big issues were, you know, is it okay? Does it pass the Monitor test?

I think, that there was a sense of we were a ring master around this process rather than being a directly in control of it so we would look to --

PROF MONTGOMERY: Some SHAs had -- they had external advisers -- over the FT application. Did you do that?

MR HENSHAW: We did some of that but we did not do it as extensively as others. Again --

PROF MONTGOMERY: And board-to-boards? Did you do --

MR HENSHAW: We did board-to-boards and we ~~kicked a~~ delayed a few back on the basis of the board-to-board performance.

PROF MONTGOMERY: Can we ask you about the Morecambe Bay bit of that? What do you remember about Morecambe Bay's FT application?

MR HENSHAW: Well, of course, the chair resigned, of course, and I ~~was~~ appointed her successor during my tenure at ~~Morecambe Bay~~, the SHA. I could not get access to the notes we know were made at the board-to-board meetings so some of this is a bit hazy. We have struggled to find some of the material from the SHA records apart from the formal minutes and things.

My recollection is that it was a pretty average

performance. Yes, it was pretty average performance. But it was the sense that and the advice coming back from internal people had been on -- the review process around the FT pipeline was "~~love~~ above the line", as the NHS phrase goes.

PROF MONTGOMERY: So the sense of the board-to-board is average but do you remember there being any particular areas of concern that were flagged up for you to probe?

MR HENSHAW: I think -- I think this is the -- you start lighting on the core issues which then were revealed then in their full glory when I went as interim chair there.

The money was good. You know, the money was -- I mean, that was a big issue. Money got you big points.

The degree to which the Trust self-declared issues was an important one. You could only discern so much ~~of the~~ through the level and depth of the scrutiny ~~and~~ the SHA was doing through the pipeline process and you were reliant on CQC around the ~~equality~~ quality agenda to a large degree.

I think the -- my overall -- well, my memory of this is that there is was going fine until the maternity ~~stuff~~ issues started bubbling up. So it looked like it was running okay and on an amber light on our dashboards.

PROF MONTGOMERY: I will ask you about that in a moment.

You have got information coming in from the CQC, which, at that time, was largely based on self-certification by the

Trust. There was a whole series of things there that obviously you have been thinking about.

Was there any independent quality monitoring that the SHA had on the performance of the Trust or was it all dependent on the things the Trust produced or that the external --

MR HENSHAW: Essentially, as you will appreciate, at that time, the quality information was pretty limited by comparison with the --

PROF MONTGOMERY: But you developed a dashboard which --

MR HENSHAW: If you look on the ~~(inaudible)~~ summary material ~~which I was looking at the other night~~, they were coming out okay. I mean, on the dashboards we were using around that time.

MR BROOKES: Were you aware that the PCTs had --

PROF MONTGOMERY: I was going to say that.

MR BROOKES: Sorry, I will leave it to you then.

PROF MONTGOMERY: We have obviously been trying to triangulate things and one of the things that we have asked is what was the PCT saying to the SHA to Monitor as part of the application process --

MR HENSHAW: Well, this is an area which is somewhat murky. Because with the -- there are those, I think, who with ~~would from~~ a the post-~~hock~~ hoc perspective say they were raising flags with the regulator, Monitor particularly. I never saw

a letter from the PCT that actually flagged up -- PCT of North Lancashire or Cumbria that actually flagged up concerns. I never saw a letter like that.

Mike Farrow -- and I think you have already seen Mike -- talked to both the Chair and the Chief Executive on a regular basis as we did with all the aspiring FTs to get a sense of what was happening.

Eddie Cane had just been appointed as part of the process -- well, not part of the process but that taken over from his predecessor -- and Eddie came with a strong track record from the Department of Health.

So, it was a level of confidence we had in the sense of this man would get a grip on the business and Tony Halsall had a good record as the Chief Executive.

So I never saw a letter that the PCTs said, "we do not think this is on" or that we would have severe reservations.

PROF MONTGOMERY: What about the something a bit less formal? Did Mike tell you that they had said anything to him?

MR HENSHAW: Mike said to me and the PCT John Ashton said to me that he was concerned. Again, the push back to them was, "well, you evidence what the concerns are".

It is all right sitting there saying, "we have concerns", but we want to see the evidence that you can use to justify and give us give the basics -- because remember

the climate was such that you are being required to justify your actions ~~about~~ in -- ~~putting~~ pulling an aspirant FT up on the process was a big deal so you had to evidence reasons why.

So we had this continuing dialogue and I remained of the view that it was nothing in that dialogue that gave us the basis to pause or halt. We did deepen our look, I think, as I recall -- again, I cannot be ~~find~~ exact this -- we did ask to go back to the internal teams and say, "just will you have another look at this" or "just review what you did", and they came back with a light that said, you know, it is okay. The governance seems okay. It was never a star.

PROF MONTGOMERY: If I can relay, what I think I have heard there is that you were aware that there was some noise from the PCT.

MR HENSHAW: Noises.

PROF MONTGOMERY: You asked for the evidence and your assessment would have been that there was no evidence because they did not actually ever put it in writing or produce that. For that reason, you have done your triangulation.

MR HENSHAW: If there had been evidence, it would have been fed into the pipeline of procedures we have in the SHA that would have been visible on the tracking schedules. If you look at the tracking schedules that we had on the record, all the aspirant FTs, Morecambe Bay was going

through a normal pattern. Money was good, et cetera, et cetera.

PROF MONTGOMERY: That is true, except that it then gets suspended; does it not?

MR HENSHAW: Yes. Until that point in which that is triggered, yes.

PROF MONTGOMERY: Talk about the point in which that normal track changes because the application gets suspended. What did the SHA do then?

MR HENSHAW: Well, as you know far better than me, the issues were revealed and to our surprise. I mean, I think -- how do I phrase this -- when you commission reports of nature of the Fielding Report and don't declare them and you are a senior executive in the NHS, (inaudible) and a Board -- an aspirant FT, that is quite tough and as a strategic leader of a system, you after reliant on --

PROF MONTGOMERY: Were you aware of the commissioning of the Fielding Report?

MR HENSHAW: No.

PROF MONTGOMERY: Because she was recommended by someone at the SHA as the person to do it but that never made it to you? Were you aware of whether Mike knew about that?

MR HENSHAW: I am not aware Mike knew. I mean, we were close. If he had known about it, he would have ...

PROF MONTGOMERY: When did you become of ...?

MR HENSHAW: Well, of course, I left.

PROF MONTGOMERY: I have asked everybody this question.

MR HENSHAW: I left the SHA in February '11 so some of this was started when ...

PROF MONTGOMERY: So by the time you left, you were still unaware?

MR HENSHAW: By that stage, the FT stage has been awarded. I think it was brought in '10, was it? And so I left it and went to Alder Hey.

PROF MONTGOMERY: Have you read the Fielding Report now?

MR HENSHAW: Yes. I read I when I went to Morecambe Bay.

PROF MONTGOMERY: Again, this is a question I have asked lot of people. We are trying get a sense of it. When you read that report, what did you think she and the team had been asked to do?

MR HENSHAW: I found the report quite difficult and I found it difficult in the context of me going there as Interim Chair because, obviously, I went when Monitor asked me to go in. So I arrived and I am trying get a grip on actually what is going on so I just soaked myself in the documentation.

I was not clear what the terms of reference were

actually, specifically, to be fair. I think that I could see what was written but -- secondly, I do not mean this in pejorative way, there were lots of trees but the wood was missing. In the sense that, actually, so much of that went back to the core of the governance of the Trust.

PROF MONTGOMERY: Did you get the impression that she would have looked at the particular index cases that prompted it all, you know -- did you get the important from the report that she would have looked at the notes of the cases going through, asked herself whether the possible cluster of cases was a connected cluster or independent cases?

MR HENSHAW: I cannot comment on that.

PROF MONTGOMERY: Fine. So it is not easy to tell -- it is not that easy to tell --

MR HENSHAW: No, I know.

PROF MONTGOMERY: -- and, therefore, people have had different interpretations.

MR HENSHAW: I think that is my point. I found --

PROF MONTGOMERY: Were you given the preceding reports -- there were two reports that had been commissioned externally prior to the Fielding Report, were you given those as well or just the Fielding Report?

MR HENSHAW: When I went to Morecambe Bay, I emptied the filing cabinet on the floor so I had a look at

everything.

DR WALTERS: Were you surprised you did not know about that from your position at the SHA?

MR HENSHAW: As the SHA? I was appalled, frankly. I mean, you know, any system like the NHS, you are reliant on senior people operating with a level of competence that -- let us use the word competence -- makes the system work and I just, you know, was very surprised. I mean, I was appalled.

DR WALTERS: Do you have --

MR HENSHAW: At the very least I would have expected a conversation between the Chief Executive of the SHA and the Chief Executive of the Trust on the landing of that report as a colleague, a partner, in the journey towards what we are trying to do with FT status.

That would have a triggered a conversation between the Chief Executives of the SHA and myself and then we would have made a judgment and I suspect judgment -- as always, hindsight is easy -- we would have said, "we need to look at this more deeply." That is what we would have done.

DR WALTERS: But would you have expected that, since the SHA had a copy of the report, that it might have found its way because it was held by the SHA?

MR HENSHAW: Say again, sorry.

DR WALTERS: Because the SHA had a copy of the report

and had initiated it, you could say that the Chief Executive could say, "well, the SHA have got the report. Obviously they know about it."

MR HENSHAW: Well, yes. I think that is a bit vague. I mean, this is a report that comes in, actually does not make good reading, and there is a whole series of recommendations which are pivotal to the FT pipeline application.

DR WALTERS: So why wouldn't the quality division within the SHA --

MR HENSHAW: I do not know the answer to that. I do not know.

DR WALTERS: So would you not have expected them to have ...

MR HENSHAW: I am still unsighted on the extent to which the seniority of which that report was received and read. So I cannot give you a judgment on what level it came in at, how it was supposed to be handled, et cetera.

MR BROOKES: I will probably step on his toes again but it is just -- it is unclear to us as well about precisely where in the organisation the report landed, in the SHA. But there were three reports that led to the recommendation commissioned by the SHA beforehand. Were you aware of those?

MR HENSHAW: Yes, in the outline. I mean, in the

sense of there is something we need to do here and et cetera, et cetera. But remember I am in the process of departing, and so I am handing over to my vice-chair and being appointed et cetera, et cetera. So, I am not giving any excuses here, I am trying to contexttualise ~~actual last~~ the issue.

But again, I keep going back to the point. Here's the SHA with a responsibility it has got to the sort of resource basis it has got and in a system like the NHS, you are reliant, to a degree, on the trust and confidence you have in the leaders of your working with. In a strategic leadership position, I would have expected that report to be highlighted by the Board of that Trust to the SHA.

PROF MONTGOMERY: And presumably you would have expected the Board in that Trust to have known about it?

MR HENSHAW: Yes.

PROF MONTGOMERY: As far we can tell --

MR HENSHAW: Exactly.

PROF MONTGOMERY: -- it was never prevented --

MR HENSHAW: That was a big discovery when I went to Morecambe Bay --

PROF MONTGOMERY: You have not discovered any evidence that the Board received a report or presentation of anything.

MR HENSHAW: We have not. I will get into what I

found when I went to Morecambe Bay.

PROF MONTGOMERY: A couple of more bits, I think. You have explained why it made sense to have confidence in Eddie Cane and the Board's appointment. I wonder whether the fact that the FT application got suspended led to any discussions about the natural capability?

MR HENSHAW: Well, it did, but, I think -- you know, again, you are sitting there thinking, "now what do we do here? We are not the ~~first dominant~~ lead, ~~all over~~ here -- the Board is with the CQC at the moment to see where we are and others. Money is okay, still." That was a consideration.

So, to put it candidly, there was again, at that point, no evidence to suggest that we had -- could say take any action that would actually suggest a change in the leadership or ...

PROF MONTGOMERY: So that sounds like a judgment that says, "this suspension is focused on one particular area, which is being looked at by the CQC as the appropriate body."

MR HENSHAW: And with the background that I was being given assurances by Eddie Cane on the telephone, as was Mike, and meetings that everything was fine.

PROF MONTGOMERY: Thank you. Can you shed any light on Eddie Cane's resignation?

MR HENSHAW: No. I was approached by Monitor in the

January -- yes, he had resigned in the December, I think, it was. I can't remember but there was -- when I was being talked to about taking over, the Vice Chair was acting. So I had, I was given --

PROF MONTGOMERY: So there was a vacancy before you were approached? You were not approached at the time of vacancy was expected?

MR HENSHAW: No. He resigned and then the Vice Chair (acting) took over as acting and I inherited the acting Vice Chair.

PROF MONTGOMERY: Thank you.

DR WALTERS: Just going back to the SHA bit, I mean, to what extent were numbers of the successful transitions to FT Trusts part of your own and the organisation's personal objectives to achieve?

MR HENSHAW: We didn't have it as a -- it was not part of our strategic vision or strategy but it was certainly because London was saying that this was a ~~matrix~~ metric thing. We need to make progress on. So we put in place a process inside the SHA, it came to Board level reporting, and we reinforced the process, we deepened the resources we put into it, et cetera, et cetera, used some external support.

So it was a metric and it was an important one that we were politically, you know, meetings with SHA chairs with

the Secretary of State. It was mentioned as, you know, an issue that was being seen as a priority.

DR WALTERS: Do you think SHAs were concerned that they did not want to be the ones who were not showing they were not making progress because that would lead to embarrassment or suggestions of failing?

MR HENSHAW: I would not put it quite like that. I mean, it is the real world NHS is that this was at the top of the agenda and, therefore, we had to dance to that tune.

DR WALTERS: You said after you had been to see the Trust, had the board-to-board and there was some anecdotal issues around quality, I think your said you quality team looked into it and had come back and said it was okay.

MR HENSHAW: I think it was the total team and FT pipeline. So we said, "can you just go back and just tell us. Have another check through this" because we had a team which, if you like, held the accountability for a the pipeline which they anchored the stuff in the SHA organisation. So they went to the bits of organisation they needed to.

DR WALTERS: Do you know what they did?

MR HENSHAW: No.

DR WALTERS: So with hindsight, do you think that process was fit for purpose?

MR HENSHAW: In a perfect world, no. I mean, but,

again, I go back to the point, 150 people, 9 billion turnover on the whole -- you know, we have got -- I am not -- this is not making excuses but you have got an agenda where Manchester is trying to reconfigure Manchester's services. You know, it is like all this is happening all over the place. There is a few other things going on and -- I'll go back to my point.

If we had seen anything formal from the PCTs saying they were concerned, there was evidence -- and that was the question. What's the evidence here that you are -- you can say it does not feel right but we can all say that when we walk into an organisation.

PROF MONTGOMERY: Just reflecting what you were saying about the difference between the bar now at Monitor and the bar then. I am wondering whether or not you feel that this is -- I think a question with the benefit of what you know now as opposed to what you knew at the time -- that the issue was that UHMB was not above the bar then and somehow the system failed to spot it was below the bar or it was above the bar then but actually the bar was in the wrong place.

MR HENSHAW: That is really good question. If you set maternity aside and the issues, which is impossible to do but let us --

PROF MONTGOMERY: Although, it is a question we want to

come back to which is whether maternity was different from the rest of the Trust.

MR HENSHAW: If you look at the bar, money was the big issue, financial sustainability and reliability. If you look at the way that Monitor did their assessments, that is where 75 percent of the work was, on that.

PROF MONTGOMERY: So I think what we are saying then is that the CQC is the main guardian of the quality of the threshold of the bar and while there is a hiccup, the CQC gives it the clean bill of health. Monitor is picking over the finances and --

MR HENSHAW: Again, again, I think you need -- we all need to reflect this but this was a particular time when the pace and the size of the Monitor, the resources base of Monitor, indeed, the resources base at CQC and I hear lots of kick-back from the CQC but if you look at the resources base CQC had then compared to what as it has now and, you know, why are you surprised actually, that -- and then with all their extra responsibility --

PROF MONTGOMERY: Yes, I am trying disentangle --

MR HENSHAW: Yes, I understand that --

PROF MONTGOMERY: So even with benefit of hindsight, you (inaudible) that could have been made at the time?

MR HENSHAW: Yes.

PROF MONTGOMERY: Thank you.

DR WALTERS: So when you had accepted to take the chair's role, what was your brief?

MR HENSHAW: Basically, I mean, Monitor got in touch with me and I had some conversations with them and they said, "we have got a bit of a, you know, it's not a good place Morecambe Bay".

I had obviously been following it in the press, as everybody had done, and I had been aware of it when I had been in the SHA and Mike Farrar had met, Mr. Titcombe -- James Titcombe, and the rest of it. So I said, "well, okay. I am happy to up there for six months and try to see what I can do." Yes, that was about it really.

I mean, you know, I do this, as you may know, my career has been mainly around these sorts of things, turnaround and things but I was pretty surprised when I got there, I have to say.

DR WALTERS: So before you got there they said there were some issues.

MR HENSHAW: Well, I am being a bit -- there are some very serious issues here.

DR WALTERS: Yes, and it was about the maternity --

MR HENSHAW: No. No, it was -- the governance review initiated by Monitor and all the other documents and the reports. So: "There is some really serious issues here. This goes to the core of what is happening in the way the Trust is led so

could you act at the Interim Chairman?" "So I said, "okay. I have got a pretty full life but I will do it and I will try to turn some things" and we managed to work out an arrangement with Alder Hey and when I went up there and walked in and then pulled the filing cabinet out, I was just staggered. Staggered.

DR WALTERS: Give us a feel of the staggered.

MR HENSHAW: Well, I think I said earlier on. The core of this problem was the lack of good governance of the Trust. It was -- the board was not in control. And "not in control" covers the whole gambit ~~from everything --~~ there was no strategic vision other than, it seemed, to become an FT. That was the game at hand.

Once they ~~got -- that~~ achieved that occurred, it seems to be that second line running was, "well, we will take over North Cumbria. That will become another game to play." So there was no clear vision, no clear strategy, the quality of the Board in its debates and the agendas and the papers was very poor. It was not what I my used to wherever I had been.

The quality of the debate, as far as I could surmise when I interviewed all the members of the Board and then talked to people about how it had operated, I mean, it was clear to me that there was just an absence of what I would call even a partially functioning Board.

What seemed to have happened is that the agenda had

become becoming a FT agenda which had become the core business that Chief Executive and the Chair had held for their main frame but when you dug deeper, the infrastructure was missing. Risk management, quality control, you know, all the things you would expect to see as basic ingredients in good governance, were just absent. They were there in formal or partial form but not being run.

Fundamentally, the way the hospital was run with the clinicians were on the edges, hanging and throwing the occasional brick this engaged, whilst managers stood there in the middle and did not lead or manage because there was a lack of strategy and vision and the rest of it. Commissioners were very disengaged.

One of the first things I did was create divisions with clinical directors leading those divisions -- I passionately believe in the doctors, the clinicians having the core part of the leadership -- and we started rebuilding an architecture of governance that actually would fit -- you could see what you see in the good places. But we started from the very low base.

Staff were disconnected. They did not feel engaged. They felt they were lied to. Money was -- it looked all right, but you could see what was going to happen. I mean, it was just -- you just had to look two or three years down it would have started. No big strategic decisions had been

taken about integrating the organisation. It all goes back to when they amalgamated.

In fact, when I arrived there ~~was still~~ it felt like three separate hospitals organisations. That is ~~where the Trust, I think, had first dominant staff building that business~~.

DR WALTERS: This really is not meant to be a criticism but how do you think the not SHA did not see that?

MR HENSHAW: I do not know.

DR WALTERS: Was it because the money was all right?

MR HENSHAW: I think partly it was money, partly it was -- and this is, remember, this is over a period, so it is not just one snapshot. From what, you know, we -- the meetings we had around the pipeline, we would tell the guys who were running the FT pipeline division in SHA. They would do Board observations, they would interview people and they were giving us a story that said this was operating okay.

I mean, it was not top of the tree or outlining here but it was operating okay. When you saw the paperwork -- I mean, that is interesting about Morecambe Bay, when you look at the paperwork that was coming into boards, if you skate across the top of the ~~ice~~ of it, you could say, "it looks all right this."

There was -- because there was some paperwork around quality of performance that actually looked all right but

when you tried to see if it was connected to the rest of the organisation it was not. So governance and risk, for example, it looked all right, but actually when you tried to take it board-to-~~board~~ ward, it ~~does~~ did not work.

So you could see how that you would get an impression if you sat in a board and looked at the paperwork. What clearly -- and I do not know this for sure but I do not think there was much walking of the place as a team of people. To give the resources base we had, you would not put people in for a week and walk the place.

DR WALTERS: No, no. From then about day four or whatever, what were your priorities then? What did you start to do?

MR HENSHAW: There were a whole series of them really. Safety was a big issue but the thing that struck me about Morecambe Bay, they were -- they were as organisations in these tailspins get into the stage of if something goes wrong and they all rush over there; something else goes wrong, they rush over there; you have the whole mess going on. So you are like, "Calm down. Let us sort a plan out."

The first thing to do was -- my question was is the Board sufficient to lead this recovery? Both executive and non-executive, that is my first test question. Is there then is there a plan, et cetera?

As you know, from some of the changes I made, my

judgment was that the board was not sufficient. So, I think, all but two of the non-executives resigned after some difficult conversations and I brought in a ~~put together this -- borrowed some of the~~ former SHA non-executive who lived in the area, and we -- then Tony Halsall and I on the very second week had a conversation, and, I think, I made it clear I didn't see him as being the Chief Executive who would lead the recovery on the basis of what I had ~~been in the previous 10 days~~ seen. ~~I had done --~~ I went to every site, I had walked around, I had talked to clinician leaders and my judgment was that the level of confidence was such that you needed to re-energise the chief executive role. I also --

PROF MONTGOMERY: Sorry, can I check on that. You are 10 days in, you have identified the Chief Executive is not going to be one for the future but he does not leave for six months or so; is that right?

MR HENSHAW: No, I think he left his operational role that second week.

PROF MONTGOMERY: That is fine. Okay.

MR HENSHAW: Some of these things that are happening in parallel so bear with me. I had a conversation with the Medical Director. ~~but i~~ It was clear to me that, I think, I had these 10 days -- two weeks, I think. ~~I was kicking the tyres as I call it and also, I had all the paperwork all over the floor in my room and it is clear to me that there~~ was quite an absence of clear clinical leadership and

Medical Directorate throughout the Trust.

I should make it clear that none of this is personal. I think for me -- I said in my press statement when Tony Halsall stood down, I paid tribute to what he had done and I said, "he stood there alone when others should have stood alongside him." and I think that is a an important point to make because I think he took the brunt of it when, actually, the there were others there who should have stood along side him.

So the Medical Director, I had conversation with him and he agreed he would stand aside once I found somebody that we could bring into the role.

Then I went on the search for an interim Chief Executive, and having locum found an interim Medical Director inside the organisation who commended great confidence from the clinicians and the general staff and then slowly worked our way through the rest of it really.

We went back to basics in building, the governance for example I said, the whole Board risk Committee just to get a grip on risk and things like that. All the thing you do when you go into these situations.

MR BROOKES: I am interested from that assessment of the Board, both non-executive and executives, how many did you feel were competent?

MR HENSHAW: Really interesting question the word

competent.

MR BROOKES: Yes, it is.

MR HENSHAW: If it helps, I have always had this view that the first thing that a successful Board that makes the journey from being non-FT to FT, the first thing they should do it is review the Board ~~resign~~. They should really put new people in because I do not think ~~at~~ the people you have in the old non-FT world are necessarily the people you need to have in the FT world.

MR BROOKES: It is a different skill base.

MR HENSHAW: It is a different skill set, it is a different way of operating, it is a mindset thing, it is cultural. It is over simplification but it says the Board should be asking itself that question. "Are we the people that can actually make this journey?"

I do not think that Board was at an appropriate non-executive level at all. It was under-governed non-executive level. There were a couple of variants -- the Vice Chair was able and he was doing a great job and holding the ring and the recently appointed University Dean of the Medical School.

The executives, I felt again, for me, from where I come from my experience, there was an absence of what I call "corporate leadership", combined with the corporate leadership a team. It was not a team. It was a pretty disparate bunch of people who were not being led properly.

So whilst they may be competent in their own areas, there was a feeling, to me, that there was a need to bring

together as a team and actually then just work out was there the depth/the hinterland around some of the people who could actually make that journey.

MR BROOKES: That is why I chose the word "competence" because you are competent for a particular role in a particular set of circumstances.

MR HENSHAW: Yes. ~~He was a director~~The Finance Director I had a very high regard for. He stood there alone as acting Chief Executive for a few weeks and he did a very good job indeed. Very good on the money and the money was becoming a big problem, as you know.

Then we were a bit -- it was the way they operated, you know, and this goes back to the leadership style. tThey seemed stuck in the ~~Westmoreland~~ Westmore Hospital, you know -- I mean, I think that we can talk about the need to get out and walk the job. You know, I was saying I do not understand this; we should base people in all the three places and actually come together as a team. If you operate as a well-run team, you don't need to worry about the geography, but then below that there was some very good people and there was some less good people and we had not made, I think, good enough judgments.

There were also some Morecambe Bay factors which, I think, particularly pertinent to Barrow that are around making sure that you can get the right quality of people. The Barrow recruitment records and looking at how -- what

success we had had in Barrow, in terms of getting doctors and the rest, was not a good story.

You look at the size of Barrow's hospital, the volumes it is dealing with, you know, why are you surprised you cannot get a aspiring ambitious clinicians applying to go to Barrow?

The Medical Director George Smith made very a good point. It had changed. When he went there, he was a general surgeon. He did everything ~~from, you know, he did tell me about the same people with bullet holes in the chest to~~ whatever but the world has changed. That general surgery base that you want to do a whole spread of things has moved on to a increasing specialist world. So it was very difficult to recruit.

I think if you look at maternity and paediatricians, that is one of the core issues. To me, that is where the core of the problem lay in the sense of -- the outside world had not really touched that area in a way that it should have done.

PROF MONTGOMERY: Can I ask you about the management of the ward aspect of that because I think the we have got a clear picture of from you and others about the challenges recruiting health professionals because of the nature of the ...

Do you think that also translates into the managers who are able to work there? And I would like to ask separately

but you may want to answer together, on the problem of the getting together an appropriate group of non-executive directors to do the job that is required, given the fairly rigid expectations that at least the majority live in the catchment area for the organisation. Would those two things also have been challenging?

MR HENSHAW: It was an issue. ~~I mean, you -- if you never see~~ I spoke ~~me~~ to the lead governor at the time. I suggested to him we extend the catchment area to become the whole of the north of England but actually, interestingly, the new Board which is, I think, very good, came from the within the catchment ~~process~~ and I think that it was a case of --

PROF MONTGOMERY: So the talent is available?

MR HENSHAW: Talent is available, yes. You have to look for it.

PROF MONTGOMERY: The people you want do not apply.

And the non-executive side, is that --

MR HENSHAW: I think it is an interesting challenge because, I think, that there are quite a few people in Morecambe Bay who go for the lifestyle and apply to join for the lifestyle.

I always has this thing about, you know, people used to complain about the challenges and I said, "but hang on a minute, the Dean the Medical School at of Lancaster University" -- ~~the relationship with the University is very poor and we have quickly tried to put~~

that together again.

The Dean is a Scott -- I have forgotten her name now -- but she had come from Aberdeen and they had a rural practice cohort in medical school training and, you know, we should be actually using the difference of Morecambe Bay and the population as a piece of advantage, you know, in our batting. Things like thinking differently about how we do these thing.

So, I do not think -- there was not for me, a work force strategy that people -- what I call a work force strategy about where is our future stock coming from? Are we growing ourselves? How are we making sure we bring in fresh blood?

Those are fundamental questions and I think we had lived too long with quite an inward looking organisation that felt a bit under siege that actually carried on promoting people.

DR WALTERS: So, you are starting to recruit people who are from the applicable to the role of the organisation, rebuild the systems. What is happening -- can you take us to what is happening in the regulatory at the same time?

MR HENSHAW: Well, I mean -- the first thing I had done was try to create good relationships with CQC and Monitor. The Monitor relationship was very good. I mean, they supported me and they got the man on the ground, the person

in the role.

CQC, I think it is fair to say, I mean, had a good --
we got off to a good relationship. I sought to meet at the
many of the families-- I mean, it is always a difficult
conversation, I will say it openly. I met James a number of
times, and incredibly --

MR BROOKES: We will touch on that later.

MR HENSHAW: Okay. The point I was going to make was
that -- it was about trying get out and make the point that
it is the difficult message to sell, that actually my job
here is not to look what happened, my job is to forward to
build for the future.

I am sorry but, you know, for those who want focus on the what had happened
~~it, that is~~is The Trust Board -- we agreed eventually that we wanted ~~to do~~ an
independent enquiry, which is -- the Board that gave birth
to you via the Secretary of State, but ~~the~~ my mission was about
to start rebuilding the Trust.

DR WALTERS: Just take us through the Monitor visits,
and the outcome of those, that took place around
November/December time.

MR HENSHAW: Before I started or ...

DR WALTERS: 2012.

MR HENSHAW: Oh '12.

DR WALTERS: Yes.

MR HENSHAW: Well, I was doing monthly reporting to

Monitor about whether we were in progress on various aspects. The money --

DR WALTERS: What were they most wanting to hear about?

MR HENSHAW: Well, it was the whole suite.

DR WALTERS: Everything?

MR HENSHAW: I mean, yes. I mean, this -- I think, the first thing I did with Monitor, I think, I revealed the full extent of the scale of the challenge.

I mean, there was -- they understood it, but I do not think -- we sat down after a month and I went through and did a presentation at the monthly meeting with Monitor, and I -- revealed basically what we have been talking about today in more detail and the plans I had put in place, which we all agreed that was probably the right way to go.

The money issue was big challenge because fundamentally it is the furture viability of the Trust in the relation to the population it served. So my plan candidly was, look, I ~~do not~~ -- we can argue as much as we want, there is a rural population premium that should be applied, but let us put that aside.

We have to show that we are highly effective, great outcomes, highly productive and efficient, before you can even bring that argument into play. So we have got to do that bit first.

So we have to produce a plan for trying to get our money under control, if -- you may know that we shut one of buildings ~~the~~ at -- Lancaster infirmary was -- ~~I mean, it is like designed by the Department of Health on a big party night -- well, I mean, it is terrible thing to say but it was too merry. You would never build it like it. Is it is just incredible.~~

Again, to cut through the some of this we shut a building, sealed it up and put a temporary building in to actually change the dynamic in that site and it worked actually to an extraordinary extent. People saying what could be, put a lot of money into emergency, for example, things like that, to shift the way things were working.

Interestingly, in Barrow and I will go back to the point that you put challenge into Barrow about something like resourcing and emergency and, actually, it was that thing about that is okay. No, it is not. By 2012 standards it is not and it is that lack of challenge inside the organisation around what was appropriate that I think had got lost.

MR BROOKES: Both clinical and managerial?

MR HENSHAW: Both. If have got good clinical leaders, fully attuned to the environment and the time they are in, reading the guidance, knowing what is right thing at the right time, working with managers who are sensitive and

supporting that, you see things happen.

What had happened was people were just disconnected from a lot of modern standards. I mean, certainly that is a story.

PROF MONTGOMERY: We had a phrase we have heard of "learned helplessness" about the management of the Trust. Is that what --

MR HENSHAW: Yes but it goes back to the leadership. They were in charge but were not empowered. So, people managed upwards. That, in my desk -- I mean, I went -- the first week I went there, I mean, the people coming in and notes for me to sign and approve this and approve that I am going, "what? I do not do that."

You know, it is classic NHS. You know, "let us manage the problem upwards, we have got to get it off my desk". So it was about creating ~~accountable~~ accountability -- that was one of the difficulties because some of the clinicians did not like the Clinical Director accountability I brought in. I ~~thought~~, "you are it now. We have got to support you in learning to become that responsible leader of that division with your management team around you." That took some -- but once, I think, once people tasted it and realised that, actually, this is good. We can make thing happen.

The learned helplessness is, you know, you could not get lifts fixed in Barrow for example. People complained

about lifts always breaking down. You could not get them fixed for days and small things that you just could not get fixed. ~~You think to yourself ...~~

MR BROOKES: Putting a door in.

DR WALTERS: What was the pattern of whistle blowing through the time you were there? Was there any? Did it change?

MR HENSHAW: Well, it was one that you see the paperwork, that whistle blowing bit was a key part of the architecture to try -- in terms of the supporting the risk issues and all the rest of it. I think, there was a fear in the organisation. There is no question about that. I don't think I did enough in my time there to remove that fear. Perhaps I could not have done much. I do not know.

I felt that we could have done more to get people released into a feeling that they were being supported. ~~I~~We used to have meetings every month on the three sites with all the employees welcome. We talked openly about the things. So "you have got direct line straight me, I ~~am~~ and the Chief Executive", things like that and then putting in procedures but they took -- the culture of the organisation took a long time to get this stuff embedded and.

It was culture embedding. It was a big challenge and that was back to the leadership and how the management team operated. We made some big changes and it took a bit of

time to bed in. We brought in an interim who was quite tough and I don't think they had been used to that.

DR WALTERS: So just to focus on maternity side of things, what sort of things did the Board do to get more assurance about the quality of the maternity services in your new world?

MR HENSHAW: Well, I mentioned the ~~architect~~ architecture we set up.

DR WALTERS: Yes.

MR HENSHAW: We then did some detailed work. We got some people in, I think from South Manchester came to help us around some of the processes around the risk. The clinical governance, integrated governance, was all changed around. Then, essentially, we started testing what the processes and procedures were and found them pretty wanting. So we had to rebuild from the bottom up effectively.

In some areas, maternity is probably one of them, where you just realise that the normal things that you assume is routine in a well-run organisation, were just missing. I mean, I have got an example of it, not maternity but it is the out-patient debacle. Where, if you look at it in hindsight, how on earth did this Board not know that there were X-thousands of follow up out-patient appointments missed? I mean, how on earth?

Then you go through it and, I mean, a piece of work

that Helen Blairs did was very good at actually showing where the assurance had been given and, actually, it was a valueless assurance because -- ~~and I just -- and~~ nobody really had the full picture or the full grip on the issues.

That was a probably a good description of actually most of the way that organisation had been run. Nobody felt -- nobody was it. It was like as a Board member you would say, "you are it."

DR WALTERS: In terms of the maternity, I mean, I suppose we have all learnt from the doing this inquiry and I suppose some things that I am reflecting on is that you can never say in incidents are not related because it actually it does go right down to the bottom of how the people work together.

MR HENSHAW: Yes.

DR WALTERS: So I am -- were the Board really ~~cited~~ sighted on what the changes really needed to be? Because you were putting in lots of processes of reporting, new paperwork, new systems, but I am just wondering how challenging that was about getting --

MR HENSHAW: Sorry, I am staying with the overall Trust. On maternity, we did the putting the architecture in et cetera. We also created the new clinical leadership so there was actually a clinical lead for the area as part of the business.

We then started satisfying ourselves that there was -- I suppose the Board was a bit more hands on, particularly the small Board before we recruited the new non-executives. They are quite hands on in actually looking at the organisation and leadership in maternity.

The work had been done by central Manchester, again, I think -- it did not, for me, it didn't -- it showed lots of things but there was, for me, an overall conclusion ~~there was not a weight around~~, ~~actually~~, this is not being led well by the team of people.

The cultural gap between ~~maternity~~ maternity midwives and paediatricians, you know, all the things that -- people like this in fighting. There was a some physical building stuff that -- when you talked to them on the ground, they knew what they wanted to do, but they could not find the power to actually make -- and we did find the power; we just knocked thorough a wall and things like that.

So we were very hands-on in actually trying to give them support to say, "you can do this." I had regular meetings with the, not senior people, but the team there, as did the Chief Executive.

We get into difficult territory here in terms of what my reflections would be on what I might have done differently.

DR WALTERS: Perhaps we should talk in the closed session?

MR HENSHAW: That will be more helpful.

MR BROOKES: That is fine.

DR WALTERS: Something else we have been trying to get to the bottom of is the removal of the CQC warning notices. Do you know what the mechanics were around that or what assurances CQC had had to remove those notices?

MR HENSHAW: Well, I haven't got a level of detail here on this. The continuing conversation with CQC was around what was -- there were two bits of this. There was the CQC lens about what was required by CQC and there was what we were trying to do to the change the business.

I was obsessed with making the two the same but actually, I think, that there was a bit of a problem of that sometimes in terms of -- leadership wise what you will do and how that is coming out. Some of it is a bit a longer piece of work ~~drag~~ than sticking plaster over something.

Similar levels of staffing, some of the -- we had a few, as you know, a few suspensions. Sickness levels were very high based on maternity side -- paediatric side. So, we had a series of, I think, levels to reach around which CQC had written down.

Once those had been achieved as far as -- we achieved them in that sense. Did it fix the problem? No, it did not. It was on a journey. It is still on a journey as you -- it is -- again, we are getting difficult territory

here.

DR WALTERS: Yes.

MR BROOKES: Thank you. I am interested in -- it is to do with your comments on staffing and work force. I am not saying I disagree with those at all.

There are two key elements in terms of the meeting operation measures which that you have got the quality staff but also the number of staff you need and there is clearly evidence now that the staffing levels were very low. Do you think that is anything to do with FT in the financial viability -- balance.

MR HENSHAW: It must be connected with what had happened but if you look at in the other parts of the business, that same challenge was not there in that degree. That is what I have always been puzzled about.

There were other parts of the Trust where the staffing was, you know, you would not say it was padded but it was certainly far more adequate than in the area you have referred to. Emergency at Lancaster, for example, we had to put a lot more in there to get some issues dealt with.

So, I could not draw a direct line between FT status and the screw down on staffing in maternity, but clearly there must be some connection because there was a general screw down on expenditure being operated with, again, a lack of clinical involvement in decision making around what the

priorities and safety -- I mean, again, how it was -- I was somewhat surprised there were decisions being taken, how they were being taken.

MR BROOKES: If I understood that correctly, I agree with you. It is difficult to make a direct correlation between FT status and financial management around the FT business case and precisely the level of compliance but there is potentially something tear.

Also, I am interested in your views of the total Trust as well. Not particularly about the maternity and staffing levels now but if you look at the governance arrangements for the organisation, from what I am hearing, you are describing an immature, infective governance regime for the total Trust and --

MR HENSHAW: There were pockets. To be fair, there were pockets.

MR BROOKES: There were pockets but the system does not work unless the top works and all the elements work. You may have some reassurance likely, but you need to have all systems working.

In that case it is not a maternity issue with governance as such, it is symptomatic of the wider issues of the Trust. Is that fair to say?

MR HENSHAW: Yes, I think I said it right from the start ~~that~~ about the Fielding Report, for me, the issue is at the

core was the good governance of the Trust, the absence of it.

MR BROOKES: Yes. I am reminded as well you say you think that, if you had looked at the tipping point in the past, it is around the merger of the three organisations of the single Trust. Is that a fair assessment?

MR HENSHAW: I think my own view is that I have seen it too much now on ~~service~~ when that you have merged organisations ~~and~~ you have ended up with three organisations in one title, rather than you have actually had a strategic plan to integrate the organisations.

Because, I think, some of the issues in leadership around Barrow would have been dealt with more effectively, if you had a cross-bay leadership style culture in the whole Trust, for example.

Now, I am not saying it would have fixed it but it certainly would have added more people into the -- refresh the place a bit more in terms of the getting more challenge and the rest of it. It did happen with some cases and some areas, in others it did not. It was a muddle.

MR BROOKES: And just final question -- it is not a question, it is a statement -- is I found it hard to reconcile what you have found and what you described as the consistent with what we have been told from other parties and from the evidence. I find it hard to reconcile what the

decision to allow it to become a FT --

MR HENSHAW: Yes.

MR BROOKES: And I am not sure how the system failed in picking up the signs, the indicators around that this was not a Trust which was suitable and at that stage to go forward to the next application.

MR HENSHAW: Yes, I agree. I think we could only point to a number of factors.

One was the prevailing imperative of the moment around the FT pipeline issue. So the game in town was to get as many FTs as you could through the system. So the bar was low.

The resource base that a number of organisations had, the regulators, the SHA, enabled you to do so much and not more.

The opaque quality of the Trust in the sense of what you could not see and that, going back, it is back to six. I mean, those days were very different from the days where we have now in terms of what you see performance information. We do not have the -- we didn't have the staff survey things, those tools to see what was happening in the bowels of the organisation.

I think the commissioner's perspective, you know, if I had -- again, I am going back to the point of the evidence. What could the commissioners have done to collect evidence

that actually there were things wrong on the scale that was being suggested? I do not know what the answer to that is from the perspective they would have because the PCTs were under huge pressure for all sorts of other reasons but, you know ...

MR BROOKES: There is a question about the --

PROF MONTGOMERY: It could then be just a very tragic set of circumstances that brought this to light and all the Trusts that went through at that stage might be slippery and vulnerable. Would that be consistent with your view?

MR HENSHAW: I think the evidence has shown that there have been a number of Trusts that have gone through who have actually been very vulnerable and there were fundamental fault lines when they went through at those the early waves. The later waves, I think, have been far more demanding.

Also, of course, you know, it is -- how do it put this -- if you think four years ago/five years ago, the game at hand was the money, you know, it was over here. The game at hand now is quality and safety and quality. Over here; isn't it?

You have seen the whole thing shift in a way that -- it difficult to talk about it quite like this but, actually, that is what happened. Money and the degree of 20 billion being taken out and costs saving that -- so you are right.

It could be the tragic set of circumstances just came together like the classic holes in slices of cheese all being aligned at one moment ~~classic cheese holes~~ classic cheese holes, but fundamentally, fundamentally, there was a break in clinical leadership at the unit level and the fundamental --

PROF MONTGOMERY: So it was an accident waiting to happen?

MR HENSHAW: -- the fundamental break down in governance which did not pick that up and the governance issue, I feel, is the core of this.

You know, you would have spotted this a lot earlier. With good governance place, you would have spotted this earlier because they would have been looking at trends on the SUIs and the rest of it. It would have picked it up and they would have taken direct action about it. That is my view.

I have been, you know, I am Chair of a Trusts now, we have had our own challenges, you know, things happen. It is amazing in the health service how things quickly spiral from what looks like a stable foundation you are standing on to you have to take quick urgent action to get back on track. It is like spinning plates; is it not? It is a moving thing all the time.

MR BROOKES: Staying ahead.

MR HENSHAW: Staying ahead and that is, you know, keeping ahead of it and seeing where things are, recognising

where you are getting to is a crucial bit of the leadership of these organisations.

MR BROOKES: I am also interested in your view -- there was a number of regulators and external organisations, including the SHA who had responsibilities around managing the system. Do you think that at the time that accountability was clear between who did what between Monitor and CQC, et cetera?

MR HENSHAW: I mean, it varied between how different SHAs operated. The relationship with the centre and SHAs was different with each SHA. I think there was a -- I will go back to the point I made right at the start.

I think it is fair to say that the theoretical view of what SHAs would do, how you deconstruct the regional health authorities, with what, culturally, the system felt they were supposed to do, and what they were expected to do early days and that changed. I mean, is always easier to write these things down than actually, you know. I think, that was a big issue.

I have often thought about this from the SHA's point of view and, you know, there are all sort of factors. What could we have done more? You keep saying you would have done this but then, of course, you ignore at the same time all the other things that were happening. The £9 billion turnover of business in the North West.

Every day coming through that door there were major

challenges. So it is, tragedy. Tragedy.

MR BROOKES: Any more questions for this session?

Can we end the open session at that stage, please, and go into private session.

(The hearing continued in closed session)

THE MORECAMBE BAY INVESTIGATION

Monday, 3 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert Advisor on Paediatrics
Mr Julian Brookes – Expert Advisor on Governance

DAVID HOLDEN

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DR KIRKUP: All right, thank you for coming. My name's Bill Kirkup , I'm The Chairman of the Investigation, and I'll ask my two colleagues to introduce themselves to you.

PROF FORSYTH: I'm Stewart Forsyth, I'm a paediatrician and Medical Director from Dundee.

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

DR KIRKUP: You'll see that we're recording proceedings, and there'll be an agreed record at the end. You'll also know, I think, that we've opened proceedings to family members as observers. As it happens we don't have any in this morning, but they may listen to the recording subsequently.

MR HOLDEN: Yes.

DR KIRKUP: And you'll also know we've asked you to hand in any mobile phones, laptops, recording devices, just to emphasise that everything that happens here stays in the room until we're ready to produce the report with all the findings in context. Do you have any questions for me about the process?

MR HOLDEN: No, that's fine, thank you.

DR KIRKUP: Okay. I'll start off with a general question then before I hand you over to my colleagues, and that is can you just explain when you first started at the Trust and what you have done there.

MR HOLDEN: I started – I'm an interim, a career interim now for the last five or six years, and I went there from April 2013 to August 2013, about six months.

DR KIRKUP: What had you done before?

MR HOLDEN: I worked for the NHS on and off for 29 years, so I started – do you want my career history?

DR KIRKUP: Just briefly.

MR HOLDEN: Yes, I started off at the North Western Regional Health Authority, ~~services~~ Services ~~planning~~Planning, managing waiting lists and times, Annual Planning and Strategic reviews.. Services planning is now essentially ~~where~~ what we might ~~make our~~ call commissioning in the NHS today. I've worked at the Blood Transfusion Service, doing everything from the payroll to organising the blood donor vans, HR and charitable donation works. I've worked at the

NHS Executive North West, ~~which~~ within the Department of Health. Wigan and Bolton Health Authority to 2002 Trafford PCT.

DR KIRKUP: What had you done immediately before 2013?

MR HOLDEN: I was in Wiltshire, and I helped close down (disestablish) Wiltshire, Bath and North-East Somerset PCT, and establish two CCGs, part assist in setting up the local area team there, and the CSU, the Commissioning Support Unit.

DR KIRKUP: And what did you do – sorry.

MR BROOKES: Sorry, Bill, I just need to say; I think we've come across each other previously when I was at the strategic health authority in South-West at that time. I think we have come across each other, but not in any direct way. I just thought I'd point that out.

DR KIRKUP: You're right in saying that. And what did you go on to do after August 2013?

MR HOLDEN: Can I just check my dates, when I went there? I just wrote that down. Okay, I essentially did a kind of a swap-over with Mary Aubrey, the new Director of Governance there, so she was at Blackpool Trust, and I think it was in – actually it might have been October, I haven't got the date with me when I moved, but I went to Blackpool Acute, and she (Mary) went to Morecambe Bay as ~~a~~ the permanent Governance Director, and we did a bit of a handover for two or three weeks at both places.

DR KIRKUP: Thanks, that's helpful. Julian.

MR BROOKES: Thank you. Interesting and varied career. Just on the basis of that, I'm quite interested on your – first of all the handover you got, or the briefing you got when you arrived.

MR HOLDEN: Yes.

MR BROOKES: And what you were given as the key tasks for the role.

MR HOLDEN: I was given the task by Jackie Daniel, the Chief Executive. And because of – probably one of the reasons why we're here now, it was looking at – essentially establishing a Governance Directorate. And if I may, can I hand out a couple of diagrams to you? It's a bit scribbly because it was what I got when I got there. I've kept it just as an example, but I'd like to talk you through it because it's in relation to your question.

[Documents are handed out]

MR HOLDEN: So the diagram there essentially shows what I inherited as the Governance Directorate. So it was essentially setting up systems and processes to improve governance, but what I found there when I got there is the people who were around or in post were probably very demoralised, poor morale or on sickness absence. And I say, 'What did I see when I got there?' I don't know if you can – well, you can see from this structure that there are lots of vacant posts in it. If we go across the top [redacted] was – [redacted] working ~~on~~ four days a week [redacted] So...

MR BROOKES: Can I just check, how long – do you know how long these people had been off when you got there? Was this a relatively recent set of sickness or is this something that had gone back a period of time?

MR HOLDEN: I think it would be a period of quite some time. I got the impression it was months rather than weeks.

MR BROOKES: Thank you.

MR HOLDEN: So as you can see, this was the structure I am inheriting with 'vacant' written all over it. Not much of a structure in terms of governance, to my mind, but regardless of the structure there wasn't really the people there anyway to do the work. [redacted] about what they thought at the time, if you've not already seen them.

Prior to me arriving and [redacted] and there is something I'd like to tell the Panel about when I met him, at some point.

DR KIRKUP: Okay, we'll come back to that.

MR BROOKES: So you inherited this structure. What [inaudible] and you...

MR HOLDEN: So for the first month I was actually working with the then Director of Nursing, who was slowly introducing me to the systems and processes in the

Trust, and how they did things, and that was with Jackie – Jackie? Not Jackie – the Director of Nursing.? Text missing here?

MR BROOKES: Which was?

MR HOLDEN: Jackie Holt, yes. So it was really seeing how they did things, the triangulation of information, audit, risk, claims, negligence, patient involvement experience work, and just see how that information came together essentially.

MR BROOKES: And what was your analysis?

MR HOLDEN: That it needed lots of improvement.

MR BROOKES: Can you expand on that?

MR HOLDEN: There didn't seem – it had seemed as though the process of systematically looking at information might have happened in the past, but for whatever reason, and it may have been the lack of people (staff) doing the work it, seemed to have been lost the skills and what to look for. So I think what I started to build up was a quality committee (and a risk committee), which started to try and see this information. And I hopefully think that when I left rather than when I started, that committee was functioning pretty well and was getting the information with the right people in the room it deserved.

MR BROOKES: Okay. So when you arrived, I'm just summarising what I think I've heard, there was a system, or systems. We'll come back to those in a second, but they would have been assessed in our eyes to the quality and governance sections or whatever. The big problem there was that most posts were vacant, people on long-term sick or posts that hadn't been filled.

MR HOLDEN: I think so. Yes [In retrospect – Yes. No people to look at governance with the skills].

MR BROOKES: So is it fair to conclude that at that stage it would have been very difficult to make an assessment as an organisation of the governance of the organisation in the identification of problems?

MR HOLDEN: Yes.

MR BROOKES: Okay.

MR HOLDEN: Because as I saw it, I didn't see that being done particularly well.

MR BROOKES: Yes. This is your view, I understand.

MR HOLDEN: It's my view, yes.

MR BROOKES: It's an assessment of you coming into post which I'm just interested in. So you'd say that was a fair assessment?

MR HOLDEN: Yes.

MR BROOKES: Okay. So you created a quality committee.

MR HOLDEN: No, it was already running. I think I improved what was already there.

MR BROOKES: Okay. What did you do about the other deficits in terms of governance in the organisation?

MR HOLDEN: I think there were other streams of work being undertaken. So one of them in particular that comes to my mind was there had been a review by Manchester, and I think it was in the first or second week I was there, there was an action plan being pulled together of the work that needed to be done. So I guess I was party to seeing what needed to be done in that action plan, and I guess the Director of Governance name was put to ensuring that some of those tasks were achieved.

The other thing I was party to, but again I didn't necessarily lead on it in terms of this particular review, was that I think there were two groups formed. There was one group formed to look at what the work was that needed to be done in the children's division. And then – so it was kind of like a working group, but there was also a higher level group chaired by a Non-Executive, John Hutton, with Jackie Daniel in the room, just seeing that the action plan that had been created was achieving what it set out to do.

MR BROOKES: Okay. I struggle with this. It's not with you, it's – I struggle. I get an impression of an organisation with lots of different work streams going on with different people involved, sometimes some of the people involved in more than one work stream. Is that a fair assessment?

MR HOLDEN: I think there was lots of work streams because...

MR BROOKES: So where does it come together, I suppose, is the question?

MR HOLDEN: It would either come together at the quality committee or the board meeting.

MR BROOKES: Did it?

MR HOLDEN: It was coming together over time. Did it come together immediately? No – ~~absolute~~ absolutely no.

MR BROOKES: No.

MR HOLDEN: I don't think so, I think it was on a track for improvement. Also within there they had other pieces of work they had to improve on because of Monitor's involvement with the Trust. So they had a number of improvement

plans to go through, and not long after I got there they got one on ~~health~~ from the Health and Safety Executive – they got four improvement notices for health and safety, so that was yet another track of governance where – that they needed to look at. So I suppose I felt they had lots of, you know, different work streams to do, yes, and probably separate ones, and I suppose sometimes not all of those things – yes, separate work streams, absolutely. And coming from the Health and Safety Executive would be another one that was at the forefront of my mind as well.

MR BROOKES: Okay. Are you aware of the PriceCooper's assessment of governance in the organisation?

MR HOLDEN: What?

MR BROOKES: Prior to your time they came in as part of the Monitor, and looked at the governance of the organisation, and provided a critical report of the current state of affairs. And I think just about your time is – I think you reported it to the Board, they came back and did a follow-up review. Does that ring any bells? You took a paper to the Board.

MR HOLDEN: I may have done. It doesn't ring any bells, but I've done a lot of papers to the Board.

MR BROOKES: Okay. I'm surprised because it was quite a fundamental piece of work that Price Coopers did on behalf of Monitor. Came in, were very critical of the systems, probably generating your involvement being brought in from somebody outside, and then in just – in the June 2013 you took – there was a paper that went to the Board, which you were the owner of – author of. I was just interested in your views on the re-review by Price Coopers of the governance systems.

MR HOLDEN: I actually can't remember that one. If you were to show it me though, I might be able to.

MR BROOKES: Okay, if you can't remember it you can't remember it. That's fine.

MR HOLDEN: I can't, no. But I'd be willing to give you a view if I saw it.

MR BROOKES: Okay, thank you. Because I was going to ask you whether you agreed with their judgment at the time, which was very much that this was – things were still below what could be expected in governance terms of a Foundation Trust.

MR HOLDEN: Yes, I'd imagine so.

MR BROOKES: You would agree with that?

MR HOLDEN: Yes. I would think – I would think that would be the case even after that time, yes. I think we were on a slow trajectory to try and get back up to standard.

MR BROOKES: Okay. Accepting that you weren't there very long, your time at the Trust – I understand about strengthening the quality committee and its functions. What else did you introduce which would have strengthened the governance of the organisation?

MR HOLDEN: They had brought in a Head of – an interim Head of Patient Experience to look after the complaint system.

MR BROOKES: So this structure stayed; it was just you focused in on filling some of the vacancies, or did you take the review of the actual structures of governance they had in the organisation?

MR HOLDEN: We took a review of the structure as well, just in terms of who was actually around at the time. We tried to do a bit of permanent recruitment as well actually. [redacted] so whilst we wanted him back, there was a piece about – it's very difficult to alter a structure when somebody isn't around.

MR BROOKES: It is.

MR HOLDEN: It may look as though you're altering it because of them rather than...

MR BROOKES: It is very difficult. But what did you feel was lacking in terms of the governance systems in the organisation?

MR HOLDEN: I think some systematic processes. I'm quite used to reports that bring together information on risk, patient safety, complaints, claims; the whole remit into one paper. And I think we were getting there, but it was as though – almost like the corporate memory bank had been wiped. It was very difficult – because there wasn't really anyone to speak to about this work it was very difficult to get the knowledge of what the baseline was, where the information was coming from.

MR BROOKES: Okay. And you said you went – Jackie Holt spent some time explaining the systems that were in the organisation to you. What were those systems and what was your assessment of the quality of those systems?

MR HOLDEN: One of the things was a workshop on ~~compliance~~ complaints management, and it seemed to me that for whatever reason, either the staff,

the number of staff or the number of complaints, I think the patient experience team were really struggling with knowing what the right thing to do was. I think they had some capacity and capability problems, and probably did for a number of months whilst I was there. The Trust, again, brought in some more interims to try – some experienced people to try and bring people up to speed, but I'm not sure – it seemed to take them the permanent staff a while to learn what they were doing. And to my mind, the people in post seemed to be fairly highly graded for that piece of work. But yet, for whatever reason, I don't know if it was morale or – but they found it really hard to draft simple letters.

MR BROOKES: Right, in the complaints...

MR HOLDEN: Yes.

MR BROOKES: So what – were you able to help with that?

MR HOLDEN: I brought in – well there was already an interim there, but I brought in another interim who'd done this piece of work before. I didn't particularly know of her, but I knew of –work - we'd crossed paths. She'd worked in Trafford when I did around 2002/2004, and had been a PALS manager. Subsequently a – I think she was a company secretary.

MR BROOKES: Okay.

MR HOLDEN: So I brought her in essentially to train those people and either system improving or we might – they might have needed to be exited from the organisation. Meanwhile, while all that was going on, [redacted] and I'm not sure if she was the right person to do that job, and I think if you spoke to [redacted] I don't think she thought she'd necessarily applied for the job that she ultimately got. I think she was more on the PALS and patient experience side of the organisation rather than dealing with complaints, for example.

[redacted]

and she was one of the senior people in the team at Morecambe Bay.

MR BROOKES: Okay.

MR HOLDEN: In terms of the middle structure, the risk and compliance, we brought in a risk manager to undertake work looking at the ~~bath~~ Board Assurance framework and the risk registers. So hopefully you've seen the work that's been done to get people to start reporting on those initially, and understand

what they're reporting, what the form looks like, the reason for doing that, and hopefully some feedback loop work.

MR BROOKES: So, again, just so I'm clear, despite complexities and difficulties in terms of sickness, etc. within the team, you were able to strengthen the function during your period of time at the Trust.

MR HOLDEN: Yes, I would like to think so, even though it was with interims, yes. However, in terms of culture and morale of permanent people, they were off the pace.

MR BROOKES: Okay.

MR HOLDEN: Because you don't want to run with interims for too long essentially.

MR BROOKES: I know, but you were in a difficult position. I assume that you were there for a fixed period of time, were you, or was that...

MR HOLDEN: Initially it was three months, which ended up being a bit longer than that because they needed to recruit a permanent person.

MR BROOKES: Yes, so it is difficult in that situation. And the only way you can function then is to have the support of your Chief Executive and the Board. Did you feel you had that support?

MR HOLDEN: Yes.

MR BROOKES: Good access?

MR HOLDEN: Yes.

MR BROOKES: Okay.

MR HOLDEN: Very good. There was one Non-Executive in particular that took – well, he chaired the quality committee, and I would meet him probably – certainly once a week if not twice a week.

MR BROOKES: Okay, and that was John Hutton, was it?

MR HOLDEN: No. I've forgotten his name, but if you – it's a gentleman, I've forgotten his name, but...Denis LIDSTONE

MR BROOKES: Don't worry, we can find that out.

MR HOLDEN: Yes, chairman of the quality committee.

MR BROOKES: Yes, okay. So you also had access to the Board. Something missing here?

MR HOLDEN: Yes.

MR BROOKES: You said that you wrote numerous papers to the Board. What was the level of debate and support and decision making taken by the Board during your time there?

MR HOLDEN: I think – I think it improved over time in terms of the importance of governance. And I say that thinking back to, for example, health and safety. I mean when I go there the health and safety function was with the Chief Operating Officer, but at a certain point in time it was agreed that that function should actually transfer to the Governance Directorate, but that was only after the full improvement notice work had been cleared, if you like.

So I started to pull in the health and safety function as well, and the local security management service into the governance team. So in terms of did they recognise what I was trying to do in terms of pull together a stronger team and all the governance functions, I think they did. Did they start to listen to work on governance? Yes, I think they started to do that. I think it felt like it was a fairly low baseline though in terms of how much governance was on the agenda when I arrived. And in terms of your question, I think it improved over the time I was there in terms of governance got more of a say at the Board level, if that makes sense.

MR BROOKES: And where there was actions required did they take those actions, take those agreements, take those decisions?

MR HOLDEN: Yes, I think so, yes. Work to move on the people on sickness absence/ability

MR BROOKES: Thank you. Were you also involved in anything to do with the maternity services action plans?

MR HOLDEN: Yes, I think I was, yes. Those would be the two groups I spoke about before.

MR BROOKES: So what was your involvement?

MR HOLDEN: I would have had, as part of the Governance Directorate, governance team, Director of Governance, there would be some actions on that action plan that I would have been responsible for, so I was part of the working group, and I also attended the group that John Hutton chaired. So as well as being part of the Panel, I was also ensuring that work in terms of governance was undertaken.

MR BROOKES: Can you recall what those tasks were?

MR HOLDEN: Some of that was about – I think it was probably about getting people – the first one would have been getting people to know about the Governance Directorate, as it were, and getting an understanding of the new way of working within the Trust. I can't remember – I can't remember them all, to be frank. Clearly my memory's not what it was, but you would see the action plan we've made, the Director of Governance title throughout that.

MR BROOKES: And we can, yes, so that's why I was interested in – and what was your take on the – was the action plan the right set of actions, in your assessment, to get the improvements that were required?

MR HOLDEN: There seemed to be a lot of actions. Probably – maybe too many, and not focused enough. But I say that because from where I was sat, it felt like there were lots of action plans in the Trust on – from – because of Monitor's regulatory involvement, the HSE, the CQC etc.... We then got health and safety notices. There was the general flow of what I was saying we needed to establish in terms of ways of working and reports from a relatively low level of capacity in terms of people actually who were in the building working on governance, but people way beyond the governance team would be working on governance matters, so lots of the maternity work would have been undertaken in the division.

MR BROOKES: Okay. I haven't got any more questions at this stage.

DR KIRKUP: Okay, Stewart?

PROF FORSYTH: Yes, can I ask a bit more about initial involvement and governance, and clinical governance in particular? So the scheme you've got here is really high level to CNA condition groups involved, and governance very much should be infiltrating right through the organisation. So can you tell me a bit more about the clinical involvement in the process, when you arrived and when you left?

MR HOLDEN: Yes. In terms of people, Geoff on – if we just take this structure for a moment, Geoff was a pharmacist in terms of his background.

PROF FORSYTH: Yes.

MR HOLDEN: My deputy, David Tansley, was a nurse by background, so that's the kind of people that were supporting me in that team. But in terms of clinical governance, for example, there would be clinical...

PROF FORSYTH: Sorry, was there any doctors involved in leading in any of these areas? Was the Medical Director involved?

MR HOLDEN: Oh, yes – sorry, the Medical Director, there was a Medical Director, George Naysmith there was Jackie Holt, the Director of Nursing, etc., but they were not in the governance team structure as such.

PROF FORSYTH: They weren't in the governance structure.

MR HOLDEN: No, they weren't, no. No, this was a separate governance structure. So previously governance had been undertaken within the Nursing Directorate as a function in terms of PALS, patient experience, risk, compliance, patient safety; and I think it had been pulled out because I think what they were finding is – well, like a lot of Trusts that sometimes create a Governance Directorate, you sometimes get the people who are saying that they're doing the work also self-policing themselves to say, 'Yes, we've done it,' so there's a bit more of a triangulation here between a Governance Director, a Medical Director and a Nursing Director. ? Also the Nursing Directors, clinical nursing agenda is now so large that to have a separate board level focus can only be good practice. A separate governance directorate brings corporate and clinical governance together and ensures compliance and reports on assurance matters. Missing text?

So rather than the Nursing Director and the nurses saying, 'Yes, we've done it,' there should be a bit of check and balance by a team looking at what those people are doing.

PROF FORSYTH: Okay, but clearly you [inaudible] when you arrived were people actually probably capable of doing that? Or you have said they're not able to do it.

MR HOLDEN: No, I'd say – no, no.

PROF FORSYTH: So I'm just going to go back to the sort of question about engaging clinicians in governance.

MR HOLDEN: Yes.

PROF FORSYTH: What were your findings when you arrived, and what did you think you had achieved in relation to that by the time you left?

MR HOLDEN: Not enough clinical involvement when I arrived. If you spoke to Owen ~~Gull[?]~~Galt, like I guess you would do, he would recognise me as somebody who was trying to assist him in ways of working in terms of, 'Let's improve

governance.' So whilst he is a clinician, if you asked him about Board assurance frameworks, risk registers, with due respect to him, he may not say he's the expert, so I was there to assist him, I hope, in terms of looking at some of those governance pieces. As far as I can remember, the Trust also put in place two assistants to work with George Nasmyth, in terms of Clinical Directors; one for Lancaster and one for Barrow. So I think it was improving, but again, I would say it was ~~on a~~ not brilliant – you know, it hadn't reached its end point in terms of improvement, but it was certainly on a track to improvement in terms of clinical involvement.

PROF FORSYTH: So did the Clinical Directors, did you feel that they allocated time for this?

MR HOLDEN: I remember a conversation about trying to get Owen, for example, more time to undertake his 'managerial and governance duties'. I think that was worked on. Did he have enough time? I think he probably said in some of those meetings that he probably would like more time, so that was a judgment call between what the Trust were probably saying was enough time and what he was thinking was enough time. I think he probably thought it wasn't, was the impression I got.

PROF FORSYTH: From the short time you were there, did you go to meetings where serious incidents were discussed; did you go into maternity or neonatal services?

MR HOLDEN: Yes, I could describe the process to you, that I think was a piece of good practice. So my deputy, David Tansley, the nurse, would have a meeting each morning, a call round 8.30 to see if there had been any new incidents, and those systems were logged on the StEIS system. Hopefully you know what I'm talking about here.

PROF FORSYTH: Mmm-hmm.

MR HOLDEN: Each month a meeting was established with the teams where an incident had occurred, so it might be a nursing team, chaired by a Non-Executive of Morecambe Bay, with invites from the local CCGs at the meeting, so the team would present the incident to those assembled. Hopefully there was always a piece of learning about ensuring it wouldn't happen again. The NED chair of that meeting asked the Medical Director particularly if we were

satisfied that that learning had taken place. We'd then ask the CCGs if that seemed appropriate to sign off those incidents.

Were there maternity issues there? There probably were, yes. But...

PROF FORSYTH: Do you remember any neonatal deaths being discussed at these meetings in 2013?

MR HOLDEN: I think – I think there was one.

PROF FORSYTH: There was sadly a record of a baby who had been – who died from infection, and they'd transferred her subsequently to another hospital.

MR HOLDEN: Yes.

PROF FORSYTH: I mean the comment at the end of that meeting from the Non-Executive Director was that, 'Care in maternity doesn't seem to have improved.' Do you remember that meeting at all? I don't know if you were at it.

MR HOLDEN: Do I remember?

PROF FORSYTH: Okay...

MR HOLDEN: Who was there?

PROF FORSYTH: There was always a Non-Executive Director, I've forgotten the name, but she would be there. [or]

MR HOLDEN: Yes.

PROF FORSYTH: I just wondered if you recalled it, because that was clearly a significant incident at a time when you were there, and I just wondered whether, again, the sort of response within the – particularly the Governance Directorate, how that was handled.

MR HOLDEN: There would have been some actions from that meeting certainly, to look at lessons learned, absolutely. But I don't think it would have been left with that comment without further work being undertaken with the team.

PROF FORSYTH: So the point was that incidents were still – serious incidents were still happening despite considerable efforts from different agencies and obviously work within the Trust.

MR HOLDEN: Yes.

PROF FORSYTH: And what was your sort of general feeling about it all? What was your sort of gut instinct about what was going on the Trust, particularly within maternity and neonatal services? Did you have any sort of thoughts on that?

MR HOLDEN: There seemed to be an overview that the Trust had to deliver maternity services from three sites. And I think the Trust had looked – well the

Trust had looked to perhaps close the unit in Kendal. And I think that was probably about resourcing of those issues, both in terms of getting people, and the quality of people into the Trust. The Trust seemed to have, and probably still did when I left, a huge problem with attracting senior clinicians to the Trust in various specialties. They probably had to pay high rates for getting clinical interims in to cover pieces of work. I think they struggled, and that wouldn't have been any different from getting people into the maternity area of the business.

I remember they tried to recruit for a permanent Divisional Manager, and that took some time to get somebody in, for example. Not a clinician, but somebody focused on the business of the day.

PROF FORSYTH: Okay. I mean also just in terms of the structure you were developing, whereabouts was the user involvement in that system?

MR HOLDEN: There was a patient experience group, and I guess that was one of the development pieces to try and get more user and carer involvement in everything that the Trust was doing essentially.

PROF FORSYTH: But in terms of services, was there a very high profile service at that time? Were there any systems in place to involve the local community in the governance of maternity and neonatal services?

MR HOLDEN: The Trust had, as it would do, it had some governors. So they were often involved in getting briefings from Jackie Daniel on what the scenarios were. I think – I do believe there was a maternity services patient experience meeting in Barrow, as far as I know, and probably one in Lancaster, to get views from the local community there.

PROF FORSYTH: Okay, thanks.

DR KIRKUP: Actually I wanted to start with something slightly more general just on the organisation chart. You referred to the fact that there were quite a lot of absences, there'd been long-term sick leave, and I think you attributed that to poor underlying morale in this unit. Is that true? What's your impression of the root cause of the underlying poor morale?

MR HOLDEN: I spoke to Graham Hall on his – probably his last day in the Trust. He wasn't working in the Trust but he came in to collect his things and leave essentially. But I spent probably an hour with him, asking him about the history of the Trust and what it was doing. So he gave me the strong

impression that he would write reports on risk and governance pieces, and he gave me the strong impression that he was then asked to alter those reports.

DR KIRKUP: Okay.

MR HOLDEN: And when he was telling me this he wasn't – he wasn't particularly happy about telling me, but he – he seemed quite tearful, he didn't seem particularly well, but I think he was pleased that he was leaving the Trust. So I got the impression from him it was a bit of bullying and harassment perhaps, but the culture in the organisation, he didn't – he definitely said he didn't like the way he'd been treated there.

DR KIRKUP: Okay, and did he give an impression of what the timescale of that was? Had it gone on until very recently?

MR HOLDEN: I think he'd been off for a little while, but yes, I got the impression it was over months rather than a short period of time. I think even perhaps years rather than months in terms of how reports should be written, and he was trying to report what he was finding and what was being reported in.

DR KIRKUP: Right. And what were the specific things that he was – well not specific, but what in general terms were the things that he was being asked to change?

MR HOLDEN: Well he didn't really go into that, but he would have been covering risk and incidents.

DR KIRKUP: Mmm, and he was being asked to change them in a way that he clearly didn't feel happy about. It wasn't, 'You could improve your report by saying this'?

MR HOLDEN: No, no, I think he was thinking that it was changing the – the governance of what he was trying to say. He didn't change them, but he said he did know because he saw subsequent reports that were not his reports, as it were, with his name on it, which he wasn't happy about.

DR KIRKUP: Okay.

MR HOLDEN: He also did say that if he was ever asked about this he would deny that conversation.

DR KIRKUP: Yes.

MR HOLDEN: But I – I strongly believe he was telling me the truth. I mentioned it to Jackie Daniel [inaudible], and I mentioned it to David Tansley, my deputy, to try and get an idea of Graham's character, Geoff Hind, his colleague, and Jo Borthwick, Assistant Chief Executive, and I got the overall pressure nobody

– none of those people, and I asked them in that order, certainly Jackie first, I didn't get – I didn't see that – I didn't think that they were surprised by what I was telling them.

DR KIRKUP: Okay. Did he say who was asking him to make the changes?

MR HOLDEN: No, but he probably inferred it was through his line management. He was in the Nursing Directorate at the time, but I think it might have gone through to Chief Executives.

DR KIRKUP: Okay, so...

MR HOLDEN: But I'm only – sorry.

DR KIRKUP: Let me be absolutely clear about this. So we're talking about a previous Director of Nursing and Chief Executive.

MR HOLDEN: I would – I – yes. Previous, yes, not Jackie.

DR KIRKUP: Yes, yes, understood.

MR HOLDEN: Not Jackie Daniel.

DR KIRKUP: Okay. What was the general response from the people who you told, apart from the lack of surprise? I mean I understand lack of surprise, but they must have said something.

MR HOLDEN: Well they were – we were into the stage of me trying to fix it by then.*

DR KIRKUP: Mmm.

MR HOLDEN: So it was a case of whatever had happened, that's not how we were doing things by the time I was there. So that conversation may have happened in May or early June, so I – I'm coming into a scenario where I felt systems were broken, so there was – you know, I'm sat there thinking where do these people get their information? It was just – to their mind at that piece of time – at that moment in time, I think they were probably – I got the impression it was just another piece of news that isn't good about that Trust, but they were – certainly with Jackie Daniel, they were certainly trying to pull it out and improve matters. And I suppose there's a point in time where you can't keep looking back on what happened, but it was essentially about, 'Well, we don't do it like that now.'

DR KIRKUP: Yes. Yes, you do though, don't you, have to look back sufficiently...

MR HOLDEN: You do.

DR KIRKUP: ... to be able to acknowledge what's happened.

MR HOLDEN: You do, you do. And I guess at this...

DR KIRKUP: You can't put a line under things unless you achieve that.

MR HOLDEN: No, and I guess at this point, Jackie would also be thinking about setting up her inquiry in the Trust at that time.

DR KIRKUP: Okay. Any follow-up?

MR BROOKES: You talked about these monthly meetings, and that process you described to look at serious untoward incidents, etc. Would that be the serious incident requiring an Investigation Panel? I'm guessing it is on the basis that you've got a Non-Executive chairing, you've got CCG's involvement.

MR HOLDEN: Yes.

MR BROOKES: Does that sound – is that the right group?

MR HOLDEN: It sounds like it's the right group. We also invited the local area team.

MR BROOKES: Yes. It doesn't say that on this particular one. And I'm just interested – and I absolutely understand this is just one meeting I'm looking at – I have to say I was surprised when I looked at this meeting. There were 16 SUIs or investigation of serious incidents looked at of which half are maternity or children's and women's services incidents. Does that sound right proportionately or is this just an exceptional meeting?

MR HOLDEN: Well, there's a few things about that, those stats. One would be the emphasis, when I got there – before I got there, when I got there about who was reporting. So there would be a definite emphasis on ensuring that that division reported. There would be an emphasis on everybody reporting, but perhaps there was a concentration on ensuring that that division in particular reported.

MR BROOKES: I'm not saying it's wrong, I'm just...

MR HOLDEN: No. No, I'm not saying it's wrong. I'm just trying to say that it might be not that the maternity area is over or under-reporting, but the rest of the Trust may be perhaps under-reporting, for example. So whilst it might be an eight and eight, is it that the eight is a good number – is a number you would expect, or is it that the rest of the Trust are not reporting? So when I go there essentially, and for that period of time there was a constant piece of work to say, 'Report incident and risk,' and hopefully that trend has continued. But we were looking at what was reported, but given the lack of probable history in terms of what had been reported, it was about building – well not building up the numbers, but ensuring that people were reporting those numbers as they

occurred. So was the eight right in terms of the incidents that had happened? Was everything being reported? Was the eight for the rest of the Trust right or was that number under-reported? And it was about looking at trend over time.

MR BROOKES: Which is exactly the point I wanted to come onto, because there are consistent elements just on the summaries, from what I can see, though it's very difficult to tell. Was there any [inaudible] discussion about trends, about consistent issues that were coming up again and again in serious untoward incidents from anywhere within the Trust so that there was an approach that wasn't just case specific but looked at system issues and system failures?

MR HOLDEN: There would have been with Owen and his group looking at that at their weekly meetings. Those reports would have gone through to the working group looking at maternity services.

MR BROOKES: Okay, thank you.

DR KIRKUP: Is there anything else that you would like to say to us?

MR HOLDEN: No, I don't think so. I think in terms of the – the only thing I'm thinking is that just in terms of asking me about time periods, I think you would be seeing an improvement over time, but I wouldn't want to say that four or five months, when I was leaving that – you know, we'd seen improvement, but was it up to the standards you would expect in Trusts? I'm not...

DR KIRKUP: Sure.

MR HOLDEN: It was a work in progress.

DR KIRKUP: Sure, I understand. Okay, thanks.

MR HOLDEN: Okay.

DR KIRKUP: Thank you.

MR HOLDEN: I'm sorry I couldn't remember the detail of that report, the June report.

MR BROOKES: That's all right.

MR HOLDEN: There are lots of reports that I look at.

MR BROOKES: Yes, thank you for that.

MR HOLDEN: Thank you.

DR KIRKUP: Thank you very much.

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15th 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
Dr Geraldine Walters – Expert Adviser on Nursing

JACQUELINE HOLT

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DR KIRKUP: Good morning, thank you for coming. I'm Bill Kirkup; I'm the Chair of the investigation and I'll ask my colleagues to introduce themselves.

DR WALTERS: Geraldine Walters.

PROF FORSYTH: Stewart Forsyth; I'm a Paediatrician and Medical Director from Tayside, Scotland.

DR KIRKUP: As you'll notice, we are wired up for sound. We will make a recording of proceedings and will produce an agreed record of what's happened. You'll also be aware that we have family members present and [inaudible] in due course. You'll also know that we've taken away any mobile phones, recording devices, etc, from the panel, from the people in attendance and from yourself and that's because what we don't want is for any material to come out ahead of time. What we want is for all this to be produced as one record of findings in context, taking account of all the information. We also just ask you to bear that in mind when we've concluded our interview.

MS HOLT: Yes.

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

MS HOLT: No, thank you.

DR KIRKUP: Okay. I'm going to start off with a very general question just to get us underway and then I'll hand over to Geraldine to start following on from me. And the general question is can you tell us when you started at the Trust and what roles you've had?

MS HOLT: May I just remove my jacket?

DR KIRKUP: Please, yes.

MS HOLT: Yes. I started in the Trust in August 2008. I'd previously worked in

Liverpool at a specialist neurological hospital there and it was early August 2008.

DR KIRKUP: And what was the post?

MS HOLT: Director of Nursing and Modernisation.

DR KIRKUP: Okay.

MS HOLT: And I actually stayed in the organisation and stayed with the turnaround team and the new board up until June of last year.

DR KIRKUP: Okay. And in June last year you left the Trust.

MS HOLT: I left the Trust on a secondment in June last year, yes.

DR KIRKUP: Alright. Okay. Where did you go to?

MS HOLT: I went to – my original secondment fell through, but I went to work for the Royal College of Nursing for a year doing a strategic piece of work and I'm now working for myself.

DR KIRKUP: Okay. Thanks for that; that's very helpful. I'll pass you over to Geraldine.

DR WALTERS: Thank you. So, when you arrived in 2008, what were the big issues for the Trust then?

MS HOLT: Well, there were significant issues for the Trust. I came from a small, specialist organisation into a large, acute NHS trust which was challenged really in a number of ways. Let me think. There were a number of issues. They hadn't had a director of nursing for about 18 months. There was someone acting in that role with very little support really. The organisation was attempting to go for foundation trust status. I understand that they had deferred earlier, but they were picking that up again and running with the

application. They also had a site - I was referring to the fact that MB was a pilot site for the national IT programme in the national information technology programme, Lorenzo. They had also – I think the week I started they had implemented the acute services review. Now, the acute services review was essentially a downgrading of the accident and emergency department in Kendal and moving the medical wards also to Lancaster, so Kendal became the primary care assessment centre and there were no acute medical wards left in Kendal. Also, they were in financial turnaround. I can't remember the exact date that they signed out of financial turnaround. And the other issue, which I have to say I spent probably 80% of my time on the first 18 months, was turnaround of infection prevention. They had – earlier that year, they had the Department of health intensive support team in and, more latterly – I can't remember the date – we were signed out, but it was a significant challenge to actually turn that around, but we were successful in doing that.

In terms of nursing, on handover, there were no significant issues in terms of midwifery, neonatal care and paediatrics that I was alerted to. I was aware though, very shortly after, that there wasn't a nursing strategy in place or midwifery strategy and there was a lack of sort of systems around care standards and assurance. So I would say that as well as the work around infection prevention there was a, you know, a good two years of putting in fundamental systems to gain assurance around quality and care, which included implementation of [inaudible] board, developing board – ward to board dashboards and developing quality assurance terms and a framework to actually gain assurance from the systems and processes and outcomes for

nursing care.

DR WALTERS: And how long did it take to sort of get some of those systems and processes up and running?

MS HOLT: It took significant time. It took significant time. We launched – I would say it was a couple of years, really, to get those embedded.

DR WALTERS: And so they then reported to the board.

MS HOLT: The ward measures were reported to the board. The quality assurance tool, which was called our nursing and quality assurance tool and there was one for every department and we developed one of them for maternity, they reported to the board. We had meetings with the board, with non-executive directors to help them understand those tools and the findings and what they meant, yes.

DR WALTERS: And were they the same for midwifery?

MS HOLT: Sorry?

DR WALTERS: Were they the same metrics for midwifery?

MS HOLT: No. The quality assurance tool, there were some fundamental standards across the board for nursing and midwifery. More latterly, we revised that quality assurance tool to tailor it more to paediatrics and midwifery. And more latterly, we developed the maternity dashboard, which incorporated a number of metrics across maternity.

DR WALTERS: So, back in sort of 2008, 2010, what information were the board getting about maternity standards and paediatric standards?

MS HOLT: Going back, that's – it's hard for me to say when things went to the board, at what period and what time, so I couldn't be exactly, you know, I

couldn't be absolutely clear about what the board were getting in that period of time. But I do know that we did develop the ward to board metrics. I won't be able to give you the absolute detail on that question, sorry.

DR WALTERS: Okay. So, when you got there, around 2008, 2010, obviously there were a lot of issues going on: reconfiguration and financial turnaround, this sort of thing. What did the board spend most of its time on? What do you recall from the board meetings?

MS HOLT: There was quite a focus on foundation trust status. There were discussions around clinical strategy and configuration of services in respect of there being three small sites, well, relatively small district general hospitals, and issues around whether you could have all services on all sites and whether that was feasible going forward and viable. Prior to my commencing, I did attend some of the informal board sessions around foundation trust status. I was actually asked to help with a membership strategy for foundation trust strategy. That's all I can specifically recall at this moment in time.

DR WALTERS: So, in a nutshell around the sort of clinical improvement agenda, how did that sort of work in the organisation in terms of issues from the floor going to the board?

MS HOLT: Right. In terms of clinical governance, they – now, they had restructured the clinical governance team and the medical director line managed the team. They had had an absence of a very senior manager for some time, some years, I think, before I arrived there. There had been a restructure and during the foundation trust application the committees to support the board and the clinical governance committee were reviewed. From my recollection, there was

a risk committee, a patient experience committee and I believe I also referred to the clinical effectiveness committee- there were 3 sub-committees reporting to the Clinical Governance Committees ~~subcommittee –~~ and integrated risk. I was mainly responsible for patient experience. The medical director chaired the clinical effectiveness and integrated risk.

There had been – I do recall that they'd achieved Clinical Negligence Scheme for Trusts Level 2 standard in maternity and there was a lot of talk about bringing the leadership of that within maternity into the general part of the hospital to enable them to achieve NHSLA Level 2. The board delegated some authority to the clinical governance committee to deal with matters and I can't really recall any more detail than that. I mean, my recollection's better in the latter, you know, the latter two years really.

DR WALTERS: Yes. So, in those early days, what do you think the [inaudible] were the main risks and clinical quality issues in the organisation?

MS HOLT: Maintaining a viable organisation and having services – all services on all three sites I think was an issue for them.

DR WALTERS: And did they see what the risks were or the risks all around that or the quality issues around that?

MS HOLT: Let me just try and reflect on the discussions. I do recall, but it was very early days, that there were a number of clinical reviews in certain areas. I think one was paediatrics, one was ear, nose and throat and I can't remember the others.

DR WALTERS: So, just coming back to the sort of division arrangements then, who in the division – or particularly in the obstetric division, was responsible for

quality and safety?

MS HOLT: Well, there was a clinical team that was made up of the clinical director, I can't remember whether that was their title, nurses who actually some of the divisions had clinical governance—~~[inaudible]~~ Managers who reported professionally to the senior nurses in the division. And there were general managers within the division, but there was a restructuring at some stage in the early years in terms of the general management arrangements and, I think, in women's and children division that the structure changed a number of times in the time that I was there.

DR WALTERS: So, if I was a midwife in the division, who would I think was responsible for quality and safety, which individual?

MS HOLT: Well, I think that's a difficult question. I think everybody has a responsibility for quality and safety from ward departments through to the board. There were structures within divisions, I can't recall the exact structures, where there was a – where there were risk meetings, quality meetings within the divisions. And there would be some individuals who would be responsible for clinical governance within the divisions and risk.

DR WALTERS: So you, as the director of nursing, who would you expect to be reporting to you if there were problems? Whose responsibility would that be?

MS HOLT: I would expect the divisional leadership team to report to the executive team if there were problems and I would expect there to be various routes that people could use through the incident reporting system, through raising concerns through just coming to talk to you about problems. And I would expect everybody to have a responsibility to report issues or problems.

Obviously, as an executive member of the corporate board, I had certain responsibilities within my portfolio, but I also had a responsibility corporately.

DR WALTERS: So, I suppose the thing I'm struggling with here is that ad hoc reporting can be a bit random, can't it, whistle-blowing [inaudible]. If you had to identify the person you felt was sort of really holding the rein in that division...

MS HOLT: The clinical leadership.

DR WALTERS: The clinical leadership.

MS HOLT: Yeah and I think, you know, nursing, midwifery, medical leadership should be – that's my personal opinion, should be very close on that with the support of the general manager.

DR WALTERS: And who did they report to outside the division or who did they report to within the division? Who was the head of midwifery or the clinical director's boss?

MS HOLT: Right. The clinical director reported to the medical director. The head of midwifery had two lines of reporting: there's a professional line to me and there's a management line to ~~[inaudible]~~ **Divisional General Manger**

DR WALTERS: Right. I don't think I've got any more questions at the moment.

DR KIRKUP: I want to ask about incident reporting [inaudible]. Do you want to?

DR WALTERS: No, no, you can.

DR KIRKUP: Did you have any involvement with incident reporting and dealing with incidents that were reported?

MS HOLT: Yes, I did.

DR KIRKUP: Can you expand a bit?

MS HOLT: Well, I had more responsibility latterly when I was asked to take on

clinical governance at the end of about 2011. When I first came to the Trust, there was the governance committees in place and they had implemented an electronic incident reporting system. That was in place when I got there. I'm going to sort of recall my role in terms of taking over additional responsibilities. So, in 2011, I was asked to take on – become the incident and compliance director in addition to my responsibilities and that was to interface with the incident investigation, interface with the regulators, support maternity turnaround and improvement. Then, more latterly, in that year, I took on additional responsibilities because the medical director was asked to take on the responsibilities of the director of operations who left the organisation. So I then took on claims and legal services and basically, also, aspects of corporate governance, which was to basically rebuild risk systems, incident reporting systems, make them consistent across the three hospitals and the whole organisation. So, one of the significant things that I put in place was the serious untoward incident panel, which became the serious incidents requiring investigation panel. And the board approved that, the clinical governance committee approved that and I wanted – it was basically because I felt the scrutiny and assurance was deficient and it needed to improve. And I had two non-executive directors on that, one of them chaired it.

DR KIRKUP: Okay.

MS HOLT: And we looked at – we started to take a different look at how we viewed incidents in more depth and more analysis and we actually looked at – got clinical teams to present incidents, we reviewed them, we looked at lessons learned and we shared those in a lessons learned bulletin.

DR KIRKUP: What you're describing there sounds like some significant improvements. What I'm interested in is the other side of that as well, which is what did you make of the system when you inherited it? It sounds as if there was serious scope for improvement because [inaudible].

MS HOLT: Well, I remember that we saw an increase in reporting, so reporting number volume was low, particularly in women's and children's, because during the time of the improvement I think we had about 100% increase in reporting, you know, at that time when we put the new risk systems in and risk [inaudible], etc. I think, from what I recall from reports I've seen, there was a lot of statistics. There was statistics reported rather than getting underneath the statistics and understanding the actual nature of the complaints, the issues and the lessons to be learned from them and sharing those lessons through the organisation. I can't remember in depth a great amount of detail about the incident reports at that time, in the early days.

DR KIRKUP: Okay. But were there proper root cause analyses being done at that stage when you inherited it?

MS HOLT: Root cause analyses were being done, but not to an acceptable standard and quality. Training had been done previously, I understood, and additional training was also put in.

The other issue was these investigations we were undertaking, people also have a day job and also were part and parcel of that division and, you know, the way it operated. So we got some help from the strategic health authority to help us review, to help put in some training, but also to help us undertake a number of root cause analyses. So, for example, some maternity

incidents, we looked at a cluster of incidents where we were looking for themes and trends coming through.

But there were some early incidents that came to my attention within weeks of my getting there and there were root cause analyses undertaken, but also there were meetings with the medical director and the chief executive and myself and the clinical team about those individual incidents and we reviewed the findings and action plans. But with hindsight, how I see it is incidents were looked at individually rather than looking at the wider picture of the themes and the trends and the issues coming out of them.

There was also, in the early days, I know that there was a number of independent reviews, one on clinical governance in the division, one on a particular incident as well by independent people.

DR KIRKUP: Okay. I think we're going to be coming on to those and I'll hand you back to Geraldine.

PROF FORSYTH: Can I just –

DR KIRKUP: Oh sorry, sorry, yes.

PROF FORSYTH: The incidents that we're obviously focusing on relate to maternity and neonatal services. Can you tell me what your direct involvement was with those particular incidents?

MS HOLT: In the early days, the incidents?

PROF FORSYTH: Yeah.

MS HOLT: I was involved in a meeting about two – I was involved particularly in two incidents, in meetings when we looked at [inaudible] root cause analyses. I was also involved in helping the division develop a plan of action following

those and I think it was called a sustainability plan in terms of pulling together the actions coming out of those. And I was also involved in providing the regulators with – supporting the division to provide the regulators with the evidence of actions following those incidents.

PROF FORSYTH: I mean, on reflection of that, do you feel that things could have been done differently to achieve a better result, both from the families' perspective, from the service perspective, from the regulators' perspective?

MS HOLT: I obviously have been away from the organisation for over a year now and, you know, I have thought a lot about this and there are a lot of lessons to be learned, so that things could have been done very differently, with hindsight. I think there was – things could be, obviously, the first sort of line of assurance is with the board, but also there is a system responsibility as well and I wasn't aware of, in the early days, that much cooperation in terms of the system in actually taking on the assurance role. I also think there's more that could have been done. Well, I know that the staff, as far as I know, attended the bereaved relative after incidents occurred, but I think we could have maybe developed more early some kind of family liaison support and I think we should have potentially looked at more independent support with these incidents earlier than we did. Although we did get an independent review of at least one incident that I'm aware of.

DR KIRKUP: Just on that, if you had suggested those kinds of measures when you first arrived in the Trust, do you think you would have got a [inaudible] response?

MS HOLT: When I first arrived in the Trust?

DR KIRKUP: Was the culture in the Trust at that stage [inaudible]?

MS HOLT: What I recollect is the board were very pleased to have a director of nursing permanent in place and they hadn't had one in place for several years really; and that they felt that nursing, in particular, and I would add midwifery to that, was not that visible in the organisation. So I would say that they were receptive to me coming to join the board and the executive team.

DR KIRKUP: Would that have extended to thinking about things like better investigation of incidents, better [inaudible], better liaison with families?

MS HOLT: Well, as I took on more responsibilities and, you know, people were very responsive to the changes that I was making and the suggestions that I had. So I'm not – just can you let me pause a minute just to think through what I need to try and explain to you and articulate it as well as I possibly can?

DR KIRKUP: Sure.

MS HOLT: With hindsight and however many years has passed, what we didn't have was a system that was robust enough to do deep dives in the divisions to actually go in there and really spend time alongside people to understand how the culture worked, what the team working was like. We had systems where divisions escalated things up, but in the latter stages, obviously, the board wanted more assurance and then we actually – I can give you some examples of that, if you wish me to do so.

DR KIRKUP: That's okay.

MS HOLT: You know, more assurance in terms of deep dives, going in there, actually working alongside teams and actually trying to understand how they functioned.

DR KIRKUP: Okay, thank you. Stewart. Sorry.

PROF FORSYTH: That's alright. I mean, just in relation to that, I just wonder whether an example in terms of there seemed to be a change following on from 2008 of trying to run the Trust very much more on a area-wide basis rather than having three separate unit managing almost in isolation but not quite. And I wonder whether some of the changes there – well, there was certainly an opportunity to look at what was happening at sort of ground level, but the sort of impression that one gets is that it was – this is how we're going to do it rather than look at the individual needs of staff and units and patients, of course. I just wondered whether again you were involved in the sort of reorganisation of the staffing and then sort of adopted an area-wide approach.

MS HOLT: In some divisions there were actually posts that worked across Bay and there were some examples of that in terms of senior nursing. There were some examples of that in terms of medical support as well, but I think more predominantly each unit functions in their own way, but there was some evidence of some cross-Bay working. The senior matrons certainly worked across Bay and, more latterly, when I did go and ask for additional support and/or two deputies to come and support me, they actually worked on site and ran the site together with the lead medics who were appointed. But I wasn't... I'm not – if you can just try and explain to me what you're trying to get at –

PROF FORSYTH: Well, what I'm getting at is, for example, there were some changes made in Furness General Hospital in midwifery and regarding, which seemed to have a major impact on the midwives in the unit and it has been claimed had an impact in terms of how they work within the unit and, in

general, morale.

MS HOLT: Regrading, right. I do recall it not being clear who was in charge and the band 7 level being looked at as it was more clear about who's in charge. I believe that I was referring to the fact that amongst the band 7's there was no clear leadership for the different areas such as maternity ward, labour ward etc. The restructuring made this clearer by appointing identified individuals as band 7 leaders for these areas. I don't recall any specific information. I think when the band 7s were identified there was a personnel process that was gone through to identify [inaudible] those. I can't recall the specifics. And what you're saying is that appears to have had an effect on the morale of the staff. Right. I think any reorganisation in terms of human resources, personnel, restructuring – and there were a number of reorganisations in that Trust – will naturally have an impact on staff morale, because people have to go through processes and [inaudible] really. That's really all I can say to you.

DR KIRKUP: Okay. I'll hand you over now to Geraldine.

DR WALTERS: When you arrived at the Trust in 2008, did you have a look at the staffing levels?

MS HOLT: There was a review of staffing levels by the Audit Commission, I think, quite early on, which I think basically said that staffing levels were acceptable across the Trust. But more latterly, there was a review of maternity services and a review of general medical I was referring to investment in general medicine not general medical. In regard to this comment I thought I had referred to investment of around c£2m into nursing and midwifery over time although this was incremental, in particular, and there was investment put in.

Some of that investment went in incrementally.

DR WALTERS: So, in terms of the sort of one to 28 guidance, do you know what the position was when you –

MS HOLT: I can't recall that at all, I'm sorry.

DR WALTERS: So, until 2008, was there any reason to sort of have concerns about midwifery or obstetrics or – and I'm thinking about before the sort of sequence of events which led to the commissioning of the Fielding report?

MS HOLT: When I arrived there, at handover I wasn't alerted to any concerns. You know, what dominates my recollection is the infection prevention issue and the care system [inaudible]. I think there had been – it might have been more latterly – issues about paediatricians and rotas and I can't remember the timescale that that occurred, but there were some issues about being able to staff paediatric rotas, which was an ongoing issue and being able to recruit ~~[inaudible]~~ I said Consultant Paediatricians - there was an on-going problem recruiting to these posts.in particular.

DR WALTERS: So, the five incidents which sort of led to the commissioning of the Fielding report, can you remember how all that happened and how that review came to take place?

MS HOLT: Well, I remember the two specific incidents around and in the autumn, just sort of weeks really after I got there. And then I remember more, after that, there were a number of other incidents that came to light and I know that a number of them were subject to inquests at a later date as well. I know that there was the in-house root cause analysis of – I recall one in particular that I was sitting in on – one meeting I was sitting in on. I know that independent

clinicians were asked to come and look at one particular incident and also that an independent consultant was asked to look at clinical problems within that division at the time.

DR WALTERS: And did that lead to cause of concern or was it just thought to be a random selection of incidents that actually could happen anywhere?

MS HOLT: I don't think – well, obviously any incident raises alarm bells and an incident needs to be analysed and investigated appropriately through the systems of the Trust. I don't think alarm bells rang in terms of there was a connection between incidents. I think – I believe there were a couple of incidents that happened prior to when I went to the organisation that were extremely traumatic, rare – rare events. And that's all I can say.

DR WALTERS: So when that report was commissioned – and I appreciate this might be quite difficult to answer, but do you think the board and the executive were under the assumption of well, we need to show that we're looking at this seriously, but actually we don't believe there's a problem?

MS HOLT: Right. I do not believe this means that I was agreeing with the question, rather it was a form of speech I believe. I think there was a feeling that there had been an independent review, there had been a clinical governance review, there had been the in-house root cause analysis of incidents and that the board needed to move forward in terms of more developmental – you know, developing and moving forward rather than going through another independent review looking at very specific issues, I believe.

DR WALTERS: So the Fielding review took place and how was that then received by the Trust? What happened as a result?

MS HOLT: Well, what I can recall about the Fielding report was that there was a meeting with the author of the report with the executive team or members of the executive team, I can't remember exactly who was there.

DR WALTERS: Were you there?

MS HOLT: Yes. I remember being at one meeting, yes. And I also recall that there as a meeting with the clinical team about that report and there were not – I was there, but I can't remember the detail of it, but the report was shared with the clinical team. I also recall working with independent auditors to get assurance on the back of the – actions on the back of the Fielding report. And I know it went to board. I can't remember when the report went to board, but it did go to the board.

DR WALTERS: And what were the changes that were implemented as a result of the actions? What actually happened on the ground?

MS HOLT: Specifically... All the action plans, to me, get merged into – there were that many action plans, I'm trying to think what –

DR WALTERS: There was quite a tricky one, I thought, about out of hours theatres being available for [inaudible]. Can you tell me what was done about that?

MS HOLT: I recall there being, you know, anaesthetic rotas being looked at, but I can't recall the timescale and I recall additional anaesthetic support being arranged. I can't remember the detail about anaesthetics and theatres, I'm sorry. Unless, you know, if there's anything that you can provide me with that I can have a look at which would help refresh my recall, I'm happy to do that.

DR WALTERS: I suppose it sounds like that that report wasn't a big event in the organisation. The outcome of that report wasn't a sort of big event in the

organisation which led to quite a lot of scrutiny of the actions and the secondary assurance. That's sort of how it comes over. Correct me if I'm wrong.

MS HOLT: I think it was seen as a developmental report rather than a, you know, an independent investigation and review, of which there had been many. I have to say that I did spend time – you know, I know that I talked to the clinical team and the head of midwifery about it and I also know that I was involved in gaining assurance with the fully independent auditors with the team to gain [sound reflections?]. Whether – and this is, you know – whether that report was embraced by the clinical team I don't know, and owned by the clinical team, I could not say.

DR WALTERS: But there wasn't a sort of management imperative to try and drive through, through the management route.

MS HOLT: Well, I can't recall when that report went to the board, if it went to clinical governance. That would be – the normal route would be things to go through the divisions, through the subcommittees, through clinical governance and to the board. That would be the normal route. Obviously, more latterly, those structures and systems were really made much more robust.

DR WALTERS: So, the sort of driver for everything becoming more robust seems to be the next little cluster of reports, which was around Central Manchester and Gold Command being set up. Would you agree?

MS HOLT: I think Monitor have their first intervention around about the autumn 2011 and that followed – there was an inquest in 2011 and there was, following – I think that might have been summer some time and then following

that – following that, obviously the regulators were in, the Care Quality Commission and the Nursing and Midwifery Council were in.

DR WALTERS: So it sounds like, from what you're saying, that those things generated some quite fundamental changes in you were asked to take over more of a governance role and set up more systems and put them in place.

MS HOLT: Yes. We also had Monitor – they intervened twice. They intervened in the autumn-time and they intervened again later, where [inaudible] interim chief executive came in and there were a number of areas that the Trust had to address in terms of putting in place ~~[inaudible]~~ **a Programme** management office, putting in place the Manchester Diagnostic Review. Those were the main things and [inaudible] PWC Governance Review, which Monitor –

DR WALTERS: So, do you think it was Monitor's intervention that was the turning point?

MS HOLT: Well, Monitor's intervention was certainly a turning point for the organisation, absolutely. Prior to that – and I can't remember the date exactly – the strategic health authority intervened in terms of the risk summit and actually there was an intervention and the Gold Command system was put in place, which was about getting the system to bring forward the resources and provide the capacity and capability for the organisation to drive the improvements at pace.

DR WALTERS: And did that really make a difference?

MS HOLT: The Gold Command or the Monitor intervention?

DR WALTERS: Both.

MS HOLT: Well, we then had a situation where the organisation was under extreme

scrutiny. There was a lack of capacity initially to deal with them, I think. I have to say, personally, trying to manage the day job, the day job has to keep being delivered to patients, and trying to manage an incident of a scale that was expanding was – I've never faced anything like that in my career. But it was extremely difficult and, I think, initially, when they had the risk summit and Gold Command was instigated, it felt very much like, you know, there was huge blame that was being pointed towards the organisation. I think, as Gold Command matured there was more support, more collaboration, additional support and systems were put in place to support the organisation. Personally, I feel that – I was the lead executive for Gold Command and sometimes those meetings were twice a day. Gold Command continued for some time. I do think that when ~~[inaudible]~~ I was referring to the turnaround team under the leadership of Sir David Henshaw- February 2012 came in additional resources came in and additional support was given, but actually the board was quite depleted still at that time and it was – you know, there was such an immense pressure to do things right but do them quickly and move at pace that, well, you know, it was very difficult.

DR WALTERS: Do you think things improved or not at the frontline?

MS HOLT: I saw improvements at the frontline, because around about that time – this would be autumn 2011 and the Manchester Diagnostic – I actually spent probably half of my time based at Barrow and walking – every time I was there, walking about, meeting teams [inaudible] I saw improvements. And I actually think it took some time to see a transformation, maybe, in the culture and the attitude, because I think some of the staff felt victims of some of this, but

actually I did see change. I'm not saying it happened quickly, but I did see change and I – you know, I was there a lot. I was physically there half my week probably.

DR WALTERS: And do you think that should have happened sooner?

MS HOLT: With hindsight and knowing what I know now, I think we all had lessons to learn.

DR WALTERS: And did you look for any tangible assurance that things were improving?

MS HOLT: Right. Well, there were a number of things in terms of getting assurance. One was to get some systems and processes in place and make sure that the way the division reported through there was much more robust clinical governance. So that was for every division there was a rotation of divisions coming to the clinical governance committee, presenting their quality standards and quality measures, talking through issues, standard performance. So there was, you know, statistics, but there was also a serious untoward panel, which actually changed the way that we looked at serious incidents and how we actually did learn lessons and share those lessons.

There were walk-arounds by other executives as well as myself, just to be informal, chat to people, pick issues up, deal with things on the spot if necessary.

There was an obstetrician who came to do a review at some stage from another trust; I can't remember when that happened. There was also a consultant midwife who came in to spend several weeks, I think, working alongside staff.

More latterly, because I wanted more assurance on the workings of the clinical governance in the division, there was a clinical governance manager brought in to do a review and it was actually to physically be there, look at the data, look at the information and see how the divisions were working in terms of clinical governance.

We continued to use independent auditors to give assurance on certain actions.

So there were, obviously you can see that throughout that time the intensity and the level and degree of assurance improved.

DR WALTERS: And just before I let my colleagues in, why do you think this all took so long?

MS HOLT: Right. Okay. I think what you had there was a small unit out in a remote part of the north west, not really exposed, maybe, to up to date practice in the way it should be. Although there was rotation between the units, I think there was a degree of lack of wanting to be an integrated unit across the Bay. I think there were three separate trusts at one stage that were merged sometime in the '90s. I think it was difficult. I've thought many times would I have known that some of those things were happening unless I'd have been in there every day with people, working alongside them. And I don't think I would unless I'd have been there.

DR WALTERS: Well, some of the early assurances externally were quite positive, weren't they?

MS HOLT: Some of the early assurances were quite positive. Obviously, we learned our lessons about assurance and the difference between reassurance

and assurance.

DR WALTERS: Thanks for that.

DR KIRKUP: Can I just pick up something on the Fielding report? Firstly, wouldn't the Fielding report have indicated that there were things awry in the maternity unit?

MS HOLT: I'm sure that the Fielding report may have indicated things that had improved, maybe, since the incidents and things that may be requiring further development. I'd have to look at the Fielding report again to give you more information. I'm very happy to do that.

DR KIRKUP: No, it's okay. What was your perception of the action planning process after the Fielding report?

MS HOLT: In terms of generally across the Trust or in terms of...?

DR KIRKUP: I'm particularly interested in what the board's view was and what the unit's view was.

MS HOLT: Right. Well, I can say, with hindsight again, that the action planning process wasn't robust enough and that following up on actions – and I know that other independent reviewers said following up on actions wasn't robust enough and the organisation didn't do that well enough.

DR KIRKUP: I'm concerned about the signal that the board was sending about the Fielding report. Do you have a view on that?

MS HOLT: I don't – I can't really recall the signals that were being – I'm sorry, I -

DR KIRKUP: Let me give you a prompt. Some of the correspondence after the Fielding report and about the action plan, I mean, you actually said at one point it's for the division to decide whether to adopt the recommendations.

MS HOLT: Did I?

DR KIRKUP: I'm not trying to trip you up. I'm just using that as an illustration of – I mean, looking at that cold, it seems to me that there was a lack of ownership by the board. It was almost as if you're passing the Fielding report to the divisions and saying, 'Think of it what you will'. Now, I'm asking you is that a fair perception on my part or is that not how you remember it?

MS HOLT: Well, I don't remember that, but obviously you've got something there that I haven't got access to and, as I have said to you, I think, you know, action planning was deficient early on and it improved as time went by. I reviewed the evidence referred to by Dr Kirkup in October 14 at the Preston office. I provided additional comments in writing via email and letter dated 22 November 2014

DR KIRKUP: Sure. Okay. Stewart.

PROF FORSYTH: You were just indicating previously that things were improving and you had good governance systems in place, etc. Did you feel, at that stage, you could say publicly that the maternity lead services at Furness General Hospital were safe?

MS HOLT: At which time, sorry?

PROF FORSYTH: Well, prior to you leaving the organisation.

MS HOLT: In 2013?

PROF FORSYTH: Yeah.

MS HOLT: Were they...?

PROF FORSYTH: Safe.

MS HOLT: Safe. Well, certainly there had been assurance and – well, actually, I

think the Care Quality Commission had been back and reviewed some of the areas where there were enforcement warning notices and had said the minimum standards – they're complying with the minimum standards in that unit. I think the Manchester report follow up review felt that there was still more assurance to get in terms of the quality of the services. I can't remember the exact details. And I know – I think they recognised that lots of change had taken place, but there was still more to do and that the –

PROF FORSYTH: So what were the main things still to do?

MS HOLT: Gosh. I think there was an action plan after the follow up review of the – with the outstanding actions in place that ran view a programme management office. I think there may have been... Some of the issues, I seem to recall [inaudible] issues that were still outstanding.

PROF FORSYTH: Sorry?

MS HOLT: Some of the medical issues were still outstanding. I can't remember the specifics. We put additional staffing in. We'd been working on the guidelines and we'd been working on CNST Level 1. We had a medic leading on those guidelines. I was leading on CNST Level 1 accreditation at that time. I can't remember, I'm sorry.

PROF FORSYTH: And can I ask – I mean, did the Trust executive team feel they were taking responsibility for all the issues whereas there may be strategic issues, other external issues that are part of the overall resolution of the problems?

MS HOLT: Right. I do recall that the executive team did become very involved in operational issues and that was said by some of the reviewers, some of the

governance reports that came out. And I do know that, as a system, some of the strategic issues around reconfiguration of services had to have buy in and leadership from clinicians and I obviously know that before I left there was a clinical strategy lead developed and the systems were working through the organisation. Prior to that, I can't remember a huge degree of cooperation in terms of the wider strategic issues in the system.

PROF FORSYTH: Did you feel that executive [inaudible] at times trying to make a system work which was unworkable?

MS HOLT: I think it was extremely complex and challenging. I've never worked in a system that was so challenging. I come from the outskirts of a city or worked in, you know, cities most of my life. I think the challenges were extremely difficult and I think there was enormous pressure on commissioners to maintain all services in all parts of the organisation right across the Bay.

PROF FORSYTH: Okay, thank you.

DR KIRKUP: Do you want to ask anything?

DR WALTERS: No, thanks.

DR KIRKUP: How did the board function? What were the relationships like –?

MS HOLT: I thought – I spent some time with all the non-executive directors when I went there and I also spent time with the executive directors before I went to work there, so I've been doing some research and, actually, how did the board function? I would say I was – me, personally, going in I was welcomed [inaudible]. From one or two executive directors in particular there was a lot of support too for the things that I was doing in the organisation. I spent time in informal board sessions as well formal board sessions where we were talking

about foundation trust status, for example. I think there was a perception – well, by others there was a perception – and this is after reviews, etc – that the non-executives of the board were not – didn't scrutinise and challenging, but I've also been on other boards where that's been a similar case. I just felt – I felt supported when I went in there and I felt there was a large degree of – I was valued.

PROF FORSYTH: You're describing a good team.

MS HOLT: I'm trying to think of how I would describe [inaudible] team and, with hindsight, what that would look like. I think all teams can improve. I think, I had had knowledge of board working prior to going there and I didn't see there were any significant differences from one board environment to another board environment.

DR KIRKUP: And did you get a fair share of their time, as director of nursing? Your issues were as important as people's to the board.

MS HOLT: I believe I did and I believe, over time, in particular, I spent – because of the additional responsibilities I took on at times, had a lot of papers going to the board and I got a reciprocal amount of their time at the board and clinical governance committee.

DR KIRKUP: How did the division responsibilities work between you and the medical director? I mean, you've described who did what, but how did that function specifically?

MS HOLT: I think it was – more latterly, I think it was more a closer working relationship. I think I said to you that the medical director had clinical governance responsibility and actually line managed the clinical governance

team, which there had been a bit of restructure.

DR KIRKUP: I'm sorry?

MS HOLT: I think in the latter stages, particularly just before – well, when the turnaround team arrived, it was much more this is dual responsibility, nursing director and the medical director working together to support the improvements. And then I actually took on responsibility for clinical governance, but... I would say I got on well before the medical director and I also think I worked well with the – when the medical director took up post when the turnaround team arrived. The meaning I believe was that I got on well with the former medical director and the newly appointed Medical director when the turnaround team arrived.

DR KIRKUP: You weren't aware of any issues that might have fallen in the gaps between you, for example.

MS HOLT: I can't recall anything at that specific time.

DR KIRKUP: Okay. You mentioned a system in the early years where the divisions were responsible for escalating concerns. What concerns were you aware of for the maternity, whatever the [inaudible] they were in at the time [inaudible]? What concerns were they escalating?

MS HOLT: In the early years?

DR KIRKUP: Yes.

MS HOLT: I have to say I can't recall significant concerns in the early years. I recall, more latterly, the concerns after the incidents and the concern about paediatric rotas, which was talked about a lot, recruitment to some – you know, to [inaudible].

DR KIRKUP: You were made aware of any concerns about safety.

MS HOLT: In the early case – initially, when I got there, it didn't feature significant – it didn't feature in the handover that I had. For clarity – I was referring to the handover I received from the Acting Director of Nursing when I arrived at the Trust in August 2008.

DR KIRKUP: Or the staff concerns that they might not have had the experience and skills to do particular jobs they were being asked to do.

MS HOLT: I can't recall.

DR KIRKUP: Any more questions? Go on.

DR WALTERS: So what did the nurses and midwives used to sort of tell you about in your interactions with them?

MS HOLT: Incidents.

DR WALTERS: I usually get a load of moans when I walk around, because I ask –

MS HOLT: Some of these are mine – you know, to there – you know, I can't get something done, so I would refer to – in the [inaudible] if there was a problem. I'd say, 'Right, that needs to be sorted'. Sometimes we can't get the estates to do this for us, we can't get people to do that for us. Those sorts of things, incidents, staffing sometimes... A whole range of things really. For clarity, I was explaining how people raised concerns that they could not get responses for example from the estates department. I would intervene to get responses and this was appreciated. I mentioned how I was known to some as the person with the 'golden phone'- inferring that if I intervened people would respond.

DR WALTERS: What about your sort of working relationship with the head of midwifery? What did you used to sort of share in terms of issues?

MS HOLT: I had one to ones with line managers like, you know, professional line managers and then I had, you know, did appraisals. More latterly, I felt that appraisals should be a three-way thing: it should be the general management, myself and the heads of nursing and the heads of midwifery. I had one formal one to ones. I had walkabouts. They were part of the nursing and midwifery strategy group. After we developed the nursing strategy, the midwives, I was involved in their focus groups developing the midwifery strategy. That's what my relationship was like.

DR WALTERS: So the head of midwifery wouldn't sort of share her concerns that she had or there wasn't anything specific shared.

MS HOLT: Well, obviously there were concerns shared and obviously when the incidents occurred there were concerns shared and also, you know, as improvements were being made the head of midwifery had a responsibility to provide any evidence that improvements were being made and actually coming forward to the clinical governance committees, etc, to talk about those things.

DR WALTERS: And you were talking about your relationship with the board. Did you ever have [inaudible]?

MS HOLT: Well, we took the ward to board measures, sometimes they had metrics, but I felt that we had to show [inaudible]. We had to talk about the areas where the things were sufficiently [inaudible] to talk about what we were doing about them. And actually, I thought it was really, really important that they didn't just hear it from me [inaudible], they also heard it from people nearer to the frontline. So I would bring the frontline senior leaders into the boardroom to share that information and talk through how they were addressing things.

Also, we had supervisors of midwives, certainly, at the board once, but also at the clinical governance committee. I thought it was important that the board heard it from people who were, you know, closer to the frontline to support really any arguments or what's happened really went straight into the board and how we're addressing issues.

DR WALTERS: Did you ever have to take an issue around actually we shouldn't be running this service in this way unless we put more money into it, because of clinical risk?

MS HOLT: Well, latterly, there was the – the medical director and I, there was the issues around the special care baby unit at the level one unit at Barrow, which went to the clinical governance executive team and the board on more than one occasion. There was a feeling obviously that because of the staff sickness, the very small unit, small number of staff, it was depleted considerably, there needed to be some decisions made about whether it was safe or advisable to keep the service in place. And the board made the decision to relocate the service for a temporary period of time over to Lancaster because of the staffing issues. That decision was halted, because the commissioners felt that wasn't an acceptable approach.

DR WALTERS: What year was that?

MS HOLT: That was later on in my time there. It might have been – I know Sir David ~~Henshall~~ Henshaw was the Chair at the time, so it was during the time he was there.

PROF FORSYTH: So, just to be clear on that point, so the decision was what when it was discussed at the board?

MS HOLT: The board decided to relocate the service to Lancaster for a temporary period of time whilst we tried to get additional support in for staff [inaudible]. The commissioners didn't feel happy about that decision and actually it didn't happen, it didn't go forward, that decision.

PROF FORSYTH: So were they aware that continuing to look after babies that would require more intensive care than level one was a breach of governance?

MS HOLT: Sorry, can you just say that again?

PROF FORSYTH: Well, level one care is really midwifery-led care in the neonatal [inaudible].

DR KIRKUP: I don't think that's quite [inaudible]. This was a temporary crisis of staffing caused by absence and sickness and it was not continuing the level one unit in Barrow that was easy. Is that correct?

MS HOLT: It was the level one neonatal unit that couldn't be staffed safely. Two staff on every shift, it was a very small unit.

PROF FORSYTH: But I think in general terms the unit at Barrow was probably caring for babies above its level one status.

MS HOLT: You felt it was?

PROF FORSYTH: A number of cases cared for in the unit were –

MS HOLT: And hadn't been moved down to a level two or a tertiary service [inaudible].

PROF FORSYTH: They should have been transferred out or you then have to raise your status [inaudible].

MS HOLT: Well, we had systems in place to transfer babies out, yes, to – sorry?

PROF FORSYTH: I think the point I'm trying to make is that level one status in

Barrow was being breached probably because they were looking after babies with more serious medical problems than there probably were staff [inaudible] facilities for.

MS HOLT: I can't say. I mean, you're putting words into my mouth there. I would have to look at the information to --

PROF FORSYTH: I just wonder whether – you're not aware of there being any discussion around that at executive level.

MS HOLT: I remember the clinical team going to board and talking about changing the way the neonatal service worked and relocating the neonatal unit onto the postnatal ward. That was, you know, not long before I left really that it happened, it was implemented. And I remember discussions about different levels of care. I can't remember anything else, I'm sorry.

PROF FORSYTH: Okay, that's fine.

DR KIRKUP: I think that we need to move on. We've got a couple of questions that we'd like to ask you that will raise issues of patient confidentiality, so can I just ask for a brief pause while we clear the room, please.

[*Attenders withdraw*]

THE MORECAMBE BAY INVESTIGATION

Friday, 10 October 2014

Held at
Park Hotel
East Cliff,
Preston
PR1 3EA

Before:

Dr Bill Kirkup - Chairman of the Investigation
Ms Jacqui Featherstone - Expert advisor on Midwifery

DR ANN HOSKINS

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two year post. And then I took on, from I think it's April 2011, I was Interim Regional Director of Public Health. And that's when the reorganisation started and I was basically supporting transition. And then from March 2013 moved to Public Health England.

DR KIRKUP: Where you still are?

DR HOSKINS: Pardon?

DR KIRKUP: Where you still are?

DR HOSKINS: Where I still am, yes. Sorry.

DR KIRKUP: Okay.

DR HOSKINS: And I went to – I was Director – yes, I was Director, Children and Young People and Families in Public Health England but I've recently taken on a new role, which is Deputy DIRECTOR Health and Wellbeing ~~Director~~, heading up Healthy People Division.

DR KIRKUP: Right, okay, is that a national responsibility?

DR HOSKINS: National responsibility. And the Children's one was a national responsibility as well.

DR KIRKUP: Okay. I think that the period that we'd be most interested in would be 2006 to 2011, when you had firstly a clinical governance responsibility, and then a responsibility for Children, Young People and Maternity. Perhaps I could just ask what your responsibilities were when you did the Children, Young People and Maternity. How did the post operate?

DR HOSKINS: Okay, ~~well I was – in that role I was~~ – it was a joint role between the Association of Northwest PCTs – Primary Care Trusts – and the Strategic Health Authority. So it was a joint role, and so I was accountable to Mike FARRAR, but also accountable to Anita Marsland who ~~chaired the~~ – took the Children's lead for the Northwest Association of PCTs.

DR KIRKUP: Yes, okay.

DR HOSKINS: And within that role – I wasn't an Executive Director of the SHA, and took on working really – which I had done beforehand, I was interim for a while. – Bbut from the ~~being~~ BEGINNING ~~– from~~ when ~~the first,~~ the SHA was set up, I'd set up a joint post between the government office northwest and the strategic health authority.

So at that time we had the government office northwest that HAD A ~~was~~ ~~a~~ Director of Children and Learners, I think they were called, and they had that

what they were doing around implementing maternity matters at that time, and we took quite a focus, from the sort of public health perspective, around the ~~12 year –~~ 12 week access. To make sure that women were getting access to antenatal care by 12 weeks. Because that's such an implication about QUALITY ~~[inaudible]~~ there, and OUTCOMES.

So those were – and also at that time it was around an overview of the every child matters and the Children's National Service Framework. So those were the sorts of areas that I was working with.

DR KIRKUP: Okay. That's a pretty broad range of things to get to grips with, with that sounds to me like a fairly heavy load of health improvement and service development and strategic configuration issues. All of that sort of thing. Did you have a responsibility for the existing services and the commissioning of existing services, and the monitoring of existing services?

DR HOSKINS: No, well, depending – from when I first started at northwest as a deputy, then we had clinical governance in our teams. So we had an overview of clinical governance, ~~so when that –~~ we were looking at the serious untoward incidents and how they were managed, and so we had that sort of overview as a team there, that was looking at both risk management and serious untoward incidents.

So that was within the remit. But then when, from March 2008, that moved over to the Director of Nursing, so I didn't particularly have a role in the clinical oversight of individual trusts, or the clinical oversight of performance. That was all undertaken underneath the performance directorate.

Obviously, if there was any issues where there was a need for maternity input, I had a midwife in my team who was leading all the sort of overall strategic or other maternity matters. And she would support ~~the sort of~~ – the ~~sort of the director, or~~ the director of nursing, and the head of ~~the sort of~~ clinical governance, underneath the Director of Nursing, around giving midwifery input and advice. But the lead was with the Director of Nursing.

DR KIRKUP: Okay. When you were doing the clinical governance side of things for the first two years, 2006, 2008, how did you work it? What did you do?

DR HOSKINS: Well it was let under ~~– with the director –~~ Head of Clinical Governance, and so we had that overview of working with the trusts. Seeing about what their risk management system, supporting and judging their clinical

take? Was that you or the medical ADVISOR~~director~~?

DR HOSKINS: That would have been the medical ADVISOR (SECONDARY CARE) ~~medical director~~ with the lead for clinical governance. So they would review all the clinical incidents, and the – and just see what was happening, what was going on. We had a primary care advisor as well. So they ran a review of what were the action plans, what was happening, and if they were happy with them. And if they weren't they would follow them up.(WORKING WITH THE NURSE WHO LEAD CLINICAL GOV.)

DR KIRKUP: Okay. I ask everybody the same thing at this point. Can you put names to posts there please, because it gets very confusing for us trying to follow who's who.

DR HOSKINS: Right.

DR KIRKUP: Who's the Medical ADVISOR (SECONDARY CARE) ~~Director~~ and who's the Primary...

DR HOSKINS: The Medical ADVISOR (SECONDARY CARE) ~~Director~~ was Peter Morgan-CAPNER~~Cavanagh[?]~~.

DR KIRKUP: Okay.

DR HOSKINS: And he used to be Medical Director in Lancashire Foundation Trust. In fact he was Chief Exec there for a while. Then he retired and he came back and worked with us, certain number of days a week, I can't remember...

DR KIRKUP: Okay. And Primary Care?

DR HOSKINS: Primary Care was DR Stephen Ward.

DR KIRKUP: Okay. And how did that system change when you went to the – when the organisation became the Northwest SHA?

DR HOSKINS: When it became the Northwest SHA we – we had primary healthcare advisers, and we also – Ruth Hussey was the Medical Director, and the RDPH. So she sort of took on the Medical Director role.

DR KIRKUP: Okay.

DR HOSKINS: As well as RDPH.

DR KIRKUP: Okay.

DR HOSKINS: And then, of course, in due course that role was split off and the Medical Director, DR Mike Cheshire, joined the organisation. That was in 2010 and that's when the Regional Director of Public Health role and the Medical Director role sort of split off.

known? Would you have been the next person who got to know, 'There's something of concern here, we need to look at this.' Would that have been you, who was asked that question?

DR HOSKINS: Yes. And I think we would have discussed it together, yes.

DR KIRKUP: Yes, yes, okay. And what action would you then have expected to have taken?

DR HOSKINS: I would have expected to go out and talk to the trust and see what was going on, and work with the medical directors and pick up the issues, and also working with the Director of Nurses as well.

DR KIRKUP: Yes, okay.

DR HOSKINS: So we would expect to go out together to look at – if there was an issue, I would go out with Angela to see what was the challenge.

DR KIRKUP: Right, and after the switchover, would that have been the Director of Nursing who then took that role on?

DR HOSKINS: Yes.

DR KIRKUP: So you weren't involved after that?

DR HOSKINS: No.

DR KIRKUP: Can you just, for the record, can you just be a bit more precise about exactly when that transfer occurred? It's either 2008 or 2009. I just need to pin it down.

DR HOSKINS: No, no. In March 2008 clinical governance moved to the Director of Nursing.

DR KIRKUP: Right. March 2008.

DR HOSKINS: Sorry. ~~2009. No, that was – no,~~ March 2008.

DR KIRKUP: Right, okay. Then in May 2009 you became responsible for Children, Young People and Maternity, and you've described the breadth of the role. In that capacity though, if there had been any – let's keep calling them hotspots – being logged with the Director of Nursing, would you have been involved in any of those discussions? If they had been incidents related to any of those services?

DR HOSKINS: I would have been sort of kept up to date if there was something around maternity. And then so – so when the Morecambe Bay incident happened I made sure that my maternity lead, who was Mary Bell, was supporting whatever was going on. But I didn't get directly involved in it.

CEMACH (Confidential Enquiry into Maternal and Child Health) ~~CMatch[?]~~ to – this was just after they were nearing finishing – got them to sort of compile all the returns from the child death overview panel.

So we did that overall report in the northwest about why children died. Obviously quite a high proportion of those were sort of presenting CONGENITAL abnormalities and things like that. But within that, we did ask to say are there any areas that there's outliers, or anything that we should worry about? But there was no – no sort of outliers identified within that process.

DR KIRKUP: Yes, that's one of the features of this. That if you look at it at a high level, the total numbers, there wasn't anything to raise concerns.

DR HOSKINS: Yes. I think that is the challenge. But so the more detailed, granular stuff that would have warned you and picked that up was being led through the performance management and the – sort of the clinical governance route, which I wasn't leading on...

DR KIRKUP: Yes...

DR HOSKINS: And again...

DR KIRKUP: But you were supplying expertise in the shape of one of your staff, which is a point that I do want to pick up. Because one of the issues here is that somebody in the SHA has formed a view, at a relatively early stage, that five maternity SUIs that occurred in a fairly short space of time were all unrelated. And therefore that there wasn't any issues of systemic concern. Were you aware of that? Did you have any knowledge of that?

DR HOSKINS: I remember there was – there was, in Cumbria, there were a few maternal deaths. And I did ask Mary – Mary Bell – to look into each one of those, to make sure that we weren't missing something that was systemic going on. But I think – I think it was therefore... I can't honestly remember. But each of them (MORECAMBE BAY TRUST AND NORTH CUMBRIA TRUST) had, you know, extenuating circumstances that didn't feel – and they were both in north and south Cumbria. So it – we did – when I noticed that I did say, 'Can you just double check that that's not something that we should be worried about.' That was around maternal deaths.

DR KIRKUP: But was there any similar process that you are aware of in relation to a cluster of neonatal deaths and stillbirths in quite a short space of time in 2008

going to be clear who was the executive lead, and if my – if they wanted the input from me that I would join it. But I thought it was very important that if there was any input needed from Mary, as the sort of midwifery lead, that she had supported that process.

DR KIRKUP: The thing that looks confusing to somebody looking from the outside is that you're still Director of Children, Young People and Maternity. But is that because of the particular focus of that director post that it was on health improvement and wider children's issues, not particularly on children's services?

DR HOSKINS: Yes. Well it was – I suppose it was – I was taking out sort of – I wasn't so heavily involved in the sort of individual trust clinical issues. But was involved around the wider things around safeguarding, supporting the clinical networks, doing that sort of piece of work that was raised by the advisory group as an area that they were concerned about. Around the paediatric surgery. And supporting around some of the sort of neonatal intensive care reviews. So I wasn't – I think we decided that I would take that more strategic overview than actually getting into the day to day clinical management. Because that was within a separate process within the Trust. But I can see, looking from the outside.

DR KIRKUP: Yes. We just need to clarify.

DR HOSKINS: No, no, no. I can understand that...

DR KIRKUP: Did you have any discussions or meetings with CQC?

DR HOSKINS: No. That was all led through the clinical governance, and the sort of Director of Nursing Route.

DR KIRKUP: Right, and the Medical Director?

DR HOSKINS: He may have – you know, I mean...

DR KIRKUP: Okay. I'm just asking. Okay. I guess I know the answer to this question, but I'll ask it anyway. Did you have any knowledge of the Parliamentary Health Service Ombudsman's decision in relation to James Titcombe's complaint?

DR HOSKINS: I probably did, yes. I mean... I'm sure I'll have heard about it, yes. I must have.

DR KIRKUP: But you didn't have any involvement in...

DR HOSKINS: No.

issue that they were worried about, they would have gone into the trust and worked with them. Certainly if it was identified through – through the information. Certainly around the sort of the performance management information that was picked up. The granularity of picking up around SUIs, I know they did sort of look at whether sort of clusters of things coming up – I suppose the issue is – and I'm not – I wasn't close enough to this system – is, you know how well – I know there was always a challenge about how well serious untoward incidents were reported, but...

DR KIRKUP: That was the same everywhere.

DR HOSKINS: Yes, exactly. So that was the same everywhere, and I'm not close enough because I wasn't then involved in that system at all.

DR KIRKUP: Okay. But the SHA, having got the information about SUIs, did it then pass it on to CQC? Was that part of its role?

DR HOSKINS: I don't know. I wasn't part of that process. Sorry. I don't want to fudge it. I don't want to make it up.

DR KIRKUP: No, that's fair enough. Neither do I. How did the overview of the local supervisory authority for midwives work in northwest?

DR HOSKINS: That was with Angela BROWN ~~Bryan~~.

DR KIRKUP: Okay, and your midwife, Mary Bell, did she have anything to do with that?

DR HOSKINS: Not in the sort of overview performance management of it, no. She may well have advised Angela, but that was if it was under the sort of – they reported to Angela, the local supervising manager.

DR KIRKUP: And was that anything that you have got involved with? Any particular problems, or particular issues?

DR HOSKINS: No, not ... I mean if there was any... no. I mean, if – Mary was there to give the advice, but that – I think it was always about trying to be clear where you get involved and where you don't.

DR KIRKUP: Sure.

DR HOSKINS: And that was clearly their lead and we were there to give advice if necessary. But we didn't lead that whole process.

DR KIRKUP: Sure. Okay.

MS FEATHERSTONE: You have answered a couple – it's just really just to clarify that Mary was your – the midwife. She did then report to the Director of

DR KIRKUP: Okay. Is there anything else that you would like to tell us that you think we haven't covered?

DR HOSKINS: I suppose it's just looking at the evolving areas that I covered throughout those sort of two years, when I was Director, and just picking up, you know, some of the sort of issues around the sort of maternity matters, and some of the others in that sort of overall area that we were looking at. Just sort of recognising, within that sort of, you know when we did the sort of child death overview. ~~Why people – you know,~~ why children died in the northwest, and then what we picked up after that. So road traffic accidents is a big issue, so we did a lot of work with the local authorities around that.

And then just sort of, I suppose, being clear that what the role was around that sort of safeguarding and making sure the safe transition (TRANSITION TO NEW ORGANISATIONS AS PART OF THE RECONFIGURATION i.e. 3 SHA -> NW SHA. NW SHA-> NORTH SHA.. And I suppose the challenge of transition, if you... you know, and how actually that whole sort of people – you're not as – well, not as focussed, but that has you build up for your portfolios as you have a new role and a new sort of organisation, and that the winding down and the building up, which is the challenge~~d~~.

DR KIRKUP: Sure. Yes. And all valuable context for us. Okay, thank you very much. Thank you for coming.

DR HOSKINS: Thank you.

(The interview concluded at 4.08 p.m.)

THE MORECAMBE BAY INVESTIGATION

Thursday, 6 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth - Expert Adviser on Paediatrics
Professor Jonathan Montgomery - Expert Adviser on Ethics
Dr Catherine Calderwood - Expert Adviser on Obstetrics
Ms Jacqui Featherstone - Expert Advisor on Midwifery

MR IBRAHIM HUSSEIN

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(At 1.56 p.m.)

DR KIRKUP: Hello, take a seat, please. Are we okay? Right. Thank you for coming. My name is Bill Kirkup. I'm chairing the Panel. I will ask my colleagues to introduce themselves to you.

DR CALDERWOOD: I'm Catherine Calderwood. I'm an Obstetrician and Gynaecologist in Edinburgh and I'm a medical advisor for the Scottish Government and also National Clinical Director for Maternity and Women's Health for NHS England.

PROF FORSYTH: Good afternoon. My name is Stewart Forsyth. I'm a paediatrician. I'm Medical Director from Dundee, Tayside.

PROF MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Healthcare Law at University College London and Chair of the Health Research Authority and in the past I've chaired [provider?] Trusts, PCTs and an SHA.

MS FEATHERSTONE: I'm Jacqui Featherstone. I'm Head of Nursing and Head of Midwifery at an acute Trust in Essex.

DR KIRKUP: You will see that we're recording proceedings and we will make an agreed record at the end. You will also know, I think, that family members have been invited to be present as observers. As it happens, we don't have any this afternoon but they may listen to the recording subsequently. And you will also know that we've asked you to hand in any mobile phone or recording device just to emphasise that nothing goes outside the room until we are ready to produce a report with everything considered in context. I should also mention that we will do the interview in two parts even though there isn't anybody present because it does make a difference to the recording. The second part will be where we talk about any information that may have a bearing on the clinical confidentiality, so any individual cases we will pick up at that point. And that bit of recording isn't open to subsequent listening. Do you have any questions for me, I should say, on the process?

DR HUSSEIN: No.

DR KIRKUP: Okay. I will start out with one very general question and that is when you first started at the Trust and what you did when you were there?

DR HUSSEIN: I started as a Consultant Obstetrician and Gynaecologist at Furness General in October 1987 and I retired in April 2012.

DR KIRKUP: And did you have any roles – You did, I think, have other roles other than Consultant?

DR HUSSEIN: Yes. [inaudible] read it because – That's the only thing I wrote. When Furness became Trust with South Cumbria NHS Trust, I forget which year but I was Clinical Director for obs, gynae, and paediatrics and this for about four or five years until the Trust merged with Lancaster and Kendal and we become Morecambe Bay NHS Trust. And I became Clinical Director at the Trust from the time of established in '98. The first few years was for obs, and gynae, and paediatrics and then after that paediatrics split up with us. They had their own Clinical Director. But I did the job from 1998 to 2008. Then they changed the structure of the directorates from 2008 and reduced the number of directorates to about three, I think. So they changed the name of the Clinical Director to Associate Medical Director, and became Clinical Lead for obs and gynae only, not paediatrics, from 2008 to 2010.

DR KIRKUP: Okay. And from 2010 did you have a management position?

DR HUSSEIN: From 2010 I became Associate Medical Director to obstetrics, gynaecology and paediatrics and this until October 2011.

DR KIRKUP: And from then? Did you go back to being a consultant?

DR HUSSEIN: For six months after that. I retired six months after that.

DR KIRKUP: Okay. That's very helpful. Thank you. I'll ask Catherine to question you, please.

DR CALDERWOOD: Thanks very much for coming to speak to us. You will understand that I have looked at case notes and all of the evidence that has been provided to us as part of this investigation, but I am not an obstetrician in your unit and I suppose what I would like is a feel for that. So I know what my unit feels like and we are here because of the deaths, so that all I have seen is notes of babies and mothers who have died. I haven't seen notes of people who have a good experience from your unit. Do you – You've obviously been a consultant but also in management; how would you describe the unit if you wanted me to come and work there?

DR HUSSEIN: How do I –?

DR CALDERWOOD: Describe it. What does it feel like to work there?

DR HUSSEIN: I enjoyed every minute of my job as consultant obstetrician and gynaecologist and also as Clinical Director. I think by the end, the last six

months, I was glad I retired because the atmosphere became very unpleasant. But I am very proud of my achievement as a consultant and as the Clinical Director.

DR CALDERWOOD: And what were your achievements that you're proud of?

DR HUSSEIN: It was very – I think when I started – I was senior registrar at Edinburgh and when I came to Furness I established COLPOSCOPY ~~compulsory~~ service, but it's not obstetrics. But also introduced day foetal assessment unit, and introduced DOPPLER ~~toddler~~, and introduced up-to-date guidelines for the maternity and labour ward. The case which stands – it's on my mind all the time – was a very, very tragic case. It was a younger woman, [redacted]

DR KIRKUP: I'm sorry to interrupt but can I stop you because we're going into clinical details here and although we haven't named the person that's potentially confidential information if we say anything that makes the person identifiable then –?

DR HUSSEIN: No. I wouldn't mention any names at all.

DR KIRKUP: If you could refrain from giving us too much clinical details at this point. If you want to give any more clinical detail it needs to be in the second part of the session.

DR HUSSEIN: [redacted] This was probably about the year 2000.

DR CALDERWOOD: Thank you. So your role as Clinical Director spans some of the time when the cases that we are investigating –

DR HUSSEIN: Yes.

DR CALDERWOOD: When you were Clinical Director how did you feel your role was when an unexpected or untoward incident had happened? What was the role of the Clinical Director in the process that followed a death of a baby or death of a mother?

DR HUSSEIN: Babies deaths or maternal deaths?

DR CALDERWOOD: Both, perhaps, an intrapartum stillbirth or a mother's.

DR HUSSEIN: I think at my time at Furness we had few maternal deaths. I think two of them were amniotic fluid embolism and another one died suddenly [redacted]

DR CALDERWOOD: And what was your role then, when – let's take a maternal death as an example – what did you do as Clinical Director?

DR HUSSEIN: Basically, with the Head of Midwifery and the consultant concerned, because none of these cases were mine at all, we sat down and discussed what happened and whether this was an avoidable death or not.

DR CALDERWOOD: What criteria did you use?

DR HUSSEIN: Sorry?

DR CALDERWOOD: What criteria did you use when you were talking about whether it was an avoidable death or not?

DR HUSSEIN: I think the confidential inquiry and the – It was felt the two cases of amniotic fluid embolism were unavoidable. But the one case which was question mark about it was this lady who [redacted]

DR CALDERWOOD: And so what was your – we do need to be careful about the details because of the recording, but as the Clinical Director you say you met with the Head of Midwifery and the consultant concerned, that you were deciding whether the death was avoidable or not.

DR HUSSEIN: Yes.

DR CALDERWOOD: What steps then did you take, because although the avoidable death could be yes or no there will always be something within an investigation process where perhaps something different might have been done even if it mightn't have made a difference to the outcome? What did

the Clinical Director – What role did you play in overseeing these after these tragic events?

DR HUSSEIN: I think the cases where, we felt, that's it's no one to blame for it we passed it to confidential inquiry to decide for themselves if we were right in our conclusion. But the one which the post-mortem suggested could be eclampsia, my advice – I didn't agree with the post-mortem and my advice to the consultant concerned was to seek second opinion, which he did. And there was professor from Leeds who looked at the case and came to the conclusion it was cardiomyopathy and there was no one to blame for the clinical management, as I said.

DR CALDERWOOD: And what about if you had been part of that? Were you involved when there was an intrapartum stillbirth? When was that?

DR HUSSEIN: Well, we –

DR CALDERWOOD: In a unit of your size, from myself working in smaller units, when you walk in in the morning onto a labour ward when there has been a death everybody knows. So you must have been aware of these cases. What was your role then as Clinical Director? Let's begin intrapartum stillbirth, perhaps.

DR HUSSEIN: Intrapartum stillbirth. I think we had one who's bad, who's sticking out in my mind because intrapartum stillbirth is not common, or wasn't common until we had a spell when people were at fault. But the first one we came across –

DR CALDERWOOD: Would you like to tell me, sorry, before we go into the detail of one, you think you had a spell when there were lots of intrapartum stillbirths and there were people at fault? Your words.

DR HUSSEIN: Yes. This was from maybe 2008 to 2010.

DR CALDERWOOD: And what makes you say there were people at fault?

DR HUSSEIN: The story I was given in one of the cases, which alarmed me very, very much, was coming back from holiday and it was mentioned to me casually that two weeks ago they had intrapartum death and I didn't feel happy at all with the management. So we had a case conference with all the people concerned, including the Risk Manager, including Head of Midwifery, and I passed the information with my concern to the Chief Executive, who was Tony Halsall.

DR CALDERWOOD: And you are alluding to the fact there were several deaths, what happened then when you had raised your concern? What did you do as Clinical Director?

DR HUSSEIN: When you have any perinatal death the Risk Manager did a root cause analysis and came to a conclusion with recommendation. But if I felt there was any complacency or negligence on part of the medical staff they would have been disciplined and investigated. From a midwifery point of view, we trusted the Head of Midwifery together with the Director of Nursing and Midwifery that they will take the necessary steps. And usually, if they did, they did it privately. They didn't announce that we suspended this person or sacked her and such. [Inaudible] internally.

DR CALDERWOOD: But would you have had oversight of what was happening? Would they report back to you to say that these were concerns? Was there some actions that were raised and then you checked, if you like, that these things had been done?

DR HUSSEIN: Part of the problem was that we had a very good group of midwives when I started and the majority of them were still working when I left. Few, I think, stood out of the guidelines and, like intrapartum death, ignoring signs of foetal distress. Unfortunately, when you do an investigation you trust the Risk Manager of the root cause analysis coming with conclusions. And she reported directly to the Medical Director. I was made aware of a report, but the Risk Manager reported directly to the Medical Director. And I think the midwives took extra responsibilities, which I think is very unwise. But it happened gradually over the years and this is a national trend, midwives taking more responsibility. But I think a good midwife will take extra responsibilities, an independent practitioner take extra responsibilities, that's good. But a good midwife will know when to ask for help. And some of these midwives at the time did not ask for help. The Risk Manager did not highlight this problem.

DR CALDERWOOD: And when you had the case conference and sent your letter of concern to Tony Halsall what happened?

DR HUSSEIN: Well, I didn't write to Tony Halsall because I think Tony was very approachable. I went and saw him. We met regularly every three months.

But whenever is there any concern I went and saw him. Tony, at the time, was very preoccupied with – Am I allowed to say names?

DR CALDERWOOD: Of staff? Yes.

DR HUSSEIN: No. Patients, clients.

DR KIRKUP: Not if we're talking about clinical details. We need to keep that.

DR HUSSEIN: Tony Halsall was very preoccupied with a case of neonatal death and I went to see him and I said, "This case, the neonatal death, is definitely our mistake, our fault. It's an inexperienced, new midwife, couldn't recognise the seriousness of certain symptoms for this baby." I said, "But the case I would have no ~~leave~~ sleep about was this intrapartum death because there was definite, definite negligence." It took Head of Midwifery about six months to suspend the midwife who was in charge and then they sent her to Lancaster for retraining and came back to Furness General to practise.

DR CALDERWOOD: And any of the other deaths then did you feel it was your role to make changes and to ensure that those happened when you had come across practice that – because you've said there were people at fault and there was a period of time over which those number of deaths happened?

DR HUSSEIN: We had a problem when there was a lot of publicity about the unit. There was a major, major problem with publicity. The Chief Executive, I think, took charge. I think he did everything possible except sacking midwives. I think he was meeting relatives, compensating them, apologising. But he stopped short of sacking the midwives. But he was in charge. He was in charge because he was fully aware of the deficiencies.

DR CALDERWOOD: What about your obstetric and gynaecology colleagues?

DR HUSSEIN: We went through a phase when people retired, who retired from their jobs, and couldn't get anyone to apply for the job and the people who applied were not accredited. It doesn't exist any more because now there is loads and loads of accredited. But we went through a phrase when we struggled to fill this post. I think we had a group of consultants who were not proactive. I think on the clinical side I couldn't fault them, but they wouldn't stand up if midwifery staff when they were on call stepped out of line, took more responsibility, didn't contact the on call obstetrician who was a staff grade or registrar, or didn't contact a consultant. Consultants who were not proactive and never told the midwife off, never took any action. I think this took a few

years for us to feel the effect of this because the midwives felt they could do this, no one is being critical of their management. They have taken more risk than they should. And over the years their practice changed dramatically. And I think it unfortunately it was at the expense of a few incidents.

DR CALDERWOOD: Where did your responsibility lie then as Clinical Director?

DR HUSSEIN: It's basically you sit down with consultants and say, "Guys, if there is an incident you should speak to the midwives, should speak to junior doctors who are on call." But, unfortunately, the way they were trained, clinically they're okay but as far as behaving, taking responsibility as a consultant I don't think they were up to the job. Things might have changed now, I think mainly because there is more choice. If you have vacancy you've got 30 or 40 applicants, all accredited. So you have a choice to pick and choose, maybe they change. But the consultants were there for the last ten years who were not proactive. They didn't stand up and say, "Why didn't you call the consultant? Why did you do that?"

DR CALDERWOOD: Were you proactive?

DR HUSSEIN: Yes. But I couldn't stand for any nonsense. I, clinically, am proud to have a clinical background, good clinical practice. But if you work with another three consultants who will not undertake any responsibility then there is a limit to what you can do. You can sit down with them. You can mention it to the Medical Director. You can mention it to the Chief Executive. But it's very difficult, I think, nowadays or, I think, in the Trust, it may be changed now, very difficult to discipline a consultant or a medical staff.

DR CALDERWOOD: I'm conscious of time so we might want to have some other people questioning. Thank you.

DR KIRKUP: Okay. You may want to come back again. Stewart?

PROF FORSYTH: Yes. I am interested in your role as a clinical director. What line management did you have, for example, over midwives?

DR HUSSEIN: Sorry?

PROF FORSYTH: As Clinical Director did you have some line management of midwives or had you any management responsibilities for midwives?

DR HUSSEIN: For midwives?

PROF FORSYTH: As clinical director.

DR HUSSEIN: In the early days when the Trust started, the Trust as Cumbria or merged with new Trust Morecambe Bay, the Clinical Directors –

PROF FORSYTH: Sorry?

DR HUSSEIN: The Clinical Directors had a lot of responsibilities.

PROF FORSYTH: Had a lot of responsibilities?

DR HUSSEIN: Yes. The managers were accountable to them. They Head of Midwifery to a certain extent, you know,accountable~~–claim~~ to a clinical director. Everything was in place. Then after maybe six or seven years they changed the system. The Clinical Directors in the past were the ones who made decisions about how the Trust was run. They sat down with the Directors and made decisions about how the Trust was run. Then they changed the system into bigger directorates, less associate medical directors, changed our names and was very little responsibility.

PROF FORSYTH: When was that done?

DR HUSSEIN: This was done in just before Tony Halsall came, so I was – I'd imagine near 2007, something like that. We didn't have any power whatsoever. We didn't have anything to do with decision-making. The manager who was accountable to someone, one of the directors, the Head of Midwifery was accountable to the director of Nursing and Midwifery. And I think as Clinical Lead in the early part of the system and Associate Medical Director later would have very, very little power. I personally think it was done deliberately. I don't know whether they've reverted back now to the clinical directors system, I don't know. But I made a lot of noises when I was a Clinical Lead and Associate Medical Director that a associate medical director should have more power, should sit down meeting with the directors regarding decision making, how the Trust is run. But the Trust wasn't run by doctors, full stop. Maybe they change it now.

PROF FORSYTH: So when you were a clinical director were you able to then ensure that there was a good working and professional relationship between obstetricians and midwives?

DR HUSSEIN: Yes. I don't think we had major problems between doctors and midwives, and obstetricians and paediatricians. I don't think this was an issue. I don't think this was a cause for any of the problems. I think the issues were clinical. Someone –

PROF FORSYTH: Surely they're not linked. I meanou can't sort of say there was clinical issues but there was a good working relationship between the two.

DR HUSSEIN: I personally got on very well with everybody, not being extra nice, but with some respect. Some other consultants maybe they were not respected.

PROF FORSYTH: As Clinical Director you're responsible for making sure that your fellow consultant obstetricians perform well and part of performance is their having good and effective working relationships with midwives.

DR HUSSEIN: This is what our meetings with midwives, and morbidity meetings, perinatal mortality meetings, we tend to work as a team and I always maintain midwives are not like nurses. They are part of the maternity team. They are more or less equal footing with the medical staff, provided everyone knows their limitations. But it was vital – I don't think if you work with midwives you can't make an enemy of the midwife. You can't because work would be ruined. It all would be ruined. I think you have to have a good working relationship with the midwife. And I always have the utmost respect for midwives, not because I'm being extra nice, no, because the shared work and what they're doing, their competence. I maintain, I will stick my neck out, the bunch at Furness General were a very good bunch. The only thing is maybe two or three stepped out of line. But the core of the midwifery there were good. I think the early Head of Midwifery I worked with was Denise Fish and she didn't stand any nonsense. After this she retired. Things were not the same as far as managing midwives.

PROF FORSYTH: What about from a clinical point of view you only had a level 1 neonatal unit in Barrow, did this present clinical difficulties for you?

DR HUSSEIN: Yes, I think it did. We tried to develop the unit but when I first started as a consultant they had two consultant paediatricians and two SHOs. That's it. And they coped alright [inaudible], but this is before the new directive and orders. Now we have about seven to eight consultant paediatricians but there is no will to develop the unit. There is no will to develop the unit. I think mainly because they didn't' have middle grade doctors ~~[inaudible]~~, and they were not prepared to live in the hospital, and SHOs were G.P.~~[inaudible]~~ trainees,with very little experience. So we accepted the limitation of the unit, and what they did as far as neonatal is concerned, they didn't take risk. If there was a problem they transferred the babies.

PROF FORSYTH: So you said you didn't take any risk, do you think that, in fact, the risk assessments weren't correct and all high risk women weren't transferred out?

DR HUSSEIN: No. We didn't transfer high-risk women. No. If, say, we have triplets and paediatricians were very unhappy looking after triplets because it means their on call system will have to change. There will have to be at least two paediatricians on call all the time from certain time.

PROF FORSYTH: So you would have been happy to deliver triplets in Barrow?

DR HUSSEIN: I think I did before with the co-operation of the paediatricians, but I will say for the last ten years it was very difficult because the paediatrician wouldn't. They said it's too risky, we're not prepared to be on call every night for three or four months, two of us, we are not prepared. But the problem with triplets, what you do if the lady will have a major problem in the middle of the night with antenatal haemorrhage. You have to deliver her. You can't transfer someone who is a major haemorrhage. Do you ask all the triplets to move and live in a place like Lancaster or Preston until they deliver, which is completely unacceptable. So there was certain problems, mainly because the unit wasn't developed.

PROF FORSYTH: It's a risk assessment, isn't it? You've got to sort of balance the risks against the benefits for mother to be delivered in their local hospital. I just wonder how thoroughly you investigated the risks of your patients, not just yours but your follow obstetric consultant patients, to ensure that those mothers who're at increased risk of delivering a baby who may require neonatal care were managed appropriately.

DR HUSSEIN: I think the problem with risk assessment if we tried to assess every patient, yes, would pick up few multiple pregnancy and someone had pretend labour, two or three previous pretend labours. Yes, the baby [inaudible] but the majority of the problem can be acute problems, unexpected, someone with perfect obstetric history and all of a sudden has a major, acute problem, which we can't transfer. It's like one of the problems we had was paediatricians if they get someone at 28 weeks, her labour five centimetres dilated with bulging ~~punctured~~ membrane and the paediatrician said we should transfer the patient. I said I don't think it will be – this is the safest way for the baby because at least here you've got paediatricians around, but

in an ambulance on the ~~and~~ M6 if you deliver there there is nothing. So I think we did our best to do risk assessment, but it didn't work the majority [inaudible].

PROF FORSYTH: So were you not aware of any cases that you felt you should have transferred out rather than deliver in Barrow?

DR HUSSEIN: Nothing I can remember off the top of my head.

DR CALDERWOOD: Can I just come in about that? Would you have felt there was expertise in Barrow that would have looked after the antenatal care of a [redacted]

DR HUSSEIN: [redacted] yes. We are isolated, the patients are isolated in Barrow. The nearest is Lancaster, which is about 50 miles, which involves A590, then the motorway, then going through as busy city centre.

DR CALDERWOOD: So the scanning, all of that would have been done in Barrow for a triplet pregnancy?

DR HUSSEIN: All of what?

DR CALDERWOOD: The scanning and the routine antenatal care?

DR HUSSEIN: Well, the unit at Furness had everything. We had excellent back up ultrasound service with foetal assessment, growth assessment, and Doppler ~~toddler.~~ I think the antenatal care we had all of the services. The main Achilles heel for Furness was babies these who were born unexpectedly early and the two unit wasn't developed. The Trust – I think there were suggestions in the past to close the paediatric unit, full stop. We objected to this because we said if you closed the paediatric unit then the obstetric unit will be too expensive, too many consultants doing little work. The consultant brought someone from London who was an ex-military paediatrician, who was involved with the Royal Free set up in London. I forgot his name. It could be Andy Mitchel ~~Richards~~. I forgot the name. And he came, he looked at the units at Furness and looked at the units at Lancaster. I was at the time the Clinical Lead. He met me, met the Associate Medical Director, George Nasmyth, who was a surgeon. He met all the paediatricians at Furness and at Lancaster. And his conclusion at the end said really if you want to close one unit out of the two it should be Lancaster because it's close to Preston. It's Furness' problem is the location and you can't solve this problem by transferring everyone. He said develop the unit. Develop. Have nurse

practitioners, increase the numbers of consultants, but don't close the unit at Furness. They didn't comply with that. I don't think we had any nursing practitioners. I don't think the Trust wanted advice.

PROF FORSYTH: How did you – Did you have good working relationships with colleagues in Lancaster?

DR HUSSEIN: Lancaster? Well, I would say I had reasonable worker relationship. What soured it was the consultant contracts.

PROF FORSYTH: What has the consultant contract got to do with it?

DR HUSSEIN: Well, we had – the Trust were in major problems financially and they were threatening closing wards, moving gynae wards to ~~and~~ surgical wards, as the used the gynae beds at Furness to aid and the reducing the gynae beds in Lancaster to twelve unless we made saving. And the saving I made, because at the time we were supposed to go through the consultants' contracts every year. But I went through all the consultant contracts and their actual timetable, job plan, wasn't as accurate as it was written down, so we made significant saving by reducing the consultant's pay ~~day~~. To act as an example, when I became Associate Medical Director, the pay ~~[inaudible]~~ was about £25,000 a year. I didn't get a penny out of it because I knew we were in trouble with finance, but I saved quite a considerable amount of money being fair, by reassessing the consultants clinical sessions and whether it was accurate or not. And I think a lot of consultants were not terribly happy about that.

PROF FORSYTH: Well, what about at a clinical level? Did you have joint meetings with them and discuss clinical cases, look at perinatal detail?

DR HUSSEIN: I think the perinatal meetings were done monthly or two monthly depending on the cases in the two units, mainly in two units. We had incident reporting, which was done every month, in Lancaster, in Kendal and Barrow, which discussed all cases which –

PROF FORSYTH: Were all the consultants were they are good attenders at these meeting?

DR HUSSEIN: No. The incident reporting was one consultant who was representing medical staff, the Risk Manager with Head of Midwifery, usually, and senior midwives. And discussed the incidents and they wrote the conclusion and the Risk Manager was responsible for the final draft and final conclusion.

PROF FORSYTH: I'm just trying to get a feel for was there, you know, across the Trust good interaction, particularly amongst obstetricians, where clinical issues were being addressed, and decisions were being made, and policies and guidelines are being developed. Dr Hussein We had – No, maybe, now we look at it as inadequate – a yearly meeting which involved the two sides and this involved obstetric cases and gynae cases, but the best example really is about working across the Trust. I was in gynae and gynae cancer. I was lead clinician for cancer at Furness. We have video conferencing with Lancaster and Preston and this was done every week. Colposcopy, who had video conferencing with Lancaster and Manchester, and this was done every month. But obstetrics didn't have such a thing. We had each unit meetings and one a year meeting to discuss. But the policies, the guidelines, were for the three sides, all the policies for the three sides, we had the same guidelines.

PROF FORSYTH: And did you feel the consultants were applying these guidelines or doing their own thing?

DR HUSSEIN: I think so because with obstetrics it's different because, you know, obstetricians never agree about same management, but somehow I think having guidelines and going by NICE recommendation that the mood shifted towards agreeing the same management, roughly.

PROF FORSYTH: Okay. Can I just ask one other area? And that is when these incidents started happening did you feel that the Trust or the more senior management supported midwives, obstetricians, the neonatal staff during that time?

DR HUSSEIN: I think the major cases the likes of the Medical Director and Chief Executive knew about it. I think, as I said, the Chief Executive also was very approachable, but he listened but didn't say what action was taken. You know, as [inaudible] say, midwives when there was a major incident he didn't say. But I know for sure, I think we had a meeting with him once with midwives and medical attendees and he said to the midwives, "We want to move on. I no ~~knew~~ one of you lost her job", which was ~~as~~ true, and whether this was the right thing to do I'm not sure.

PROF FORSYTH: Did you in your clinical directorate role did you feel you supported the staff during that time? You felt that the right actions were taken?

DR HUSSEIN: Of course, yes.

PROF FORSYTH: You don't feel in hindsight you have any regrets about why these incidents happened in the first place and how they could have been managed better?

DR HUSSEIN: I think my only hindsight regret is – I looked at really how it should have been done – is to make sure that the consultants listened to what I'd been saying to them, to be proactive. I think it would change the system to a certain extent is for them, the consultant, to sign a register [inaudible] unless the chose, to sign a book labour ward at the beginning of the shift when they take over, and then we tighten this to make sure everyone have a change of shift report about cases, if there is any case to worry about and the midwives were on board with that. We changed all that but if you want my honest opinion, in fact, I wish we had more choice of choosing consultants when we appointed them, but we didn't have a choice.

PROF FORSYTH: Okay.

MS FEATHERSTONE: I just want to clarify, you talked about having perinatal mortality but I don't get the feeling that a lot of the incidents were discussed in great detail and that lessons were learnt. Just explain a bit more, how did it happen and cascade down to the doctors on the shop floor and the midwives on the shop floor?

DR HUSSEIN: We had regular perinatal morbidity and mortality, when it was attended by midwives, and obstetricians, paediatricians and stenographers, and we discussed these cases and we discussed how the management should have been done rather than the way patients were managed at the time. We discussed that.

MS FEATHERSTONE: But it was always only a small amount of people there, how did the rest of the unit find out about it? How did you share that?

DR HUSSEIN: These perinatal mortality meetings were open to all the midwives, open to all the medical staff and all the paediatricians. And usually they all attended. Sometimes if the midwives are too busy then we get few of them but the majority of these meetings were well attend: paediatricians, obstetricians, junior doctors and midwives, and –

MS FEATHERSONE: But there will still be other incidents, so not just perinatal, other incidents that happen. How would you say the things that happen in

the unit was cascaded down so that everybody knew? Because we all make mistakes, we're human, but we can only learn and change things if we all know what the actions are.

DR HUSSEIN: I think if it was a medical problem, a mistake done by junior doctors or a consultant, we sat down and discussed it and say, "Well, we shouldn't have done this and we should have done that." I think this is a good thing about obstetrics. Obstetricians are open to criticism. I don't think they shy from criticism. We expected the same to be done by the midwives i.e. matrons and the Head of Midwifery. And I think the Head of Midwifery and the matrons met regularly, maybe every two weeks, maybe every four weeks and they met with their own other midwives as well. So we assume they imparted the same information. But it's not about them being in the perinatal mortality. I just can't go to the midwives and say, "You should have learned this and should have done that." I think we pass the information to the matrons and the matrons will make sure it's implemented.

MS FEATHERSTONE: But as the Clinical Director what sort of relationship did you have with the Head of Midwifery then?

DR HUSSEIN: I think we had two head of midwifery in my time. It was Denise Fish. I had a very good relationship with her. And Angela Oxley, I had a good relationship with her. Their styles of management were totally different. I think Denise was old-fashioned style, but she didn't stand any nonsense. Angela wasn't that experienced. She wasn't that experienced and I think some of the problems took place while she was in charge.

MS FEATHERSTONE: And did you have directorate meetings, so all the consultants got together and so those things were discussed there as well with the management team?

DR HUSSEIN: I think we have directorate meetings every month but it wasn't clinical, indirectly clinical but mainly to discuss how things are running, what we suggest management-wise, if anyone has any grievances about the way it's running, any suggestions. So we had directorate meetings every month. We had clinical governance meetings every month, which was attended by myself, a representative obstetrician from Lancaster, a representative obstetrician for Furness General, and all the matrons from the three sides,

the midwives from the three sides. We had these meetings every month and the clinical governance did discuss cases like that.

MS FEATHERSTONE: Okay. Thank you.

PROF MONTGOMERY: I can't quite reconcile a couple of things you've just said. You've described Denise Fish and yet you described you not really any confidence that the midwives actually took seriously the things that you were taking seriously on the medical side, and you talked about the fact that an experienced midwife would know her limitation ~~no the limitations~~, the implication being that you weren't confident that was the case. I can't reconcile that picture.

DR HUSSEIN: What I'm saying is we've got a good group of competent midwives. I trust the midwives. Over the years, not all of them, some of them took extra responsibilities i.e. doubting the significance of foetal heart rate and normally you should ask the registrar, the medical staff. The middle grade work shifts, so they slept very well the night before or they work an eight hour shift or ten hour shift. So they are well rested. There is no excuse to say, "No, I'm tired." No. It's the midwife's responsibility, a good midwife, if she is not 100 percent sure, to ask for a second opinion. But some midwives didn't. And I think it's very, very unfortunate this developed over the years. And I think it showed itself in the last couple of years.

PROF MONTGOMERY: Are you saying it happened after Denise stopped or –?

DR HUSSEIN: After?

PROF MONTGOMERY: Are you saying that only started after the change of the Head of Midwifery?

DR HUSSEIN: I think I would say from 2008/2010 problems started showing, because if you have such practice it doesn't show itself straight away. It's gradual, gradually, and then all of a sudden you have a problem.

PROF MONTGOMERY: And when was the change of Head of Midwifery?

DR HUSSEIN: Denise left about five years – Well, maybe about five/six years ago and Angela –

PROF MONTGOMERY: So you had traced that change from the time of the change of the Head of Midwifery?

DR HUSSEIN: It's very difficult to say the Head of Midwifery is 100 percent responsible, but I know for a fact Denise didn't stand any nonsense. I don't

think the midwives would have stepped out of line. With Angela things changed. Whether it's a national thing that midwives take on more responsibility or not, but I think the problem we have is it's a consultant unit, it is not a midwifery unit. So I think the midwives working there should follow strict guidelines about – We have a midwifery unit in Kendal and they have their own guidelines, deviation ~~innovation~~ from these guidelines, transfer patients usually to Lancaster.

PROF MONTGOMERY: So this consultant unit does that make the consultants absolutely responsible for –?

DR HUSSEIN: Absolutely, yes.

PROF MONTGOMERY: And yet you exercise no authority over the midwives on the account you described?

DR HUSSEIN: Well, it's a very difficult – You can have talks with the Head of Midwifery. You can have talks with the midwives. But if I have concerns I would expect the Head of Midwifery to take action. I had concern about this case I spoke to Tony Halsall about and the Head of Midwifery didn't take any action until about six months later when she felt the case had been in the spotlight.

PROF MONTGOMERY: So during that sixth month period you feel that the service is unsafe?

DR HUSSEIN: No. I think because the clear instructions were given to the medical staff, junior doctors and consultants, to do frequent ward rounds. Weekends is not holiday. The weekend should be like any other day, ward round in morning, lunchtime, evening, and before the night shift. And this applies to consultants, this applies to junior doctors. We spoke to the midwives as well. We said, "You know, the problem is there, if there is any problem you contact the junior doctors. If you have a problem the junior doctor will inform the consultant directly at home." I think certain actions were taken but I think it will take time to sort it out.

PROF MONTGOMERY: Thank you. I'm slightly confused about the clinical governance system. You began to talk about the clinical governance meetings and I'd like to understand how the information was fed into that to monitor the quality of the care that you were giving in the directorate and how they were – because you've talked about the incident reporting meeting,

which I understand as being separate, so how did the unit identify whether the quality of care was the quality it wanted to be delivering?

DR HUSSEIN: I think the maternity units and obstetric units are judged by perinatal mortality and the morbidity as well, and if you start having the rise [inaudible] you know for sure there is something very, very wrong.

If you look at Furness figures in 2004, 2006, 2008 I think the perinatal figures were very respectable, were comparable with the national average, sometimes below the national average. But you don't take one year, because it's a small unit, to have about 1100 or 1200 deliveries, so even if you take [two years?] together the perinatal figures are okay.

From 2008 to 2010 or from 2009 to 2011 I think the perinatal figures started to go up and this is when everyone got involved: the Head of Midwifery, myself, the Medical Director, the Chief Executive. Everyone was involved. I think the Chief Executive brought some group – Fielding Group. They came and looked at the unit. Then we had some people later on after that from Manchester. I forgot his first name. [Mr Maresh?], but I forgot his first name. We got Dr Sarah Vose [~~SIRVOS?~~]. We got different people who inspected the unit.

And before that I think the Chief Executive in confidence with our manager, without telling me, asked the Manager to look at the perinatal figures and the number of complaints in the two units, Lancaster and Furness. And I think the Manager did it in confidence and presented to the Chief Executive, and I was told after that the was not much difference whatsoever between the two units. And this must have been around 2007/2008. But the figures were definitely different for about a couple of years.

PROF MONTGOMERY: So did you ask yourself at that stage whether there was a pattern that you should worry about? You've seen this rise. It's a small unit so you might get occasional rises.

DR HUSSEIN: I think when you have a misfortune during labour as an experienced obstetrician you can say this can happen on any unit, but when it happens again and again the alarm bell starts ringing. And yes, when we needed to speak to junior doctors, and consultants, midwives, we did. And whether the

midwives were managed properly I don't know, because I wasn't involved in meeting of ~~with~~ Head of Midwifery and the matrons and –

PROF MONTGOMERY: So it's a consultant lead unit?

DR HUSSEIN: Yes.

PROF MONTGOMERY: You're responsible for the quality of care?

DR HUSSEIN: Yes.

PROF MONTGOMERY: But you don't know whether or not midwives were managed?

DR HUSSEIN: We expected they heed our recommendation.

PROF MONTGOMERY: And when you drew up those recommendations, I mean, did you recognise there was a pattern to these events?

DR HUSSEIN: I think it wasn't until this unfortunate case when the midwives don't ask for help. We looked at – there was a case in 2004. But think that one in 2004, very unfortunate case, isolated case. It didn't happen until 2008. Something like that. I forgot the exact year. But there is no pattern. And then after that was complaints about the unit. I think in the past, ten years ago, we get complaints against medical staff. All of a sudden these complaints shifted to midwives.

PROF MONTGOMERY: When are we talking about?

DR HUSSEIN: I would image 2007 to 2011.

PROF MONTGOMERY: Okay. So you had this group of incidents you described, I think you said it was 2008 to 10?

DR HUSSEIN: Yes.

PROF MONTGOMERY: So is it your opinion that they area series of coincidences or is there some common theme there?

DR HUSSEIN: If they are jus a coincidence? In the past we say it's an unfortunate isolate case, but my feeling is recent ones, there was a pattern to them and the pattern was midwives taking more responsibility and not asking for help when they should.

PROF MONTGOMERY: And that was a pattern that Tony Halsall and the Director of Nursing –

DR HUSSEIN: Yes, fully aware. Tony was involved from the word go.

PROF MONTGOMERY: What did he say he was going to do about it? You indicated he said he would do something.

DR HUSSEIN: He never said. He never said. I think Tony was very preoccupied with another case, a neonatal death. He was very preoccupied. And I tried to bring attention, "Yes, it's tragic. Blah, blah. But this is where we have a major, major problem." He had meetings with midwives, group meetings. I attended one of them and I said to him in the meeting, "We make mistakes, but we make sure we will be no ~~more and~~ more – mishaps like that if can be avoided." And he ~~they~~ said the midwives who were made to move on, "I didn't sack any of you but you need to move on." [inaudible] back to normal.

PROF MONTGOMERY: A couple of other quick areas. One was – you mentioned the Fielding Report.

DR HUSSEIN: Yes.

PROF MONTGOMERY: Were you part of any discussion about commissioning that report or was it a surprise to you when it came?

DR HUSSEIN: No. Well, I think it was only mentioned there was some group coming. I didn't know what was the background but it happened near the early neonatal death case we had. And they came, they met with different obstetricians and midwives.

PROF MONTGOMERY: And when did you see the report?

DR HUSSEIN: Probably about a year and a half to two years afterwards.

PROF MONTGOMERY: After when? When they came in?

DR HUSSEIN: After they came in.

PROF MONTGOMERY: Okay. And were you part of any of the action planning to respond to that?

DR HUSSEIN: I think not directly. Not directly, no.

PROF MONTGOMERY: Thank you. The other question I want to ask you about is people raising concerns about quality with you. Did any of the local GPs raise concerns about the quality of maternity care at Barrow with you?

DR HUSSEIN: Not that I can remember, really. Not that I can remember. The thing with maternity care I think is gradually the midwives took over from general practitioners. They were running their own community antenatal clinics. In the past GPs did. But I think the GPs gradually, through lack of training or lack of interest, they became less involved with maternity. It was mainly between obstetricians and community midwives, not obstetricians and general practitioners.

PROF MONTGOMERY: Thank you. Last question is did medical staff in hospital raise concerns about quality with you, junior doctors, your colleagues, registrars?

DR HUSSEIN: I'm sorry?

PROF MONTGOMERY: Did the medical staff inside the hospital raise concerns with you as Director about the quality of services, junior staff, registrars, consultants?

DR HUSSEIN: I think you get sometimes you find things yourself but this is my main concern about the consultants. They were not proactive and didn't take steps. But it's like – example, one of the registrars he has no communication skills whatsoever and I mean communication skills with colleagues, with midwives, with patients. Completely. And there were – I think the patients and families resented having him around because there was no communication ~~complication~~.

And there was a training course about – which was compulsory for clinical leads for cancer, how to deal with communications ~~complications~~ etc. And I went there ~~because~~ it was for three days and because it was compulsory, and I was found it useful. It was run by two ladies, I think psychologists, and it had actors. I had a word with one of the ladies who was running it. I said, "Do you take anyone else apart from cancer lead clinicians?" She said, "Yes, anyone." So I sent this guy.

He attended a course and there was some improvement but not as much as I expected. And I wrote to Human Resources, I forgot the lady's name, I said, "This guy, we have repeated problems with communication. I sent him to this course about a year ago. Some improvement but still a concern." And she didn't do anything.

PROF MONTGOMERY: That's interesting but it's not really an answer to my question, which was whether junior medical staff, your colleagues, raised questions of quality with you.

DR HUSSEIN: Not against consultants. Junior doctors did not against consultants, whether out of fear or respect they didn't. But I didn't have major clinical problems with consultants. The problems I had occasionally, midwives would complain about someone not responding to the calls as quickly as –

PROF MONTGOMERY: So your medical colleagues were comfortable with the quality of service?

DR HUSSEIN: I had no major, major problem.

DR KIRKUP: Okay. I'll pass at this stage because I'm very conscious that we need to move to the second part of the interview where we can talk about confidential details. Help yourself to some water if you want.

(In Private Session)

THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Tuesday, 22 July 2014

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

Before:

Dr Bill Kirkup CBE – Chairman
Professor Stewart Forsyth – Expert Adviser, Paediatrics
Professor Jonathan Montgomery – Expert Adviser, Ethics

RUTH HUSSEY

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THE CHAIRMAN: Right, thank you. Apologies for the delay. Thank you for coming. I will say for the record I'm Bill Kirkup, chairing the investigation, and I will ask my fellow panel members to introduce themselves.

MR FORSYTH: Good morning. My name is Stewart Forsyth and I'm a paediatrician and medical director from Dundee.

MR MONTGOMERY: I'm Jonathan Montgomery. I am a Professor of Health Care Law and Ethics at University College London. I am also PCT and SHA chair in the period we're talking about. I was also involved in [inaudible] and, just for the record, I think you would have had a recent correspondence in relation to that.

THE CHAIRMAN: Yes, indeed. You will see that we're recording proceedings and we'll make an agreed record at the end of that. You will also be aware that there are family members present as observers of the meeting and others may listen to the recording at a subsequent stage.

We've asked you to hand in any mobile phones, tablets and all the rest of it and that's just to underline the fact that we want what goes on in this room to stay in the room until we produce the report at the end that puts everything into context. Do you have any questions for me about the process?

MS HUSSEY: No, thank you.

THE CHAIRMAN: Okay. I will start out with the obvious one which is can you just run through your involvement in the region; when did it start? When did it finish. What did you do?

MS HUSSEY: ~~Yeah~~Yes. I was appointed in 2006 to the role in the North West region. That was a coming together of three former SHA medical director roles and the regional director of public health role and it was four roles into one. It was a very broad based

role. It had three major components to it. It had a role in the strategic health authority, it had a role overseeing the Department of Health in the region and it also had a relationship with the government office in the North West. That was more of a dotted-line relationship, nevertheless I became part of their corporate management ~~structures~~ arrangements as well. So it was a ~~sort of [inaudible]~~ strategic and overarching role. On top of that ~~we~~ each Regional Director of Public Health had a lead responsibility for particular government department links at national level as well. So it ~~was~~, that was how it was set up.

THE CHAIRMAN: Okay. And you left in 2011?

MS HUSSEY: Yes. ~~I went on to~~ — I had a month off in March 2011 and I went on secondment to the Department of Health ~~pretty much~~ during the first couple of weeks in April. I haven't got the precise date, but I left from there on secondment ~~and moved away~~.

I think what's important to explain also is the role changed immensely during that period. ~~Pretty much~~ Almost every year there was a different mix of responsibilities. Perhaps if I just run through of some of those you will get a feel for how each year ~~sort of~~ changed and evolved.

THE CHAIRMAN: Sure.

MS HUSSEY: So if I explain the starting point in 2006. Clearly that first year was completely focussed on establishing the new system in primary care trusts, overseeing lots of new appointments. We had to downsize the SHA staff from about 900 to about 400, something like that. So that's pretty much the flavour of the first part of that year. There were changes within the SHA in 2007. A new Director of Quality ~~and Performance~~ was created with nursing so I divested myself of the responsibilities

around clinical governance ~~side I initially started with~~ in 2007. So all quality and patient safety went to that role. The performance function was added to the quality role in 2008/09 I think. Then in 2008 we were asked to establish a social care function in the Department of Health part of the region, so we appointed a Deputy Director for Social Care in the team as well. ~~So t~~There was ~~as~~ much ~~a~~ focus on the external local government relationships at the time, ~~and p~~Part of the role was signing off things called local area agreements, and comprehensive performance agreements which then became comprehensive area agreements which were then abolished, but that was part of the function around that ~~sort of~~ time in 2008/2009.

THE CHAIRMAN: What you are describing there is less involvement on the NHS and more involvement on the wider aspects of health?

MS HUSSEY: Yes. In that year it was quite a broad base, I was personally spending quite a lot of time setting up this new social care approach and then trying to connect the teams across the different functions to make sure they ~~stayed~~ worked together. I had a deputy in each side of the role. Coinciding with that, there were some ~~then~~ changes in the deputies in 2009 which were significant in the sense that the deputy I had running the SHA function, ~~if you like,~~ was appointed as Director of Maternity and Children's Services within the SHA. So all maternity and children's issues, ~~it would have been her special interest anyway but she took over all that~~ became her responsibility reporting to CEO. The only thing that she left with me and my Department of Health team was childhood obesity.

MR MONTGOMERY: Just to be clear, who was that so we don't get confused?

MS HUSSEY: That was Anne Hoskins.

MR MONTGOMERY: Thank you.

MS HUSSEY: So she separated from the team and ~~pulled~~ created a small team ~~together~~ to do children's and maternity work. At the very same time at the end of 2008, early 2009 we had been asked to create a new medical director role, a clinical role and we had tried to appoint in ~~the~~, May 2009. Having ~~and~~ not appointed anybody ~~so~~ we had interim arrangements from then until we had a substantive medical director appointed in December 2009 and that was Mike Cheshire. So that was quite an evolving situation in terms of, ~~you know,~~ the different responsibilities.

At the same time, although it's not about structure and roles and you may not recall the significance of this, but at the end of April 2009 the flu pandemic started and so at the very time when the clinical responsibilities were being developed in the clinical medical director role and that children's responsibilities were moving away, my deputy was moving away, I became completely responsible for the pandemic response throughout that summer period. It's a distant memory for most people but not I think, for most of us who were directly involved with it. I was personally responsible for making sure we dealt with it appropriately for seven million people. So it was pretty much a pre-occupation the whole ~~time~~ of that period. I secured some managerial support and then ~~the~~ a Chief Exec joined me late August early September to get ready for the winter period. So that's ~~the sort of~~ the characterisation of the 2009 period. Then, as I say, the medical director started substantively in the December and took over the clinical responsibilities from the temporary cover that had been in place during 2009.

Then within about a month or two, probably late January 2010, I was ~~then~~ asked to take on responsibility for a programme, a transformation programme called Transforming Community Services. This was, in part ~~at the time the~~, recognition that I

probably needed a few more staff because all the staff were dissipating to different functions and it was, I don't know if I should say this, but a sort of dormant policy. It wasn't ~~an~~ actively, ~~it was~~ being progressed ~~but~~ and the sense was it was a manageable thing for me to take on and because ~~it's~~ within community services there were public health services involved ~~so~~ I took it on. However, the policy expectation changed and ~~I~~it then became a ~~major~~, major programme of work. So 2010 was characterised by significant shifting in focus and responsibility on to that, lots of, ~~you know,~~ assurance and process involved in trying to make sure these new models of care were appropriate, because it was about splitting the commissioning and provider function. ~~So t~~That carried on through 2010, ~~until I think we were~~ The SHA was announced to be abolished in, I think - was it June 2010?

THE CHAIRMAN: Mm-hmm.

MS HUSSEY: And then by October 2010 we had redesigned roles and responsibilities again because it was recognised that we had to now start splitting up the SHA. So what was created ~~there~~ was something called 'the bridge' which was led by the Chief Executive, the Director of Quality and Performance and the Finance Director and then the rest of us were allocated to specific responsibilities. So from about September/October time I was exclusively focussed on managing the public health transition at that stage, although when I say 'exclusively', from about the summer of 2010 onwards I was also leading the investigation and management of two major clinical issues ~~to~~ in the screening ~~programs~~programmes. ~~So I personally had responsibility for those as well~~.

So it was quite, I suppose, a complex set of roles and changes through that period. So ~~it's not, it didn't,~~ it didn't end up where it started by any means.

THE CHAIRMAN: Sure, okay.

MS HUSSEY: I suppose the other material thing to put in was a concern about resources during that period which led me to write to the Chief Exec about it in the middle of 2010. Clearly management and cost cuttings ~~hadn't~~ had been done ~~at that time [inaudible],~~ and I was so concerned by that time that I wrote formally to him.

THE CHAIRMAN: Did that have an effect?

MS HUSSEY: Yes in part. Obviously within weeks we were being abolished so it's difficult to respond.

THE CHAIRMAN: Okay.

MS HUSSEY: The response, the initial response was 'we think you can manage ~~your unit~~ okay, keep an eye on it'. The department of health had also ~~we had~~ been cost cutting at the ~~department side~~ as well, all the programmes were coming to an end, we had been instructed to finish the ~~programs there~~programmes.

THE CHAIRMAN: Sure.

MS HUSSEY: ~~So I think probably f~~From the ~~department~~Department's of Health side one of the issues was we couldn't spend any money on communications at all, that all had to stop, unless we had approval by the Secretary of State for business cases. So it was a similar time of pulling back I suppose in much of the areas of work and then I ~~think I actually~~ pursued it a ~~little~~ bit. I broke my wrist ~~and so~~ in the summer of 2010, ~~w~~When I picked it up again in October 2010, when these new arrangements were made, ~~and~~ I pulled back from everything I possibly could and focused just on the public health transition.

THE CHAIRMAN: Right, right.

MS HUSSEY: So it was a very different set of roles during that period.

THE CHAIRMAN: Okay. That's a very helpful context. Obviously the bulk of the

questioning will be on one particular aspect of the role but it's really useful to understand how it changed over time where it fitted into the rest of your duties. I will hand over to Jonathan.

MR MONTGOMERY: Thanks very much.

Can I take you back to the beginning of that story then and you brought the three SHAs together in 2006. Can you tell us something about the hand over in relation to quality concerns and how things were flagged up to sort of prioritize?

MS HUSSEY: The way –

MR MONTGOMERY: Because you weren't in bit of the world before, were you?

MS HUSSEY: No. I was in the other two ~~bits~~ parts of the region.

MR MONTGOMERY: Yes.

MS HUSSEY: So I was personally involved in that and the person who came to lead the quality function at that time was from Cumbria and Lancashire and had been dealing with all the issues in Cumbria and Lancashire. My deputy also came from Cumbria and Lancs. So corporate knowledge transferred with ~~her~~ them through that process and I had been mainly based in Cheshire and Merseyside but I had about ~~—oh gosh, how long is it—about~~ a year, I think, covering Greater Manchester as well so I was familiar with that part of ~~it~~ the Region. I have to say at that time my recollection is of a large number of mental health investigations that needed attention. There were lots of cases that needed to be drawn to a conclusion and had been, I think, built up over so time. So, in recollection that's the feel I had at the time.

MR MONTGOMERY: And the university hospitals at Morecambe Bay, was it flagged up for particular purposes at that stage?

MS HUSSEY: ~~I~~ It wasn't specifically – that wasn't one of the areas I was particularly

focussed on.

MR MONTGOMERY: And similarly, maternity issues in Cumbria, were they in any way on the radar?

MS HUSSEY: I don't recall that. I've checked back on notes and so on, I can't find a reference to that but, you know, as I say, I don't have a specific recollection, but it is possible that it was raised.

MR MONTGOMERY: That's helpful. So do you have a recollection of at what point the university hospitals at Morecambe Bay did register on the radar and for what reasons?

MS HUSSEY: I think, well again it's looking back trying to work it out. There were places that I was particularly focussed on, if I can put it like that. I think, trying to piece back the story, it's probably in 2009, wasn't it, I think that there was an amber rating. It was coming through the foundation Trust pipeline. Their performance had been a little bit variable before that but I don't recall that it was, such that it was coming up as a significant concern so that would have been the early part of 2009 when we saw that rating. ~~so I was aware~~. At that time all the quality and performance issues were led by the director that led that function. Looking back at the board papers obviously there was reference to an amber rating. So I think then periodically it was referenced that CQC was involved at that time.

MR MONTGOMERY: Can you tell us a bit about how the corporate bit of the SHA worked? Obviously you've described the particular portfolios within that but you also [inaudible]?

MS HUSSEY: Yes.

MR MONTGOMERY: So tell us a bit about how that board function operated, you had begun to touch on that.

MS HUSSEY: The usual board system obviously with ~~monthly~~ formal and informal meetings~~, and so on, and informal meetings in between.~~ There were sub-committees; namely audit committee, integrated governance committee ~~established~~, and then more ~~laterally~~ ~~latterley~~latterly there was a new sub-committee created for the provider approvals process just when the Transforming Community Services pressure was building up because there were so many to consider. We had to do 24 all at once.

MR MONTGOMERY: So that wasn't for the FT pipeline?

MS HUSSEY: They brought that together with it at that time. That was about early 2010.

MR MONTGOMERY: Okay.

MS HUSSEY: I think.

MR MONTGOMERY: So quality surveillance would have fed into the integrated governance committee, would it?

MS HUSSEY: Yes, ~~yes,~~ which in the first part of the SHA was attended by ~~the~~ my deputy because ~~[inaudible]~~of her role in the SHA function and then when she left in 2009 other members of my team were delegated to be members of that committee. It could have been in 2010. So that was the basic structure of the board. ~~and then there was obviously they~~The relevant staff had meetings pulling together all the serious incidents, looking at them and following up with investigations. There was an investigations panel looking at things that needed in-depth investigation. ~~following on.~~

MR MONTGOMERY: And how were they discussed at board level? Was all the discussion in the committees with minutes of the board or were there substantive discussions at the board?

MS HUSSEY: Well the board received reports on ~~the~~ quality and performance and obviously other things, so discussion took place then. The minutes of the audit committee came

to the board. The minutes of the integrated governance committee, as I recollect, went ~~through~~ to the next avalible audit committee ~~to the board~~.

MR MONTGOMERY: They didn't go directly to the board, they went via the –

MS HUSSEY: ~~Not to my recollection. I would need to check that~~that the Terms of Reference for intergrated governance committee state that is it a quarterly report to the Board and an annual report. And if there were major ~~sort of~~ investigations or whatever then they would come to be ~~fully~~ presented at the board and there were a number of these that you would have seen from the ~~papers~~files.

MR MONTGOMERY: And how often would the board discuss a particular provider as a concerned risk?

MS HUSSEY: ~~I don't recall the board t~~There were 63 organisations so I think my recollection of discussions would have been, you know, looking at the breadth of ~~what~~ information that was coming in and looking ~~at~~ and commenting on any issues. I don't recall a specific frequency.

MR MONTGOMERY: I presume there would have been exception reports if they were thought appropriate. And do you recall any exception reports on Morecambe Bay?

MS HUSSEY: Through that period of 2009, again looking back, there was reference I think a few times that CQC was looking at them. They weren't progressing in the ~~pipe~~, foundation Trust pipeline ~~because of everything~~ and there were references to various ~~things~~ matters at that time.

MR MONTGOMERY: And the five deaths that came through which at various points seem to have been discussed as a cluster, and was a cluster linked, not linked. Do you know how the view was reached that they were not linked?

MS HUSSEY: I don't. I don't recall being asked to give advice or comment on the cluster or

being involved. I don't know who was.

MR MONTGOMERY: So I mean that strikes me as slightly odd that that wasn't the clinical assessment as to –

MS HUSSEY: That doesn't mean it didn't happen.

MR MONTGOMERY: – whether they were related or not.

MS HUSSEY: ~~Yeah~~Yes. Serious incidents came into the quality team.

MR MONTGOMERY: Yeah.

MS HUSSEY: They pulled in advice from other members, clinicians in my team. I don't know exactly what happened so I would be speculating. Whether they involved the deputy who had a particular interest in maternity and child health I don't know, or whether the interim medical director at that time was involved I don't know and I haven't been able to check back.

MR MONTGOMERY: But you would have expected a clinical involvement of some sort in making that assessment?

MS HUSSEY: I would have thought so. ~~I mean the head – although, having said that, t~~The head of quality, the ~~assistant~~ associate director is a clinician herself.

MR MONTGOMERY: My colleagues may want to come back to that later on. I think it's something we're trying to understand.

Could I move on now to the FT pipeline and how that was handled at board level. So I mean what would your involvement have been in the SHA forming its view about whether it would support or didn't support a foundation trust?

MS HUSSEY: The assessment changed, as you will recall during that period of 2009/10 it became very much something that needed clinical sign off and with this one that was at the point when the new medical director was appointed, so I personally didn't sign off

the clinical issues of that organisation. My recollection, again going back through papers and so on, was that it didn't come through, it was held up and it was reported to the board many times that CQC was involved. And then the sub-committee met, I think in the March, and I noted from the ~~note~~ minutes there, I didn't recollect until I looked back as I wasn't at the meeting, there was a decision to do a desk top exercise. This is what I've seen in the notes.

MR MONTGOMERY: Explain what that would mean?

MS HUSSEY: I think that would have been to look at the breadth of the issues that people wanted to look at in terms of quality and what they knew about it to triangulate all the different measures and things that we used to make a decision as to whether it was appropriate.

MR MONTGOMERY: And how much board discussion was there around the quality system? I mean what was the information the SHA needed to pull in, how they collated it; was that something that the board signed off that system?

MS HUSSEY: In general?

MR MONTGOMERY: Yes.

MS HUSSEY: There was a huge focus on quality across the North West SHA. It set about a whole raft of quality improvement measures. Not directly my responsibility so others will tell you more of the detail. It set up a pioneering quality improvement programme called Advancing Quality. It established a quality observatory called AQuA. It promoted patient safety programs and it did a whole raft of different things to try and promote measurable quality improvements but, as I say, that was led by other people.

MR MONTGOMERY: And did that feed in then, that would have fed into the desk top exercise, did it feed into briefings on where the hot spots were, where the anxieties

were about quality?

MS HUSSEY: I don't know. They were ~~sort of~~ quality improvement focussed activities although by that time as they were starting, I would have to check as to whether the measures that were being reported, which were quite experimental at that stage, ~~so~~ whether they would have been seen to be valid measures. I think the first year they were certainly encouraged, incentivized to ~~get colletcollect~~ the data and then after that it was ~~then~~ more valid data reporting. ~~So it was all about that sort of time.~~

MR MONTGOMERY: And this was around 2010 when that was settling?

MS HUSSEY: 2009. 2008/9 maybe was the first year. tThen it started to come through, I think in 2010, but I would have to check.

MR MONTGOMERY: And the mortality and serious incidents, they would have gone into that observatory, would they?

MS HUSSEY: They started to come through around that time. So the AQuA observatory started to build up expertise in looking at that, but that was 10/11 ~~sort of~~ period I think, if I am right, or maybe even a bit later.

MR MONTGOMERY: And did that include some sort of flagging system where there were deviations from what you would have expected that needed greater scrutiny?

MS HUSSEY: I don't think the observatory were at that stage, although obviously I think around that time Dr Foster was starting to do some of that.

MR MONTGOMERY: Okay.

MS HUSSEY: They wouldn't have come to me at that stage because the new clinical ~~director~~, medical director had been appointed.

MR MONTGOMERY: And was that process connected with SUIs and intelligence coming in through that route?

MS HUSSEY: The quality and performance system was run in a different directorate so they would have been looking at the quality and performance measures and collating everything ~~to~~ into the board reports. You will see from the board reports they do cover mortality. I think there's discussion, if I remember rightly, being pointed out.

MR MONTGOMERY: So they would only come together at the board report level, would they, the SUIs and the mortality and other intelligence?

MS HUSSEY: I think if you were looking for one place where everything was brought into one place, I think it would have been there~~.~~, though the quality team would have an oversight of incidents and quality data. The eExecutive Director meetings would discuss specific issues.

THE CHAIRMAN: And when you reported on them at the board or when somebody reported on those at the board, was that overall numbers? Did you ever look at individual SUIs?

MS HUSSEY: Only the ones that ~~then became, that~~ went on to be an investigation and then there was a formal report from the investigation team. To my recollection anyway.

MR MONTGOMERY: Thank you. So you wouldn't have got an overall picture of all the information held except at board level when those reports were put together?

MS HUSSEY: ~~And t~~That would have been quite high level. The Executive team would discuss specific concerns.

MR MONTGOMERY: Yeah, okay. So quite hard to pick up about individual organisations. Thank you. Can I just say a little bit more about the FT pipeline. In most places SHAs were involved in board-to-board meetings [inaudible] foundation trusts. Was that the case in North West and were you involved in those?

MS HUSSEY: It was the case and again with this particular organisation I didn't participate

in it to my knowledge. ~~Again~~ tThe new clinical medical director was by then, ~~who~~ inpost and it was one of their functions, ~~it namely was the~~ quality ~~of~~in acute trusts. I don't recall being involved. ~~And~~ I was leading all the Transforming Community Service work, I think it was in 2010 but I haven't been able to track the paperwork on that so I can't comment.

MR MONTGOMERY: Okay. So we should ask Mike Cheshire about that bit. Thank you. Sticking with the general system for a little bit more. The relationship with CQC, with Monitor, with the Department of Health around quality issues, did that flow through you, or you're sort of bridging all those organisations locally but did you flow through you?

MS HUSSEY: No, most of the relationship with CQC was through the quality team.

MR MONTGOMERY: Right.

MS HUSSEY: In fact, I was trying to track whether I had met the new CQC and I did actually meet the CQC director in the context of the comprehensive area agreements and the sign off of those, which were local government focussed, I think ~~again until~~in late 2009 but I didn't link with them routinely.

THE CHAIRMAN: Was that the regional director of the CQC?

MS HUSSEY: Yes.

THE CHAIRMAN: Yeah.

MR MONTGOMERY: And the director of quality and performance reported to you from 2007 onwards, is that what you described earlier? You said they created a director of quality and performance?

MS HUSSEY: A directorate.

MR MONTGOMERY: A directorate.

MS HUSSEY: ~~They~~ The quality team didn't report to me~~, no~~after 2007.

MR MONTGOMERY: They didn't report to you.

MS HUSSEY: No, no. This was lead by Jane Cummings, the chief nurse in quality and performance. She was appointed to lead quality in 2007 and performance was added in 2008, I think.

MR MONTGOMERY: Thank you. That's helpful. And then I wanted to ask you about the various reports that were done in the university hospitals at Morecambe Bay which the one that gets the headlines most is the Fielding Report but there were a number of others around that time. What was your knowledge of those reports?

MS HUSSEY: I have been trying to work back in terms of the Fielding Report and I don't recall seeing it. Now I've been trying to find out when it became known and I've a feeling it was around the time I'd left or was about to leave, so I wasn't familiar with it when I went back to them. It's possible I saw it but, as I say, it was a ~~very~~ changing time. I was preparing to leave at that point.

MR MONTGOMERY: So initially when it was commissioned there was some contact with the SHA in terms of [inaudible] but that didn't come anywhere near?

MS HUSSEY: I don't know. I am not aware of – I don't recall any contact on it.

MR MONTGOMERY: And once it came to light do you recall it being discussed at the board? It was –

MS HUSSEY: That's the bit I –

MR MONTGOMERY: – the summer of 2010?

MS HUSSEY: ~~Yeah, yeah.~~ I've been trying to track back and I don't recall it. You know, I just don't so, as I say, I wasn't clear whether it was referenced in a meeting with the exec team. I've been trying to go back but I haven't been able to access the papers so I

haven't been able to pinpoint. As I say, it didn't feel familiar to me looking back now when I was trying to understand events, so I don't know, I just can't pinpoint when it was.

MR MONTGOMERY: I understand that. I'd much rather you told us what you did and didn't know than speculate. That's helpful.

MS HUSSEY: ~~Yeah~~Yes.

MR MONTGOMERY: I think this is the last bit from me to try and understand. I'm trying to get a picture of the SHA's assessment of the management competence capability capacity of the university hospitals of Morecambe Bay which must have come up through the FT process for assessment and I wondered what had got near you in terms of the extent to which it was felt that the management was making progress and there needed to be a new space to do it when it needed support?

MS HUSSEY: The assessment I was seeing was that, ~~you know,~~ it was ~~pretty much~~ reasonably well rated except the clinical score, if I remember rightly. There were other organisations where I was acutely conscious of issues but this one ~~didn't, it~~ didn't come over in that way to me personally. That's my recollection at the time.

MR MONTGOMERY: When you didn't say it didn't come over, it wasn't flagged up to you?

MS HUSSEY: Well, I read the material.

MR MONTGOMERY: The papers coming through it didn't jump out.

MS HUSSEY: I was aware of concerns. I am somebody who is known to challenge. ~~I, you know, usually~~usually, if I think there's something to probe then I would and, as I say, only in hindsight now looking back you could start to pick out different signals and, ~~you know,~~ I've reflected ~~like mad~~deeply about the bits I've been able to put together to work out, could I have challenged certain things but, you know, at the time it came through it

wasn't on my list of ones to watch in detail. Others had responsibility for following up matters. Clearly there were some things flagging at the CQC, I can only speculate as to I must have thought they were looking into things and I would know then if there were issues but, you know, that's me retrospectively trying to explain what I was thinking at the time.

MR MONTGOMERY: It would be helpful for us then to have the benefit of that thinking about what the flags might have been, whether or not they were possible to spot at the time. So with hindsight what are the things that you had asked yourself 'might I have known that at the time'?

MS HUSSEY: ~~Yeah~~Yes. I think some of the performance signals were not consistent. The CQC flags I think were infection and A&E. I'd picked up that the cardiac network was looking at cardiac pathways. I recall a ~~Maternal~~maternal death event – I think the previous year. At that point I went straight into the pandemic and I guess I wasn't close enough then to have, ~~you know,~~ been aware of the detail. I've looked at 2010 and there's a point there when I've questioned myself severely in terms of the reports to the integrated governance committee. ~~in terms of~~ Specifically, the reports into the tragic case of Mr Titcombe and reading through the account, ~~you know,~~ obviously knowing what I know now, and what I have read since then, I took it on trust when the matter was reported at the committee in June 2010. ~~and I think it~~The matter came up again at the end of 2010 and it was reported ~~as~~ that people were satisfied ~~and~~ there had been an investigation and CQC had been involved. So they were points where, you know, again in hindsight you might have wanted to, 'Are you sure? Have you looked further', you know, and so on. But if you read the material it's ~~very much it's~~presented as a resolved issue. Matters have been looked at; other people are looking at it. I don't remember the

exact conversations at the time.

MR MONTGOMERY: Could we tease that out a little bit because I'm trying to understand the balance between we've looked all it and we get some assurance from that, other people have looked or are looking at it and you take assurance from that. Can you just expand a little bit on the picture that was presented through those papers?

MS HUSSEY: Well I'm reading it, you know, with hindsight.

MR MONTGOMERY: Of course.

MS HUSSEY: Don't forget this was the end of 2010. ~~We were pretty much, I at that time~~ I was focussed externally on transferring the public health system to local government but I know I was ~~in~~ at this particular meeting. The papers at the time talk about it as, it was a, ~~I forget the words, a~~ complex case, that the family had been involved, that the CQC and NMC had been involved and improvements had been made, I think it said in the paperwork as well. So, you know, in hindsight if I was to go back and rewind I think one of the characteristics at the time was this was a trust based system. I don't mean trust organisations I mean trusting people. The person presenting the information was highly experienced, highly regarded. I took it that, as ever, it was a thorough piece of work because ~~they, you know,~~ they were capable professionals and I look back and one of the things I take away in reflection is never stop challenging, always look for more. I would say that I'm known for challenging all sorts of things but I didn't press further on this occasion, as ~~for~~far as I can understand from the minutes.

MR MONTGOMERY: You described that as being a complex case as opposed to a system problem.

MS HUSSEY: Yes:, that ~~this~~ is how it is described in the minutes

MR MONTGOMERY: Would that [inaudible] in saying?

MS HUSSEY: Well I think, as I say I am trying to go back by reading the papers. I think it was a complex case but it does say improvements in maternity service has been made I think is the wording in it. Again it was not clear that ~~whether~~ I tuned into, you know, what's underneath that. Well I clearly didn't because if I had at the time I would have done something about it. So in hindsight again, you know, challenging, challenging, challenging is a message for me.

MR MONTGOMERY: So that's coming to the board in mid 2010 and then again at the end of 2010?

MS HUSSEY: That was the integrated governance committee.

MR MONTGOMERY: Sorry, yes. And it only gets to the board –

MS HUSSEY: ~~And it~~The minutes of the December meeting wouldn't get to the board until early 2011, I ~~guess~~ think.

MR MONTGOMERY: Okay. And do you recall whether any context was offered in terms of the Fielding Report when that came to an integrated governance process?

MS HUSSEY: I don't remember that conversation.

MR MONTGOMERY: And would the integrated governance committee have links to CQC system at registration, so that would have been a separate set of questions driven by the SUI process, would it have been?

MS HUSSEY: It was ~~driven by the~~brought to the committee because of ~~by~~ the SHA responsibility for supervising midwives. It came in the context of that, as an investigation into that.

MR MONTGOMERY: And the local supervising authority comes within your portfolio –

MS HUSSEY: No.

MR MONTGOMERY: – at any point?

MS HUSSEY: No.

MR MONTGOMERY: Okay. I think those are my questions, Bill.

THE CHAIRMAN: Okay. Just before I pass you on to Stewart, I'd like to pick up something that you said about trust based system because I think that's absolutely right and I think it's very important. Did the SHA have the kind of relationship with the Trust that would function as a trust based relationship?

MS HUSSEY: It's difficult for me to comment. My relationships with the acute organisations was, ~~you know, there was a sort of big~~based on coming together of all 63 organisations every, I think six weeks in the region, something like that. ~~So I think it was taken it as a trust based relationship.~~There would have been Performance meetings and other interactions led by others.

THE CHAIRMAN: Was that the feedback that you got from fellow board members that generally they felt they could rely on what they were getting from –

MS HUSSEY: ~~I didn't pick up, I didn't pick up that there was suspicions or anything.~~ I mean maybe something, people said something but I'm not sitting here conscious that that's what I was thinking that I needed to go looking for something.

THE CHAIRMAN: Yeah. I mean, often the first sort of faint fluttering of a red flag is the breakdown of that relationship and that the Trust becomes a closed organisation; they don't share information. You didn't pick up that?

MS HUSSEY: The main quality and performance ~~sort of~~ interaction with the Trust was through the other directorate ~~who had~~which led on quality and performance who would have had regular performance meetings with them. As I say, you know, ~~I didn't pick~~I don't recall picking it up, it doesn't mean that they weren't clues there for me. I, through 2009 as I say, I was completely focussed from April onwards on the pandemic

day and night working on that, so if there were things, conversations then, you know, I may have missed some of that aspect.

THE CHAIRMAN: Yeah, I know, I appreciate that. I'm just pushing really to see whether you can recall those kind of conversations with kind of fellow board members where you were having discussions about different places on the Trust and people saying 'oh, yeah, you know, Morecambe Bay I'm concerned we're not really getting to the bottom of the story here.

MS HUSSEY: ~~I hadn't.~~I can't recall much detail of the time.

THE CHAIRMAN: I appreciate it wasn't in your directorate.

MS HUSSEY: ~~I hadn't picked that up.~~ I have a recollection of a discussion with Mike Cheshire about the importance of assuring the information that was being provided in his role as MD assessing the Trust.

THE CHAIRMAN: Okay. Stewart.

MR FORSYTH: Not working in the English health service I must say I find it very difficult to get a handle on the fluid structures that are in place to plan and deliver health services and certainly your introduction sort of reinforced my view that it is complex and it is fluid and I'm just really beginning to understand, have come to see why that was then abolished.

Clearly there was a lot happening at the sort of strategic health authority level around 2-6 to 2-10, which is very much the area we are focusing on. Do you think that the strategic health authority was performing well itself in actually providing a very strong performance management supervision of the Trust?

MS HUSSEY: The SHA I think had an enormous task on its plate; 63 organisations, the largest region, and so on. So yes, it had systems for performance management. Yes, it

had systems for gathering data. By 2009, I think middle of 2009, the performance team had developed a comprehensive ~~sort of~~ dashboard of knowledge about organisations and they systematized it all and ~~was~~ were really trying to drive to, ~~you know,~~ present the data, so it was data driven and systematically data informed. ~~So that's~~ It was an evolving system. If you can imagine you start from scratch and bring all these organisations to one place. ~~So t~~That was a development that Jane Cummings led. The relationship would have been through the performance directors, performance associate directors going out and meeting Trusts and discussing things with them.

MR FORYSTH: But were they really operating fully at what part of the establishment of the merger around 2006 when do you think they had systems in place?

MS HUSSEY: We had – I think they were constantly evolving.

MR FORYSTH: Yes.

MS HUSSEY: ~~We had, you know, don't forget p~~People were ~~often~~ reorganised into a job and then often in a reorganisation you then go out to another cycle of reshaping how the organisation works because the first task is just to make a safe transition. ~~So~~ I wasn't running the performance team. There were other changes in personnel I think at that time as well. We had another director who left, in fact two I think around that time. ~~So t~~There were other changes going on, ~~so~~ I think the landmark point, for me to answer the question that you've posed which is ~~was it~~, "were the systems robust", was the SHA assurance process which was a Department of Health led inspection, if you like, of the SHA which took place in 2009. ~~So t~~That was a stock take point to see whether by that stage the organisation had ~~got~~ good systems and processes. I'm sure you have read the report.

MR FORYSTH: I mean I am just wondering whether obviously from a Trust perspective if

[inaudible] undertaking a major change, new personnel coming in, personnel leaving, systems are slowly evolving whether they, in fact, relaxed knowing that their performance management was probably not going to be as robust as it could be?

MS HUSSEY: I don't know what the climate of performance management was in the old Cumbria and Lancashire SHA because I hadn't worked in that one but I do know what it was like in the other two and it was different again when the North West SHA was created. ~~There was no~~ I think the whole culture at that time was also less bureaucracy ~~and~~ through the changes around that time. ~~So it was, i~~It was a different approach but again the sheer scale of trying to, I think, understand and of being in close contact with every organisation was probably significant in that regard.

MR FORYSTH: And particularly in relation to that latter part, do you feel that clearly you are being given data and you were given traffic light systems and all the rest? I mean obviously your judgment had to depend on the quality of the data you were being provided with. Did you ever have concerns about that?

MS HUSSEY: About the quality of the data?

MR FORSYTH: Yeah.

MS HUSSEY: I think the evolution of the performance dashboard, as it was called, was a major step forward ~~together in us bringing data, or~~ in the organisation bringing data together and being able to interpret it. The sheer volume of what you're told, I think, is a challenge, isn't it, and it's inevitably, as I said before, high level.

MR FORYSTH: Yeah, high level. When that data was presented at the board, for example, who presented it?

MS HUSSEY: The Director of Quality and Performance presented.

MR FORSYTH: So would you have people from the Trust there presenting it and

commenting on it?

MS HUSSEY: I don't recall ~~at~~ them being present. Very occasionally we had a Trust come ~~— now, gosh, I'm trying to remember~~ to attend. The times when they came were, I think, related to major service change because obviously at the same time there ~~were~~ was enormous reconfiguration of services going on. So I'm trying to think, I think they were the occasions when Trusts themselves came to present data or if there was a major investigation report.

MR FORYSTH: So you would have data that was generated in the Trust being passed on upwards and then some director then presenting this data to the board?

MS HUSSEY: Yes.

MR FORSYTH: So there was therefore no contact between the sort of highest level of the board with actually people who are working on the ward or at a –

MS HUSSEY: On the ward, not usually. ~~T~~though SHA members did undertake visits occasionally.

MR FORSYTH: – at a clinical level?

MS HUSSEY: No, not usually at the Board meeting, though there were clinical meetings of MDs and NDs across the region and an extensive engagement process as part of the DARZI review and the clinical leadership network.

MR FORYSTH: You mentioned about in 2009 that the Care Quality Commission were involved and there seemed to be an amber rating. It didn't come over to me as if that was something that got the SHA terribly excited.

MS HUSSEY: This is where I've got a period of 2009 when I've been trying to work out what the conversations were because they would have been followed up through the quality and performance directorate. I, from the end of April until September/October,

was full-time on pandemic so personally I haven't been able to track back and understand what the linkages were between the quality and performance team and CQC at that time, so I can't comment, it's an area that I can't shed light on.

MR FORSYTH: Would it not, that might be generally seen as a fairly important issue and something to be followed through.

MS HUSSEY: Yes. As I say, at the time the leadership for the quality and performance team ~~they~~ would have been working with CQC. They would have been the people coming back with information.

MR FORYSTH: How many amber ratings might there have been at the time; do you recall that? Amber would look very worrying if all the others were green, if they were all red.

MS HUSSEY: Yes, ~~I haven't got that at the top of my mind.~~ I can't recall it. I know it's there but I haven't got it with me.

THE CHAIRMAN: I mean as a matter of record it was actually red, the CQC rating was red in the middle of 2009.

MS HUSSEY: Right.

THE CHAIRMAN: And then it went to amber later in the year.

MS HUSSEY: Right.

THE CHAIRMAN: And then in the April when it got registered it went to green shortly after it was registered.

MS HUSSEY: Right.

MR MONTGOMERY: But I think there's a separate risk rating within the SHA.

THE CHAIRMAN: Yes, but I wondered, I wondered how they –

MS HUSSEY: That's what I'm referring to.

THE CHAIRMAN: Okay. But was there any cross-referencing between the CQC's rating

and the SHA's rating?

MS HUSSEY: I don't know because that would have been prepared by others. I personally am not ~~wasn't~~ aware of the detail.

MR MONTGOMERY: I had that as a question to ask earlier on.

THE CHAIRMAN: Okay. Sorry. Did you want to come back, Jonathan?

MR MONTGOMERY: No, I think I was trying to get a sense but I think we can ask later on because the SHA shifted the rating from green to amber in February 2010 so that's independent of the CQC so we would want to understand that.

MS HUSSEY: That's fair enough.

THE CHAIRMAN: It's going in the opposite direction from the CQC.

MR MONTGOMERY: Exactly.

THE CHAIRMAN: Yeah, okay. Yeah, I've got a few just things to follow up on. There's another relationship involved in all of this that we haven't discussed, which is between the SHA and the PCTs. How did that operate and were you involved in them?

MS HUSSEY: Yes, they were part of the coming together every six weeks of the NHS group, then over time they set up their own separate meetings which I would go to for various issues and attend for topics.

THE CHAIRMAN: And were things like Trust performance and quality discussed in those meetings?

MS HUSSEY: Quality matters were discussed though~~T~~to my recollection not in detail. There were strategic issues being discussed. ~~I don't,~~ I haven't been back to those papers to double check. I'm not sure of exactly what was covered. However, quality and safety was discussed at the meeting of 63 organisations which ~~ususally~~usually followed the PCT meeting.

THE CHAIRMAN: Yeah, okay. And the relationship with Department of Health as well, or NHS England it became at some subsequent point but I think at this period it would have been DH. What was the relationship like with the SHA? How did it work?

MS HUSSEY: I had a separate relationship with the Department of Health through a different route, through the public health route. So the SHA chief executives obviously met and led through that route and then there were professional connections with the different heads of the different directorates. I suppose the formal relationship was the SHA assurance process, that was probably the main focal point when the whole thing came together. When they assessed the SHA they contacted all the NHS system, asked them about the SHA and then assessed the SHA's workings and did a deep ~~down~~ dive within the various topics areas. ~~y~~You would have seen the papers and the response.

THE CHAIRMAN: Sure.

MS HUSSEY: They flagged up, as you will be aware, areas for improvement which we ~~got~~ recieved in March 2010. The response around that time, which linked also to the implementation of a new initiative called QIPP, quality innovation productivity and prevention, was to ~~create a~~strengthen the programme office to try and improve the ~~sort of control~~co-ordination of all different elements of the workings of the SHA. ~~and then, that then also well that~~After the abolition of SHAs was announced QIPP as a programme stood but then ~~this~~ a 'bridge' thing was created in September or October when it became the chief exec, the director of quality and performance and the finance director ~~sort of controlled~~who oversaw things. ~~because~~ ~~a~~At that point it was signalled we needed to break things up into~~, so~~ transition roles. ~~a~~A new provider director was appointed in October 2010 and so I stopped doing all the things I was doing on transforming community services and handed over various things and then we ~~sort of~~

started looking at different elements we were responsible for at that point and re-designed responsibilities.

THE CHAIRMAN: Okay. What was the main – this is a question in your corporate role really. What were the main themes that were coming down from the Department of Health? Was foundation trust status an important issue?

MS HUSSEY: It did come across as such. I mean you will see in the board papers it was fed back that one of the objectives was to make progress on FT organisations., ~~t~~There was a ~~whole~~ provider development work programme, it was very much a flavour at the time and then on top of that we had the split of the PCTs ~~and~~ to create ~~the~~ commissioners and providers of ~~the~~ PCT services as well. So provider creation was a strong theme at the time and there was an expectation that trusts would get to FT provider status. As you will see from the board papers that was explicit. ~~I mean~~ I don't recall feeling, you know, you have to do it regardless ~~sort of thing~~. I think it was 'you have to make progress' was my recollection of it. Others might have felt it more strongly, I don't know.

THE CHAIRMAN: Yes, that's what I'm getting at really. What was the degree of drive to achieve this?

MS HUSSEY: Again, I personally didn't, you know, ~~worry~~ feel pressure that we had to create all these FT providers ~~arms~~ for the hospital side. Clearly, when I was responsible for the transforming ~~the~~ community services programme then the job was to create 24 provider arms and that's a complex negotiation of different models. But on the acute trust side, as I say, I personally didn't feel that pressure but it was evident in the board that the corporate requirement was that we should make progress., ~~but, you know.~~

THE CHAIRMAN: Okay. Okay. I want to ask you a couple of hypotheticals because I

know from what you've said that you weren't directly involved in these issues but I do want to get your view on them. The first one is if you have five clinical incidents where the clinical details of what happened differ, does that mean that there's no systemic common factors?

MS HUSSEY: No, not at all. You can't assume that. The things I'm really interested in and, you know, one of the huge bits of learning I've taken away is how do you get out of the trap ~~almost~~ of looking at issues as individual issues, especially if they're, thankfully, relatively rare but then don't aggregate them up so much that you lose the detail_, ~~and I think with,~~ I've just read ~~the report on~~, the latest report from The Royal College of Paediatrics on why children die and it's well described, the difficulties of trying to work out patterns and themes but I think there's a lot more to develop in this area of how you ~~get~~ move from individual events to being able to then create a more useful understanding that ~~triggered something~~, that triggers an in-depth questioning and improvement.

THE CHAIRMAN: Yeah.

MS HUSSEY: So no, I don't think those five things would automatically lead to a conclusion, you know, because they appear on the surface of it to be different. What I think we need to be moving more towards is where you ~~get~~ use statistical process control, to use the jargon, you know when something pops up that says, 'Go and have a look'.

THE CHAIRMAN: Yeah.

MS HUSSEY: Now you can't rely on data completely.

THE CHAIRMAN: Sure.

MS HUSSEY: Data ~~is~~ are imperfect but there's something that needs to happen between

individual incidents and the sort of surveillance, the general surveillance that's done at population level. I think there's something in between.

THE CHAIRMAN: One way might be not to classify them on a clinical basis but to classify them on a behavioural basis or a systems basis?

MS HUSSEY: ~~Yeah.~~Yes.

THE CHAIRMAN: Okay.

MS HUSSEY: I think there's work to be done there and it's something that I'm very interested in.

THE CHAIRMAN: Sure, sure. Okay. And the second one is you must be familiar with the Fielding Report now.

MS HUSSEY: Yes.

THE CHAIRMAN: And I realise this is in hindsight, but I mean had you been aware of that in 2010 would that have raised concerns?

MS HUSSEY: Well, yes. It would have triggered questions, wouldn't it, and a response, which it did ultimately.

THE CHAIRMAN: Well that's a different issue. But you weren't responsible for the response?

MS HUSSEY: As I say, I've been trying to piece whether I saw it and I don't recall seeing it. I don't know when it became evident. Looking at it now, there's a whole raft of things that need to happen. ~~We did it in hindsight.~~ I don't recall seeing it at the time.

THE CHAIRMAN: But I mean the logical extension of that is that whoever did see it at the time really probably should have had the same thoughts about it?

MS HUSSEY: Yes.

THE CHAIRMAN: Okay. Would anybody like to?

MR MONTGOMERY: There's two, one or two very quick.

You talked about discussions and treated issues with the PCTs I think it was in relation to Stewart's question. I wonder whether the sustainability of maternity services at Barrow was ever flagged up with [inaudible].

MS HUSSEY: I recall conversations about Whitehaven. I think there was quite a lot of interest in Whitehaven. I think generally awareness that small services and sustainability was an issue at ~~[inaudible]~~the time. Again I wasn't close to it.

The other thing I haven't mentioned, going back to PCTs, was the role of World Class Commissioning and that ~~whole~~ in-depth assurance ~~in-depth~~ process that we did. I led on a number of PCTs in Greater Manchester so again I didn't get exposure to ~~that~~ Cumbria and Lancs but that's a really rigorous in-depth process over a whole week.

MR MONTGOMERY: If I can ask a hypothetical, a little bit like the one Bill asked, whoever was [inaudible] with Cumbria, would you have expected them to have seen the sustainability problem of maternity services coming up through World Class Commission as a priority?

MS HUSSEY: I think they would have seen the issues that the PCT was wrestling with and I know that ~~I in, without drawing other organisations into this, but the piece that I did in~~ in another part of the patch the relationships issues came up and issues about what they were wrestling with and those sort of things. But, as I said, by the time we got the feedback on all 24 ~~it was again~~the discussion was 'are they okay, are they classified appropriately', and so on.

MR MONTGOMERY: With the benefit of hindsight you would have expected the World Class Commissioning assessment to have teased out whether Cumbria PCT knew that

this was a set of issues or they were under the radar?

MS HUSSEY: I think – I don't know. It's not fair of me to comment, I wasn't there. The other thing, of course, there was strategic work on maternity and child health at the time which my colleague can tell you about. ~~So t~~There's a strategy called ~~m~~Maternity ~~m~~Matters and there was the 'eEvery child counts' strategy as well. So ~~t~~There were major national level reports ~~on where there was~~ and work ~~programs~~ programmes. ~~flagged up there as well and~~ I think a number of children services were flagged up in that process to follow up as well. ~~and the reports around them.~~

MR MONTGOMERY: The last question is really a general one. SHA cultures varied enormously.

MS HUSSEY: Yes.

MR MONTGOMERY: Possibly almost as much as under 10, as under 20, and you saw the three in this area. Some had a very controlled process, some had a very devolved process. What the North West like?

MS HUSSEY: I'd characterise it as innovative, ~~some~~ encouraging, improving services, focussed on that probably more than the "banging the table" performance management style. I can characterise it like that.

MR MONTGOMERY: So the expectation would have been with an organisation that was struggling that it would be helped to succeed as opposed to –

MS HUSSEY: It was a positive environment ~~too~~. That's my reflection on it. As I say, I've been in other situations where it's been much more ~~iffy~~critical. ~~And don't forget t~~That sort of style of heavy performance management was I think also being questioned, wasn't it~~.~~? So getting the balance ~~I think~~ is important~~,~~ I think ~~we were~~the SHA was probably more on the positivist side, creating new opportunities, new ways of working

if I was to look at the spectrum. However, there were situations where performance interventions were made if concerns were unresolved.

MR MONTGOMERY: And last question, I know I said that before.

THE CHAIRMAN: That's three you've had.

MR MONTGOMERY: Yeah. Gold command postdates your involvement, but one of the things we've heard is that the idea of calling an incident made sense in Cumbria because of this experience of dealing with incidents, including flooding and shooting over that period. Can you say a little bit about whether you have any perceptions on whether declaring incidents and pulling people together like that worked particularly well in this area from what you saw?

MS HUSSEY: Oh, gosh, that's hard for me to comment. Obviously, I had no ~~handle~~ role in that. Looking at ~~some of~~ it now, it does galvanize people, it galvanizes resources, it galvanizes attention. Cumbria definitely had a track record, and more than their fair share, of significant events so they did have, you know, an experience of working like that. I don't know the detail of how that came about. What struck me though, as I was looking through it, was the difference between having a major incident like they'd experienced such as a train crash and a shooting is one type of major incident. There's another type, which is the 'rising tide' where things start to come together and you come to a critical point and you ~~go~~say, 'this has now come to a critical point, we have to change what we currently do to do something different'. As I say, I can't comment on what the thought processes were at the time. ~~but I would be resonating.~~

MR MONTGOMERY: We can ask that later. Thank you.

THE CHAIRMAN: Stewart.

MR FORYSTH: Yes. My last question was similar to Jonathan's around the strategic

planning of children's services within the area. You said there was some work going on, but was there anything, was there a strategic plan for maternity and children's services across the North West and particularly across Cumbria and the Morecambe Bay area?

MS HUSSEY: My colleague, as I say, led on maternity and child health. They started developing an overarching ~~sort of~~ plan for the North West. Again it wasn't expected that the North West, ~~you know~~that is the region as a whole, had had its own plans. I know there was a report on paediatric services in Cumbria around that time. There would have been discussions I'm sure. As I say, I wasn't close to them, but her role was very much about focusing on maternity and child health so I think she would be able to answer more about the detail of that.

MR FORYSTH: And do you recall ever maternity and children's services coming to you at board level?

MS HUSSEY: Yes, it did from the proposals that had been ten years in the gestation in Greater Manchester. We had a big focus on reconfiguration there. ~~I don't — oh gosh, I would have to go back.~~ I don't recall, I don't think there was a specific position brought forward in Cumbria and Lancashire but I may be wrong. There was work underway in East Lancs too. We also received a report on childhood mortality.

MR FORYSTH: Okay. Thank you.

THE CHAIRMAN: Two final points from me. I'm assuming that you don't have any information about individual clinical cases and therefore that we don't need a confidential session, but correct me if I am wrong there?

MS HUSSEY: No.

THE CHAIRMAN: Fine. In that case is there anything that you would like to say that you

feel that we haven't covered that you would like to put forward?

MS HUSSEY: I think I've pretty much explained, ~~you know,~~ my remit ~~on it~~ and obviously, ~~you know~~, my personal reflection that there's a lot of learning here, ~~and~~ I look forward to ~~sort of~~ understanding better all the different components to it. It's a tragedy that we got to the point that we did and I can only apologise for that.

THE CHAIRMAN: Thank you. That's the end of the interview. Thanks for coming.

MS HUSSEY: Thank you.

[Interview Concluded]