THE MORECAMBE BAY INVESTIGATION

Tuesday, 1 July 2014

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

Before:

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

Professor Andrew Calder

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1

1 (At 1.30 pm)

2 DR KIRKUP: Thanks very much for coming. I've introduced myself, but I'll get the

3 other panel members – oh, you know Stewart, obviously.

4 PROF MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Health Care

5 Law at University College London, and also chair the Health Research

6 Authority and have previously chaired PCTs and an SHA in the South.

7 MS FEATHERSTONE: And I'm Jacqui Featherstone and I'm Head of Midwifery and

8 Head of Nursing at a district general hospital in Essex.

9 PROF CALDER: Right. I'm a little bit hard of hearing, so I'll ask you to repeat

10 things.

11 DR KIRKUP: The acoustics aren't all that good in this room actually. That's partly

12 the reason why we have all the electronic gear. It's not that we're

13 broadcasting, but we are recording what we say and what you say, and we will

14 produce a record of that at the end of the interview. These sessions are open

15 to family members to attend. As it happens, we haven't got anybody here this

16 afternoon, but they will be able to listen to parts of the transcript if they want to,

17 as long as there's no confidential information on there; we don't expect there to

18 be, in your case. As you know, we have removed any devices that you've got

19 that might be able to record things, and we'd ask you not to transmit any

20 written notes or any recollections –

21 PROF CALDER: I'm not wired, if that's what you're wondering.

22 DR KIRKUP: Yes, okay. You might just have a good memory. Please don't

23 transmit any of the material in advance. We want to be able to consider all the

24 evidence and put it all into context before any of it starts to come out. Okay,

1 can I lead off then just by asking what your involvement was with the report
2 that was produced? Your involvement was with the Fielding report, I think.
3 PROF CALDER: I'm surprised you're asking that question. I'd have thought it would
4 be fairly clear. Maybe it's just for the record, but I was asked, in fact, by
5 Professor Anne Garden, who's the Dean of Medicine at Lancaster University, if
6 I would help the process. I think she'd been approached by a Medical Director,
7 and it was explained to me that this was an internal request from the trust to
8 review the maternity services across Morecambe Bay, and, under the
9 chairmanship of Pauline Fielding, a very eminent lady, and a midwife, Yana
10 Richens, so I was, I suppose, the obstetric input to that.
11 DR KIRKUP: Okay, thanks. I'll hand over to Jonathan.
12 PROF MONTGOMERY: That was almost my first question. So we went over quite
13 a lot of the report with Dame Pauline, but there were a few things that it wasn't
14 quite clear to her or to us that we needed to –
15 PROF CALDER: I may not be much better, actually.
16 PROF MONTGOMERY: No, that's fine. And the first bit was really around how the
17 panel was put together, so you started answering that, I think, where the
18 approach came to, but can you tell us whether that was before or after the
19 terms of reference were finalised, what sort of opportunity you had to shape
20 the remit?
21 PROF CALDER: I'm sure the terms of reference were already in place. I don't
22 remember having any input to that, although it seemed that they were
23 appropriate, but I think that was the timescale.
24 PROF MONTGOMERY: Okay, and you described it in fairly broad terms, in terms of

1 reviewing maternity services. There had been already a couple of reports into
2 some of the issues by that stage, so can you help us to understand what the
3 trust said to you was the relationship between the work that you were expected
4 to do and what had already been done?

5 PROF CALDER: Well, there was clearly a background of episodes or incidents, and
6 there had been a cluster of serious untoward events in Furness. It was made
7 clear to us that we were not expected to reinvestigate these issues, and,
8 indeed, with hindsight, I'm perhaps a little sorry that we didn't have more
9 insight into exactly what had gone on with those, but that was really quite clear.
10 And, in fact, that made it, I suppose, a more straightforward process, as far as
11 we were concerned, in that we were looking at how the service was set up,
12 how it was functioning and exploring where we might be able to recommend
13 improvements. So I'm not sure if that's answered your question.

14 PROF MONTGOMERY: It's gone quite a long way towards it. So what you said
15 initially was about a review of maternity services, but you were asked to review
16 in the light of the fact that work had already gone on.

17 PROF CALDER: Yes, well, that's right. I mean, we knew that there had been
18 concern – there was a lot of media interest – and that the trust had already had
19 various processes that they'd gone through. So we felt that our remit was –
20 and it was explicit – that we were to review the current state of affairs and
21 make recommendations as to where improvements might be made.

22 PROF MONTGOMERY: Thank you. Can you say a little bit about how you divided
23 up the...? There were three of you, so you've got a senior nurse, although,
24 from what she said, as much there as an experienced chair of investigations as

1 around nursing. You've got a colleague midwife. You don't, for example, have
2 a paediatrician. Was there any discussion around what information support
3 you might have wanted?

4 PROF CALDER: As a member of our group? No, that never really was considered,
5 I don't think, and I don't really think... I mean, I think both the midwife on the
6 panel and myself had pretty good insights into what the paediatric issues were.
7 Possibly that was an error, but the main thrust was certainly on the clinical
8 obstetric side of it and the midwifery side of the thing.

9 PROF MONTGOMERY: And you saw quite a lot of people and you went through –

10 PROF CALDER: Yes, you were asking how this was conducted. We must have
11 seen 30 or 40 people altogether, and the interviews were quite carefully
12 structured. Sometimes, all three of us would be interviewing people, either
13 individually or in groups. Sometimes it would be Dame Pauline and Yana
14 Richens there, if it was mostly on the nursing and midwifery side, and, on some
15 occasions, it was myself on my own, I think, on a couple of occasions, but at
16 least on others with Pauline Fielding, but my recall is fairly patchy, as you might
17 imagine, after four years.

18 PROF MONTGOMERY: I can understand that. We were a little unclear, when we
19 were hearing from Dame Pauline, whether you managed to see all the people
20 that you felt you needed to see, and how cooperative the trust had been.

21 PROF CALDER: I think there was a feeling that maybe they could have been more
22 helpful. I had a bit of difficulty arranging a meeting with the Medical Director,
23 but eventually I did manage to do that, quite late on in the process. So I think
24 we did get to all the individuals that we felt we needed to speak to, but perhaps

1 there was that – just a slight feeling that maybe the trust weren't as engaged
2 with the process as maybe they should have bene, but I think that's – I would
3 hate that to be more than –
4 PROF MONTGOMERY: And you saw the Medical Director. Who else did you relate
5 to at board level in the trust?
6 PROF CALDER: Well, we saw the Chief Executive, and we saw a non-executive
7 director at some point.
8 PROF MONTGOMERY: You didn't go to board or –
9 PROF CALDER: No.
10 PROF MONTGOMERY: No, and the non-executive you saw, was that because they
11 had a particular role or they happened to be around on...?
12 PROF CALDER: I think that was just somebody that could be made available to us,
13 but, again, I'm not absolutely recalling in detail.
14 PROF MONTGOMERY: Okay, and you did site visits.
15 PROF CALDER: Yes, we went to all three sites. I can't remember in which order. I
16 think we probably went to Helme Chase first and then to Barrow – or, rather,
17 Furness, and then, finally, down to the Royal Lancaster Infirmary. But we
18 certainly had good visits to all the places, where we met a lot of the people we
19 were wanting to interview.
20 PROF MONTGOMERY: And you can remember your impressions of them?
21 PROF CALDER: Of the places? Yeah. I mean, Helme Chase, as I think probably
22 came through in the report, we saw it as a kind of privileged arrangement in a
23 nice part of Cumbria with a different clientele than the other places. I was
24 shocked. I had no understanding, before I came to Cumbria, that Barrow-in-

1 Furness was quite such a deprived area with quite the complexity of social
2 issues, and that was very apparent when we went there. And I think we were
3 also, perhaps, of a view that the investment in the facilities there was less
4 impressive than perhaps it was in the other two sites, but that was a broad
5 generalisation. There were specific issues that came out in the report about
6 facilities and so on.

7 PROF MONTGOMERY: Can you elaborate a little on those?

8 PROF CALDER: I beg your pardon?

9 PROF MONTGOMERY: Can you elaborate a little on the things you were most
10 concerned about in terms of...?

11 PROF CALDER: Well, at Furness, there was the issue of the operating theatre in
12 particular, access to the operating theatre for emergency processes in
13 particular, and that that was really not as satisfactory as it might have been,
14 and, also, facilities for the staff – you know, where they able to have places
15 where they could take their breaks and so on?. These were, I suppose, issues
16 which were more in the nature of the – what's the word I'm looking for – just the
17 niceness or otherwise of the facility, rather than specifically clinically important
18 issues, but we were unhappy at the idea that midwives and nursing staff were
19 eating their breaks at the nursing station and so on, when they should have
20 been perhaps given a chance to do that elsewhere.

21 DR KIRKUP: What about the access to the theatre? Did you think that came under
22 the same heading?

23 PROF CALDER: Sorry?

24 DR KIRKUP: How about access to the theatre? Did that have any clinical

1 implications?

2 PROF CALDER: Oh, yes, absolutely. I mean, that was one of our main concerns
3 on the clinical side, that that was something that really needed to be
4 addressed. I mean, I should have said at the very start of this process that I'm
5 astonished that I'm now coming back to talk to you about this without any
6 insight into what happened subsequent to our report. It was our clear
7 understanding that we would be invited back within, perhaps, two years to see
8 what had happened to our three dozen recommendations, and I'm sitting here
9 with no understanding of what has changed in that time. Now, maybe that's
10 not helpful to you, but it certainly makes it difficult for me to see what has
11 happened, but, presumably, the fact this is happening as a process suggests
12 that there are still ongoing concerns.

13 PROF MONTGOMERY: I think if we said that CQC published a report last week
14 and it took them eight minutes to find the –

15 PROF CALDER: Sorry, I'm not hearing you.

16 PROF MONTGOMERY: The Care Quality Commission published a report last
17 week, which states that it took them eight minutes, when they visited, to find
18 the key to the corridor to enable an emergency section to get through to theatre
19 suggests that it's not necessarily moved on. Could we ask you about when...?
20 I think one of the themes we have to trace through, because it still hasn't been
21 sorted, is who knew what about it at what stage. So we've obviously been able
22 to pick up in your report that you made reference to access to theatre. What
23 about at the time of the visit? Was that something that you raised with people
24 who were there?

1 PROF CALDER: Oh yes, and they were unhappy about it as well. I think the clinical
2 staff were. I think there was a general feeling in our visit to Furness that they
3 felt they were the poor relations and they hadn't really been given the support
4 in terms of supervision, leadership, staffing and so on that perhaps they ought
5 to have had.
6 PROF MONTGOMERY: And so staff locally are concerned about that.
7 PROF CALDER: Yes.
8 PROF MONTGOMERY: Did you get any feel that staff higher up in the organisation
9 were cognisant of the problems?
10 PROF CALDER: I think they were aware of it. I mean, I don't want to seem to be
11 very specific about this, but I got the sense that there was a divergence
12 between the clinical setup at Royal Lancaster, where they seemed to have a
13 fairly coherent set of consultants, who – albeit perhaps their priorities were not
14 as balanced as I might have felt was appropriate, but that Furness was seen
15 as a remote, quite a long way away, not really giving them a great deal of
16 concern, although they were probably aware of the fact that it wasn't
17 functioning as well as it should have been. But I think that really reflected an
18 overall view that this trust didn't seem to work as a coherent unit, which is of
19 course quite understandable in a sense, because of the geography of the
20 setup.
21 PROF MONTGOMERY: But the centre of gravity for the trust leadership was at
22 Lancaster.
23 PROF CALDER: Certainly seemed to be in Lancaster, yes, that was my impression.
24 PROF MONTGOMERY: So did you see senior trust people when you were out and

1 on the visits to the other two places?

2 PROF CALDER: Yes. I don't know how you define senior trust people. I mean, we

3 saw the consultant staff; we saw the midwives, the ones that were in

4 supervisory roles. I don't think we saw any administrative staff at Furness. I

5 think that was more at the... I'm even trying to remember where – the trust

6 offices were in Kendall, I think, and we were based in Kendall, so the meetings

7 we had with the administrative staff were, I think, at the trust offices in Kendall,

8 and, on the other sites, we were really meeting clinical staff, including... I think

9 I met the Medical Director down at Lancaster, or it might have been in Kendall

10 as well, but not sure.

11 PROF MONTGOMERY: And the theatre issue – whose responsibility did you think

12 that was within the trust to sort that out?

13 PROF CALDER: That was... I mean, at the time, that was drawn verbally to the

14 attention of the Chief Executive and the Medical Director, I think, but it's very

15 clearly a quite explicit part of the report, which indicates that we felt that was an

16 important issue that needed to be addressed.

17 PROF MONTGOMERY: And you raised it at the time when you went around as

18 well.

19 PROF CALDER: Oh yes.

20 PROF MONTGOMERY: And had you got any assurance between the time you

21 visited and the publication of the report, which is quite a few months, about any

22 progress on that?

23 PROF CALDER: No. I mean, as I've indicated, we have had no feedback – I don't

24 think Pauline Fielding has either – as to what steps have been taken to

1 implement the recommendations in the report.

2 PROF MONTGOMERY: What was the expectation when you agreed to take it on?

3 You've talked about the expectation of being able to go back a couple of years

4 later and follow up. Who was the report said to be for? Who were you

5 reporting to?

6 PROF CALDER: I presume it was directed specifically to the senior management – I

7 mean, the Chief Executive and, I would have thought, the Medical Director. I

8 didn't address the envelope, but I think... I mean, I suppose I would like to be

9 assured that the report didn't go into a filing cabinet somewhere and gather

10 dust, because that happens far too often with things in the health service.

11 People feel, 'Oh, well, we've had a report now; we can move on.' But I'm in the

12 dark, and I'd be delighted if these recommendations had been implemented,

13 but I've no way of knowing.

14 PROF MONTGOMERY: So what efforts did you and colleagues make to find out?

15 PROF CALDER: None whatsoever. We didn't feel that was our role. I mean, I

16 suppose, as time passed, we became surprised that we hadn't been invited

17 back. Possibly we should have made a firm arrangement before we left

18 Cumbria that we would return. That may well be something that we should

19 have considered, but it didn't seem... At the time, we'd indicated that we

20 expected to be invited back, but it wasn't as if we were descending on them as

21 an external review like you're doing. It was an internal request that we should

22 make recommendations to help them to improve the service, and therefore it

23 seemed logical that we'd be invited back to see.

24 DR KIRKUP: Who had led you to believe you'd be invited back?

1 PROF CALDER: I think the Chief Executive especially.

2 DR KIRKUP: Okay. Who was the Chief Executive at that time?

3 PROF CALDER: I haven't a clue. I can't remember.

4 DR KIRKUP: Mr Halsall?

5 PROF CALDER: Hmm?

6 DR KIRKUP: Tony Halsall?

7 PROF CALDER: Sounds possible, yeah. That might be a name I can recall, yeah.

8 PROF MONTGOMERY: Do you remember what stage you met with him and with
9 the Medical Director? So you were engaged by the Professor of Nursing from
10 the university – or the trust?

11 PROF CALDER: No, no. No, it was the Dean of the Medical Faculty at Lancaster,
12 Professor Garden, that contacted me, but, I mean, I had just indicated to her
13 that I was willing to help, and then I was approach by, I presume, the Chief
14 Executive and asked to take part – or the Medical Director. I think it was the
15 Medical Director, in fact, but I missed one of your responses there, what you
16 said, something else, before I –

17 PROF MONTGOMERY: I was trying to understand at what point you met the Chief
18 Executive and Medical Director.

19 PROF CALDER: Oh yes. I think we may have had a very quick initial meeting with
20 some senior management from RLI, but I think the meeting with the Chief
21 Executive and the Medical Director came quite late in the process. I'm even
22 not absolutely clear how many visits we made. I think there were three. There
23 were certainly at least three, I think, when we came, and we were based in
24 Kendall, and we then went around the different sites – probably not more than

1 three, maybe even two, but it would be a few days at a time, but I'm sorry; I
2 really should remember, but I didn't think there was any reason to.
3 PROF MONTGOMERY: It was a long time ago; I entirely understand that. Did you
4 visit any of the sites more than once? I guess I'm particularly interested in
5 whether or not you had an opportunity to ask them what they were doing –
6 PROF CALDER: I have a hunch we went back to Furness a second time. Yeah, I
7 think we did.
8 PROF MONTGOMERY: And did you get any indication that they were taking
9 seriously the theatre issues that you'd raised with them?
10 PROF CALDER: Well, I think they realised there was a problem and they were
11 anxious – and I think they felt that, with luck, our report would actually help
12 them to implement that. I think the other thing was that they were –
13 PROF MONTGOMERY: So you think they knew there was a problem already,
14 before you came.
15 PROF CALDER: Well, yes, I think they were aware of it, and the junior staff were
16 unhappy about it. But I think also there were uncertainties as to what was
17 going to be happening about the medical staff. I have a feeling that somebody
18 was approaching retirement, and one of our principal concerns was to see
19 appropriate leadership coming into the Furness hospital, with hopefully an
20 appointment of somebody externally with an interest in – a particular interest in
21 obstetrics and perinatal medicine, because that seemed to be the poor ~~more~~
22 relation of the whole setup, as it so often is, I'm afraid, in our specialty.
23 PROF MONTGOMERY: And can you say a bit about your impression of the
24 relationships between the different groups of staff? It's implicit in the report, I

1 think.

2 PROF CALDER: There were certainly tensions, I think we saw, maybe not any more

3 so than you often find between disciplines. I think the midwives, by and large,

4 were a fairly coherent group themselves. I think there were different

5 expectations that perhaps – between the obstetricians and the paediatric staff

6 and maybe a feeling that the paediatricians should be more heavily involved in

7 the day-to-day activities in Furness, and I think that was one of the things that

8 we highlighted in the report.

9 PROF FORSYTH: I was keen to get your views on how they were working together.

10 Secondly, did you feel, from the information you got on quality of care, good in

11 some parts and not good in others – how was that all coming together or not

12 coming together to have a good result at the end of the day?

13 PROF CALDER: Well, I think there was a feeling that they weren't getting on as well

14 as they might. I think it's clear that Furness is not an attractive place to work,

15 and, therefore, it's not surprising that perhaps the calibre of clinical staff that

16 they were able to recruit wasn't of the highest order. But, within that context, I

17 think those that were in post, by and large, were doing their best in difficult

18 circumstances, and, while we were able to suggest that there might be more

19 explicit involvement of the paediatric staff in the setup – because, I mean, as I

20 recall – and, Stewart, I can't remember specifically whether... I mean, there

21 was no neonatologist as such. There were people with neonatal interests, and

22 I think the person, I recall, that had most of the neonatal interest seemed to me

23 to be working pretty well and having quite good relations with the obstetric staff,

24 but then that individual couldn't do the whole thing on his or her own – I can't

1 even remember the gender.

2 PROF FORSYTH: I think it's a problem with providing 24/7 cover for an event that
3 could occur at any time. I did wonder, also – I'm not sure if – the staff
4 community midwives – you discussed with them how they were linking into the
5 hospital service.

6 PROF CALDER: Yes. Again, I'm trying to recall exactly what we heard, but one
7 thing that impressed us quite strongly was that there didn't seem to be a lot of
8 priority given to the issues in Barrow of social deprivation, drug addiction and
9 various other issues that maybe could have benefited from an arrangement to
10 tailor the antenatal service more clearly to the needs of the people of Barrow,
11 who were having to travel for their antenatal care to Furness, which is not 100
12 miles away, but it was not immediately convenient. And that's been an issue in
13 antenatal care for several decades now, of the need to make care available to
14 people who are not very inclined to – not very able sometimes, for distance and
15 costs of travel and so on, so that was one of the things, and I don't know
16 whether that was something that's been addressed and implemented or not.

17 PROF FORSYTH: When you got to end of your input, did you feel that the service
18 was safe?

19 PROF CALDER: Well, I don't know how you define 'safe'. I mean, is there any
20 service that's absolutely safe? Things go wrong under any circumstances. We
21 didn't see that there was anything that was glaringly obvious that would cause
22 us to say the unit should be closed down. It didn't come to that. The issue
23 with theatre was a concern, because, if there was significant delay for a cord
24 prolapse or something of the sort, then that would be an issue, but that was

1 one of the things that we were hoping would be sorted. And we were given an
2 indication that that was on the agenda, to review and sort that particular issue.
3 PROF FORSYTH: And, coming to your point about there not being a paediatrician
4 there, did you have any feedback in terms of the competency of resuscitation?
5 PROF CALDER: Among the midwifery staff
6 PROF FORSYTH: Well, yes. Obviously, in many cases, it's midwives or –
7 PROF CALDER: No, I don't think... I mean, maybe it was an assumption we made
8 that they would be capable of immediate resuscitation. I mean, it's a fairly
9 standard, basic piece of training for midwives, surely.
10 PROF FORSYTH: And, finally, my question on the relationship with the tertiary
11 services. Did you feel that they worked or there was regular communication
12 between them?
13 PROF CALDER: Do you mean like general medical and surgical?
14 PROF FORSYTH: Well, no, I was thinking, moving out of – for the most complex
15 obstetric or high-risk baby situation, going off to Manchester or Preston.
16 PROF CALDER: I think there were probably processes in place for that to be
17 addressed, but... I mean, I couldn't see any reason to think that that wasn't
18 appropriate. Maybe that's something we should have explored.
19 PROF FORSYTH: One of the things that seems to strike me is that, of course – and
20 this is not uncommon – there's almost a full obstetric service, but, actually, their
21 neonatal service is just a level 1 special care service.
22 PROF CALDER: Yes.
23 PROF FORSYTH: I just wonder if you felt that that had presented specific
24 difficulties.

1 PROF CALDER: No, I can't think that I did, but I suppose one thing that this
2 question maybe is highlighting is that I didn't get an impression that there was
3 a clear... I mean, Lancaster was the main hub with Helme Chase and Barrow,
4 but it didn't seem as if there was specifically a lot more in terms of high-level
5 care in Lancaster than was available in Furness, and maybe the tertiary centre
6 elsewhere should have been... I mean, I don't know what is now in place as a
7 relationship between clinical problems arising in Furness; do you go to
8 Lancaster or do they go to the tertiary centre elsewhere? I really can't answer
9 that.
10 PROF FORSYTH: Okay, thanks.
11 DR KIRKUP: Jonathan.
12 PROF MONTGOMERY: Can I go back to something you said about the relationship
13 with the other groups? And you identified tensions between the professional
14 groups, but you said it didn't feel as though it was any more than was present
15 elsewhere. I'd be really interested to know your impression of what was
16 unusual about this trust that you came in, and what was similar to what you'd
17 imagine most organisations were challenged with, because it's never plain
18 sailing, is it?
19 PROF CALDER: I think one of the problems about this is that we don't go in our
20 own services and say, 'Well, where are the tensions here?' And the tensions
21 are there, you know, and perhaps it's something that... I think if that came
22 across in the report, and I'm sure it did, it was because we felt there was
23 probably a need for clearer explicit leadership within the service, I think more
24 particularly on the medical side than the midwifery side, but people just had

1 their own agendas, and maybe there was a need for something to pull it all
2 together.
3 PROF MONTGOMERY: Can you elaborate a bit more about the divergence of
4 agendas?
5 PROF CALDER: Sorry, I can't hear you.
6 PROF MONTGOMERY: Can you elaborate a bit about the divergence of agendas
7 you've just described?
8 PROF CALDER: No, I'm not still hearing you. Try again.
9 PROF MONTGOMERY: You talked about people having different agendas. Can
10 you elaborate a bit about the divergence?
11 PROF CALDER: Well, I mean, I suppose it's often an issue, and it's something that
12 has improved a lot in our speciality – ~~out~~ or specialties over the last 20 years,
13 whereby – and I think it's been more of a problem in England than it has been
14 in my part of the world – where people trained in obstetrics and gynaecology,
15 particularly where there's a private practice element, see gynaecology as the
16 thing they're interested in, and the obstetrics is the kind of price they have to
17 pay in order to be a specialist. Now, I'm delighted that that has changed
18 considerably, and that nearly all appointments now, certainly in our part of the
19 world, are for people who are specifically – especially in the bigger centres –
20 there'll be pure gynaecologists, or gynae-oncologists, reproductive medicine
21 specialists, or on the obstetrics side there'll be pure obstetricians with a
22 fetomaternal interest.
23 Now, where that breaks down and maybe still continues to be a
24 problem is where units are small and there only are maybe three or four

1 consultants, but nowadays you can't run a service with three or four
2 consultants, and I don't know what the staffing arrangements are now in
3 Cumbria, but, hopefully, there are enough investigations? that the different
4 bases can all be covered in terms of the specialties. But I think what we saw,
5 perhaps, both in Lancaster and here, was that the obstetrics was seen as a
6 secondary issue for a lot of the consultants.

7 PROF MONTGOMERY: So that explains the focus of the consultants being away
8 from obstetrics, perhaps being more to the gynaecology.

9 PROF CALDER: Yes.

10 PROF MONTGOMERY: What about the agenda for the midwives?

11 PROF CALDER: I don't think that applies to the same extent within the midwives,
12 but one of the things that I was clear about in this whole process was that I
13 didn't really understand how midwives functioned as well as I perhaps should
14 have done, but maybe I do now a little better.

15 PROF MONTGOMERY: My wife's a midwife. I'm sure you'd have had more
16 discussions about the tensions if you'd been on that side. Can I ask you...?
17 It's related, but it's trying to understand what might be different about this
18 situation from elsewhere in the country, so I've asked about the relationship
19 between the professions, but the sort of recommendations about the need for
20 leadership and the training, those sorts of things, I mean, did you feel that this
21 trust was worse off than you might have expected from others, or was it similar
22 to what you'd have expected to see?

23 PROF CALDER: No. I felt that they had more challenges geographically and with
24 the fact that the socially deprived... In most circumstances where there's

1 social deprivation, it's in the middle of a city, and that's where most of the
2 resources are concentrated. The fact that Barrow is a good many miles away
3 from what might be seen as the centre of the organisation I think was a
4 difficulty.
5 PROF MONTGOMERY: So if I can relay one possible way in which that might be
6 understood, is that this wasn't a failure of the management of the trust so much
7 as an impossible task. I mean, if I ask you to reflect on – did it feel like a badly
8 led trust with a difficult task and now quite on top of it, or did it feel like a task
9 that, it didn't matter how good the trust was, would be challenge?
10 PROF CALDER: Well, you're putting me on the spot here. I think we felt that things
11 could be considerably better, but a lot of their difficulties were specific to this
12 set of challenges, which are not faced by other... I mean, it's almost as if this
13 part of England has a remote and rural component. We've got that in
14 Scotland, albeit with much smaller populations, but they present challenges
15 that are harder to deal with, and often very expensive, so that resources are an
16 issue.
17 PROF MONTGOMERY: And did you get the sense that the trust was being helped
18 grappling those, or did it have a sense of being left by the system on its own?
19 PROF CALDER: I don't think that was something I could really make a judgement
20 of. We didn't go into the financial provisions. We, I suppose, assumed that
21 they were on the basis of a formula which applies across the health service in
22 England.
23 PROF MONTGOMERY: Thank you.
24 DR KIRKUP: Thanks. Jacqui?

1 MS FEATHERSTONE: I think you've answered all the questions I was going to ask.
2 DR KIRKUP: Okay. Stewart?
3 PROF FORSYTH:: Are you sure, Jacqui, you've not got any questions?
4 MS FEATHERSTONE: Well, the thing that I was asking, it was really about – you'd
5 asked the ones about the staff, so I just wanted to know about the culture when
6 you went onto the unit. Were there organised visits, or were you allowed to
7 freely roam around the ward, and did you speak to people on spec or did you
8 actually – you know, just so that you got a bit of a feeling about what it was like
9 on the shop floor and when things were going on, really.
10 PROF CALDER: Yeah. I think we had a feeling that the fact that we were visiting
11 seemed to be threatening to the staff, in a way that I would prefer not to have
12 happened. I mean, they seemed to be on the defensive a bit, and I think they
13 were not... I mean, the morale was low because of all the things that had gone
14 on, bad media coverage and things of that sort, and I think there were some
15 really high quality people who were trying very hard, but they were often feeling
16 they were banging their head against a brick wall. But we were able to have
17 very constructive discussions with all of them, I think. I've lost the –
18 MS FEATHERSTONE: So then were they fairly open about what – you know, when
19 you were just talking to them, rather than an interview where it was perhaps
20 quite organised? So while you were on the unit, they were quite open with you,
21 talking about what was going on.
22 PROF CALDER: No, they were. I don't think there was any tendency to hold things
23 back from us, and, if they had reasons to be concerned and felt that... I mean,
24 I think – I hope we were able to convey to the people we met that we were

1 there to help them, and therefore we were anxious to be open to any
2 suggestions they might make which we could incorporate into the report that
3 we produced.
4 MS FEATHERSTONE: And do you know what was said to the staff...? I was going
5 to ask were they suspicious of what you were going to do, but what was said to
6 the staff? So, when you went in, were they expecting you and did they know
7 what you were actually doing?
8 PROF CALDER: Yes, I think they had a pretty good idea, but maybe they hadn't
9 been briefed quite to the – I don't know how that was handled, to be honest,
10 but they knew – there was a schedule of visits and they knew when they were
11 to appear and that worked pretty well, I think.
12 MS FEATHERSTONE: And when you were on the ward, did you ever look at any
13 notes at all – any clinical notes?
14 PROF CALDER: I don't think we looked at clinical notes at all, except maybe some
15 examples. There was an issue of clarity of note-keeping, and the midwives are
16 clearly better at that than the medical staff, which is often the way of things.
17 But, beyond that, I don't think we delved very deeply into the clinical notes.
18 MS FEATHERSTONE: For your clarity of note-keeping – you wanted the clarity or
19 they were – what do you mean?
20 PROF CALDER: Well, I mean, often it's difficult to know who has made entries in
21 clinical notes, as you know, and that's something that hasn't really greatly
22 improved over the years, I'm afraid.
23 MS FEATHERSTONE: Okay, thank you.
24 DR KIRKUP: Stewart?

1 PROF FORSYTH: There were three versions of the report at the end. I just wonder
2 if –
3 PROF CALDER: Yes, I noticed that when I got it. I mean, it was amended and
4 amended.
5 PROF FORSYTH: There were several – yeah, one version, then amended, then the
6 second version amended, then the final version. Were you involved in that at
7 all?
8 PROF CALDER: No, I don't remember being involved in that at all. I mean, I
9 think... And I can't remember why there was a need for any amendment. I
10 mean, Pauline Fielding would know about that, and maybe it's something you
11 asked her about, but I, to be candid, when I knew you wanted to see me, I
12 thought, 'Well, where on earth are all my notes and my copy of the report?'
13 And I didn't find it anywhere, so I got Pauline and Nick Heaps to send me
14 copies, and, to be honest, I was quite surprised to see that this was – the
15 report – amended and amended. It still read more or less as I expected. I
16 couldn't see any –
17 PROF MONTGOMERY: Were the two copies identical, or did you get two different
18 copies?
19 PROF CALDER: There's an interesting point. I don't think I even ran them both off.
20 I ran one off from Pauline Fielding that had the amendments, but do you think
21 they might be different?
22 PROF FORSYTH: Could be.
23 PROF CALDER: I shall undertake to go back and check that.
24 PROF MONTGOMERY: If they turn out to be different, we will be very grateful. I

1 don't think they will, but there were only three versions.

2 PROF CALDER: It's not for me to ask the question, but do you know what sort of
3 changes were – what sort of issues?

4 PROF FORSYTH: There were phrases taken out and phrases added in.

5 DR KIRKUP: I just want to get to the bottom of this point. You weren't involved at
6 all in any of the redrafting.

7 PROF CALDER: No.

8 DR KIRKUP: You didn't see version 1 and then version 2 or –

9 PROF CALDER: I imagine they were probably sent to me, but I don't remember it
10 being something that really engaged me with any concern.

11 DR KIRKUP: Were you asked to kind of sign off the final version of the report?

12 PROF CALDER: No, I don't think we signed anything. We just –

13 DR KIRKUP: Perhaps not literally, but was there a circulation where Dame Pauline
14 said, 'Are you two content with this?'

15 PROF CALDER: I'm sure that would have been the case, yes. I'm sure nothing
16 would have happened without us feeling we'd been given the chance to do
17 that.

18 DR KIRKUP: The only other thing I wanted to ask – and I don't know whether you
19 can answer this – but did you have any involvement with the strategic health
20 authority? Did you talk to them at all? Were they interested in the report? Did
21 they know about the report?

22 PROF CALDER: No. I'm not even sure who the strategic health authority is.

23 DR KIRKUP: I know you don't have them in Scotland.

24 PROF CALDER: No. I mean, that is one of the problems, the great cultural

1 difference we had.

2 DR KIRKUP: Okay. Is there anything else you want to say to us?

3 PROF CALDER: No, not really. I don't think so. I hope you get... I mean, I'd be
4 very interested to know what – I mean, presumably this will come out
5 eventually in your report – what changes have been made, particularly in terms
6 of the clinical leadership. Have they been able to appoint somebody taking a
7 lead in obstetrics across the trust, and specifically at Furness? But anyway, I'll
8 not lose too much sleep about that.

9 DR KIRKUP: Okay, well, read the report.

10 PROF CALDER: I look forward to that.

11 DR KIRKUP: Thank you very much.

12 (End of interview)

THE MORECAMBE BAY INVESTIGATION

Thursday, 10 July 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
Professor James Walker – Expert Adviser on Obstetrics
Professor Jonathan Montgomery – Expert Adviser on Ethics
Dr Geraldine Walters – Expert Advisor on Nursing

FRASER CANT

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1 DR KIRKUP: Okay, thank you for coming. I'm Bill Kirkup, I'm the chair of the
2 Investigation Panel, and I'll ask my colleagues to introduce themselves.
3 DR WALTERS: I'm Geraldine Walters, I'm the director of nursing at King's College
4 Hospital.
5 PROF FORSYTH: Stewart Forsyth, I'm a paediatrician and a medical director from
6 Tayside, in Scotland.
7 MR BROOKES: I'm Julian Brookes, I'm currently deputy chief operating officer of
8 Public Health England, but I was previously head of clinical quality for the
9 Department of Health.
10 PROF MONTGOMERY: Jonathan Montgomery, I'm professor of healthcare law at
11 University College London, and chair of the Health Research Authority. I
12 previously chaired PCTs, and before that an SHA.
13 PROF WALKER: I'm Jimmy walker, I'm an obstetrician and a professor in Leeds.
14 Previously I was Chairman of CMACE, and also obstetric advisor to the
15 National Patient Safety Agency.
16 DR KIRKUP: You'll see that we're wired for sound; we're going to make a recording
17 of the proceedings, and we'll produce an agreed record of what's taken place.
18 I see that you're wanting to make notes, and that's fine...
19 MR CANT: Well, can I qualify that? I'm not taking this out of the room, it's purely for
20 the point of – because this goes over a number of years, things might just
21 come into my mind that I might want to get out, but forget about sort of...
22 DR KIRKUP: That's absolutely fine. That's exactly the point that I was going to
23 make. We don't want information going out until we're ready to produce a
24 report that can put everything into context and stuff like that.

1 MR CANT: Right, I understand that.

2 DR KIRKUP: So as long as you appreciate that, that's really helpful, thank you. Is
3 there anything else that you want to ask me about concerning the process?

4 MR CANT: No.

5 DR KIRKUP: I should have mentioned that we have had family members present as
6 observers. We haven't, as it happens, this afternoon, but they are able to
7 listen to the recording if they want to.

8 MR CANT: No, I understand. That's fine.

9 DR KIRKUP: Okay. I'm going to hand over to Geraldine in a moment to ask the
10 bulk of the questions. You'll be relieved to hear we aren't necessarily all going
11 to ask questions this afternoon, because there's a rather a lot of us. Can I just
12 start out, though, by asking you to say when you first started with the Trust,
13 and what have you done with them since you started?

14 MR CANT: Right, I joined the Trust on 1 October 2009. I was appointed on a part
15 time basis, a couple of days a week, as an assistant director of operations for
16 the newly created division, family services, and it was on a secondment for 12
17 months. It's important to say at that juncture I was also requested by the PCT
18 – Cumbria PCT, to work with a consultant on trying to take forward some of the
19 recommendations of the Mitchell Report, in terms of the provision of
20 paediatrics for the whole of Cumbria.

21 After about 11 months into the secondment ~~there was an opportunity –~~
22 ~~or the Trust took the decision to merge the demerged family services from~~
23 ~~surgery and critical care, but less than 12 months later they decided to merge it~~
24 ~~with core clinical services~~the Trust took the decision to merge the Family

Services division, which prior to October 2009 had previously been part of the Surgery and Critical Care Division, with the Core Clinical Services division, taking it from a £20 million division to a £60 million division, and I was appointed as assistant director for operations for what became known as a FACCS division, which was family and core clinical services.

DR KIRKUP: Okay, and was that a substantive role?

MR CANT: Yes, it was.

DR KIRKUP: Not on secondment.

MR CANT: No. And that was a role that I held for 20 months approximately, 18 to 20 months, and then following the PWC review of governance, I think it was that particular report, and also the Central Manchester Report, there was a recommendation to demerge family services from core clinical, and to create a women and children's division within a very short period of time. At that juncture I was asked ~~if I would~~ which division I would like to lead on~~,~~ and I decided to stay with ~~where I came into the Trust, with~~ family services, which then became women and children's, because I wanted to see it through because that was right in the middle of many of the changes that were taking place, and I wanted to see it to its conclusion.

DR KIRKUP: Okay.

MR CANT: And I did that until I left the Trust in the end of July 2013.

DR KIRKUP: Okay, what did you move onto?

MR CANT: I set myself up on my own as an interim general manager/assistant director.

DR KIRKUP: Thank you. Geraldine.

1 DR WALTERS: Okay, so I was going to start by asking you about the structure in
2 your role, but actually I think I'll go back to the sort of merging/demerging of
3 this – the divisions, what we're interested in.
4 MR CANT: Yes.
5 DR WALTERS: What was happening around that? What was the rationale for it
6 while those decisions were made?
7 MR CANT: Well, the rationale for demerging from surgery – remember, I inherited
8 that position, because the decision had been taken by the Board in the
9 summer of 2009, was basically on the recommendations in the Mitchell Report,
10 which said that Andrew Mitchell felt that women and children's services were
11 the Cinderella service within the ~~whole~~ Surgery and Critical care division, and
12 therefore it would benefit from being separate and having its own divisional
13 structure. So that, as I understand it, was the pretext to that.
14 The reason for the subsequent – so we demerged, and then we
15 remerged with somebody else, was around the vacancy within another division,
16 which the powers that be took the decision to bring them together. ~~And I~~ guess
17 you'd have to – ~~you know~~ask the Trusts Executive Team, their reason for that.
18 ~~– you know,~~ I could suggest that there was possibly a financial reason to that. I
19 would also suggest, and it's something I'll talk about when I talk about family
20 services, was that when it was demerged from surgery it was almost ~~like –~~
21 ~~not~~in name only, but no substructure was created to support that. It basically
22 just separated it, and many of the supporting functions that sat with the bigger
23 division of surgery and critical care stayed there, and therefore we were left
24 with a relatively small division with a very poor infrastructure that wasn't

1 invested in at the time.

2 DR WALTERS: And those years were which ones again?

3 MR CANT: This is 2009, as I came into the Trust. I came in and there was very little

4 sharing of – there was no sharing of infrastructure, ~~[inaudible] half the whole~~

5 ~~division~~ to help family services establish itself as a new division. It was

6 basically appointing assistant director, that was myself, for part time. So – and

7 therefore when you come to 12 months later, there was – from my perspective

8 there was two ways of viewing it. ~~One was – or maybe there.~~ One, there was

9 the opportunity to have a substantive post within the Trust, and recognition of

10 achievement. Secondly, there was a vacancy because there was no divisional

11 general manager at that time for core clinical services. And thirdly, why I

12 thought it might help the situation was that core clinical services had quite a

13 substantial infrastructure which women and children's services didn't have, and

14 I'd struggled to create that in the 12 months that I'd been there, due to financial

15 restrictions.

16 DR WALTERS: So what did the Cinderella thing, what do you think were the

17 consequences of that, or did you take the Cinderella thing was wrong?

18 MR CANT: No, I can describe to you what I found when I went into the organisation,

19 and I found a disengaged family services team. ~~That was from the~~This

20 included the two clinical ~~– there were~~ two clinical directors at the time. The

21 head of midwifery, head of children's services, and the ~~– I think it was~~ deputy

22 divisional general manager at the time. ~~But they~~They were very demotivated,

23 they were very flat, they were disengaged. I tried to work out – I wasn't there at

24 the time – whether there was a two-way street in the sense they were

disengaged because they didn't want to be part of ~~family services, and whether or not they were overlooked, apart from surgery, sorry, and~~ the Surgery and Critical care Division and whether they felt overlooked. I think it was two-sided coin, to be honest with you, I think there were two sides to the story.

But nevertheless, they were very demotivated, and in particular, the deputy general manager, who – because when I'd asked about the substructure going into the job, I'd been told there was this ~~– a~~ person in a relatively senior role, you know, in a way. I didn't know who it was, but it gave me some confidence that I had something to work with. But I have to say, when I met the individual, first of all, he was off [redacted] when I first arrived at the Trust, and he was very disengaged, very demotivated, and I had my work cut out for me to be able to ~~make that~~reengage him – and I never managed. He subsequently [redacted] left within about six months, causing another problem to the infrastructure, which was already inadequate.

So I think that's – if that answers your question, I think that was the backdrop as I perceived, from what I heard from the people and the Trust.

DR WALTERS: So you've taken on the divisional manager role, and it's now a larger division, but hopefully with more potential to create some infrastructure.

MR CANT: With core clinical, yes.

DR WALTERS: And you just had this series of external reports about the service.

MR CANT: The year started – we merged in the – well we came together initially around October/November of 2012 – no, sorry, 2010. And I started to bring that team together, you know, to create a new management team, two associate medical directors. I had to try and merge – well I did merge, I

1 brought it together and created new roles. And we were starting to make
2 progress. I instigated a divisional governance committee for this new ~~—~~<u>merged</u>
3 <u>Division</u> there hadn't been a governance committee with the core clinical
4 services, interestingly. There had been the beginnings of one evolving within
5 family services, so that was one of the things I put in place very quickly. And
6 then I had a senior management team that ~~met~~<u>I had to create</u>, and I'll come to
7 – I'm just trying to say I was building~~, I had to start from~~ – I had to start
8 rebuilding again in a quite short period of time this new team.
9 And then we had a number of conflicting reports about our service, I
10 think it's fair to say, in 2010.
11 DR WALTERS: Just before we get to those, because I just want to sort of stick to
12 the structure first, and then I'll give everybody the opportunity in case I forget
13 anything. So what were you in charge – who were you in charge of? Who
14 reported to you in terms of...
15 MR CANT: When it was a merged division?
16 DR WALTERS: Yes.
17 MR CANT: Yes. I had – well I was accountable to the MD, associate medical
18 director. I had a head of midwifery, gynaecology and obstetrics, I had a head
19 of paediatrics, I had a head of outpatients and therapy services. I had a head
20 of radiology, pathology, ~~clinical~~ <u>medical</u> engineering. It was a very – I'm
21 probably going to miss something, it was a very diverse bunch of services.
22 DR WALTERS: So you were really line managing...
23 MR CANT: Right across that six – yes. And within that I would have some clinical
24 leads.

1 DR WALTERS: So you were managing the doctors.

2 MR CANT: Well, the clarity in doctors is something that I think is an issue in the
3 management of doctors. But the clinical leads within that as well, and I also
4 had a governance lead as well. I created a governance lead post.

5 DR WALTERS: Right. And you were reporting to the ~~assistant~~ Associate medical
6 director.

7 MR CANT: Well, there was two – there was a lack of clarity on the accountability in
8 terms of – my direct accountability was to the director of operations and
9 Performance. That was my line manager structure. But interestingly, in the job
10 description for associate medical directors that I saw, their accountability was
11 to the ~~heads~~ Director of operations and Performance as well. So there was
12 ambiguity around that.

13 DR WALTERS: And the director of ops at that time was who?

14 MR CANT: ~~[Steve Finnborn?], Stephen~~Steve Vaughan. The medical directors also
15 had ~~to~~ professional link in to – the associate medical directors~~,~~. sorry~~, also had~~
16 ~~a professional link into the medical director~~.

17 DR WALTERS: Right, so it's a little bit of you sort of reported to the Associate
18 medical director(s) and, you sort of reported to the director of... Operations and
19 performance.

20 MR CANT: I didn't report to the medical director, but ~~they~~ the Associate Medical
21 Directors had a dotted line to the medical director from a professional
22 perspective. And their job descriptions, their line management said 'Director of
23 ops'.

24 DR WALTERS: Right, okay. And what would you say were your three major

1 objectives in your job description?

2 MR CANT: It would be – I'll just give them, not necessarily in this order, but there
3 was clearly the financial management of the division, there was the
4 performance management of the division and a responsibility for governance,
5 but not clear there was a total responsibility for clinical governance, but
6 certainly a role in governance.

7 DR WALTERS: So who in the division would you say was responsible for safety?

8 MR CANT: I don't think that was clearly defined.

9 DR WALTERS: Right.

10 MR CANT: I think it was – I think everybody had a responsibility for clinical safety,
11 particularly the professional leads and the heads of service. But we didn't have
12 – I mean latterly we had a head of governance, but I think it was a sort of – I
13 don't think it was any one person's role, I think it was within everybody's role.

14 DR WALTERS: Right. And the management structure within the – beneath you,
15 what were the relationships like between the different clinical groups?

16 MR CANT: Am I talking within family services?

17 DR WALTERS: Yes.

18 MR CANT: I think it's more appropriate to talk about family services really.

19 DR WALTERS: Yes, I was thinking paediatricians, obstetricians...

20 MR CANT: Yes, that's what [inaudible] to focus on around the whole lot. It took me
21 – as you go into an organisation, and just an analogy of ~~sort of dropping~~being
22 dropped into ~~a~~ into the deep end of a pond and then you start to come up and
23 you start to see what's what. And initially it's hard to work out relationships.
24 And also you've got to sift what you hear, what people say and what's

personal, and triangulate some of that and make some sense of it, because if you react to something people say to you then it's not necessarily ~~–~~ ~~that's~~representative as it is their view, but not necessarily ~~–~~true so my view has always been to try and triangulate the views of people that I hear.

Initially, and I'm going to talk relationships; I probably need to talk about relationships between key people, and also relationships between professional groups, because they're kind of interlinked. ~~If we take the – and there's~~ There's also a geographical relationship as well. So if I start with that one, just so I can remember it. There's definitely – was definitely, and I don't know if there still is, but I suggest there possibly is, a separate view of the ~~role~~ world between Lancaster and Barrow. When you're in a corporate role that I was in, you don't really understand that particularly, and I didn't live in the area, so you just think we're one Trust, we're working to a common good and a common aim. But it becomes quite clear, it became quite clear to me that we are two very different cultures, so whilst we had a merged organisation, we hadn't ~~merged our~~merged culturally – you know, the OD part of the organisation, there was a lot to do.

And there was a kind of – I don't necessarily know if elitist is the right word, from Lancaster. It possibly isn't, but there was a certain feeling that that partially might describe it. And there was a degree of resentment in Barrow, so you had this neither the two would mix in a way. It was a bit like oil and water, so that – and it was quite – it's hard to work with. So that was difficult to ~~create that sort of unit~~unify. Certainly at a divisional level and a service level, to try and keep that degree of unity was a real big challenge.

1 And then there were some clashes within personalities as well, but
2 they became apparent to me over time. The associate medical director at the
3 time, Ibrahim Hussein~~[?], was not — he was — he~~ seemed to be respected in
4 Barrow, and had a senior prominence in Barrow, but he was less so in
5 Lancaster, and he never really integrated in with the Lancaster consultants.
6 They didn't really accept him in his role, so that was problematic, particularly
7 with the obs and gynae.
8 Within paediatrics, there was a clinical director for paediatrics called
9 Paul Gibson~~[?]~~, who had been in the role up until ~~— as~~ I came into post, and he
10 had struggled with the —Barrow Paediatricians he was a Lancaster consultant,
11 he'd struggled with working with the Barrow consultants. He'd found that an
12 incredibly personally challenging task, I think that it burned him out, if I'm
13 honest with you. So he didn't – that resentment with Paul Gibson wasn't there,
14 if you know what I mean, it was a different type of – he just had a difficulty
15 moving that service forward and working with those consultants.
16 And then within the Barrow more than the Lancaster, there were
17 tensions between the midwives and the obstetricians and gynaecologists. I
18 don't know how far back – I can't speak for how far back they go. I think they
19 probably go back, you know, predate me by quite a significant period of time,
20 but I don't think they've been helped by the incidents that took place in 2008,
21 and how that was – again, I wasn't there, but clearly there was – I'm trying to
22 think – wounds that haven't healed, both ways. I think that's the best way I can
23 describe it.
24 DR WALTERS: So there is an issue with people not getting on who work at the

same site.

MR CANT: Yes.

DR WALTERS: To what extent did it matter from a patient benefit, that the two hospitals didn't get on?

MR CANT: Well, it wasn't as evident to me that it mattered to any great extent until the Central Manchester ~~– one of the reviews, probably the Central Manchester Review, where — it was the Central Manchester Review~~Review, where differences in practice, clinical practice were highlighted. Some of the subtleties of these things, as a general manager, I would not necessarily know what they were. But there were subtleties in the way that they practised, the way they used guidelines, and that's where I think it does matter. But that matters as a Trust, and a corporate view of providing a standard, a common standard of care, and there were definite differences that were highlighted by the professionals going in to look at that with a professional eye.

And therefore I think that was probably one of the most worrying things, in a sense, that as you say, ~~they can co-exist if they're very –~~ because they were 50 miles apart, in one sense, but they need to be working to a common set of standards, possibly flexed for individual geographical nuances, but then that can be done through governance and agreed. But this was going slightly off-piste, is the only way I could probably describe it, so that's where I think it matters, if I'm honest.

DR WALTERS: So they were my sort of structure and role questions. I'd like to open that to anybody else.

DR KIRKUP: Anybody want to come in on structure and role, then we'll go back to

1 Geraldine.

2 PROF FORSYTH: I'm not sure if my questions fall within the instructions. I'll wait.

3 Go on, Geraldine.

4 DR WALTERS: So your day-to-day job, what were your big issues?

5 MR CANT: Well, my first view of my big issues was I didn't have the resources to do

6 what needed to be done. I had this unreasonable expectation that I could run

7 this division, be the general manager of this division and all that goes with that,

8 and at the same time have this other part time job developing a strategic – well,

9 making a strategic change in the whole of Cumbria, which is why they weren't

10 compatible and they certainly weren't doable from my point of view. I found

11 that in the time that I was supposed to be spending in Cumbria, I spent

12 increasing times in Morecambe Bay, doing the Morecambe Bay job, because

13 that's where I felt I ought to be, if I was honest with you, because the strategic

14 was important, but it wasn't – and I need to talk about that, I think, because it

15 wasn't getting the support it needed to get any traction and be successful at

16 that time.

17 So I felt, knowing what I was facing, I had a deputy general manager

18 who was off [redacted] I had financial targets to meet. I had the performance targets

19 to meet, which were all – you know, I can't describe how important those are.

20 So I had those to ensure that we met, and I wanted to develop the governance

21 because I was concerned. I said to the Fielding Inquiry – and sorry if I'm going

22 slightly back, but it's important to say it. I went to the – I'd only been in the

23 Trust three months when Dame Pauline Fielding came to the Trust, and I did

24 say to her that I was a bit concerned that – and I hadn't managed midwifery

1 before, but there was very much a focus on mismanagement, but there wasn't
2 a wider focus on clinical governance, and that's actually quoted in the report.
3 There was a meeting and I actually contributed that to the report. So that was
4 another thing I wanted to develop and build.
5 So I guess I had finance, performance, the workforce issues and the
6 governance issue, so I had all three.
7 DR WALTERS: So that's going back to 2009.
8 MR CANT: Yes, and I think there's another important factor to mention. The first
9 week in the Trust I was called to an extraordinary meeting with the exec team
10 on the financial performance of women and children – of the family services.
11 I'd only been there a week and it had only just been created. And it was
12 £600,000 adrift. How that could be in a newly created division, I don't know,
13 but clearly that was a pressure that I felt day one, week one. Whereas in the
14 meeting I had – my colleague from surgery was there, because clearly it had
15 been a demerged division, but when they demerged it they suddenly had the
16 situation where family services were £600,000 adrift. And the importance and
17 significance – that's quite a significant thing to happen to you in week one in
18 the organisation, so clearly I could see there was a real financial challenge as
19 well as a cost improvement programme to deliver, so I had a number of very
20 early warnings of what some of the priorities were in the organisation as well.
21 DR KIRKUP: What was the financial position of the other bit of the previously
22 merged...
23 MR CANT: I can't recall that. Honestly, I can't recall that. I was kind of shocked
24 with my own position, to be honest. It was £600,000 of a £20 million...

1 DR KIRKUP: Isn't the first question, 'Well, hang on, has this been fairly apportioned
2 to you?'
3 MR CANT: I felt at the time it hadn't been. That's all I can – but I didn't know
4 enough about it. The surgery were adrift as well, but in a way that, to me, is –
5 if you're creating a division, you need to resource that division. You can't set it
6 up when it's financially failing to start, without a hope, at that juncture, to make
7 a fist of it in year one. And therefore, my hands at the time – I mean the
8 reason I give you it as a backdrop is I started – I need to build something here
9 that's going to be fit for purpose, and I felt my hands were tied behind my back.
10 DR WALTERS: So that's ~~2000 and...~~2009
11 MR CANT: ~~9, sorry~~Sorry. And that was the first year, when you were saying what
12 other priorities as we're working through.
13 DR WALTERS: And so rolling forward a year later, you then got the Fielding Report.
14 MR CANT: We got the Fielding Report was – she came in January 2010, the team
15 came. And then there was the report; there was two editions, or two versions
16 of the report, April and August. And so there were two iterations of those of
17 those at first, then there was a modified and then there was a further
18 modification made to the report.
19 DR WALTERS: So did you agree with the modifications?
20 MR CANT: I felt the first report did need to be modified because it had been – when
21 I read it I felt that it was – it was written in such a way that it kind of – it named
22 people, individuals, and it was quite – I think it could be written in a different
23 way to say the same thing, if I'm honest with you. It wasn't about necessarily
24 content, it was about how it was presented, and I felt it could be – and also

thinking that it was particularly critical of the associate medical director, and named him. And I didn't think it needed to do it in that way because he is currently in a senior position within the division and we've got the staff as well. I didn't know how the Trust were going to manage that, because remember, I've just come in, and I've got this person who I'm developing a relationship and trying to build a service with. So I understood why there was a need for the report to be refined...

DR WALTERS: Yes.

MR CANT: Yes, I understood that, I thought there was myself.

DR WALTERS: So in the middle of a lot of financial pressure, which I assume was sustained.

MR CANT: It did, yes.

DR WALTERS: Then there's the Fielding Report, which is really about – more about the quality and safety issues. What was the organisational importance attached to that report and taking that forward, the evidence forward?

MR CANT: For me, the report got lost in its other iterations. It seemed to ~~be—~~me it left the division ~~– you know, it resolved the division or resolved the service, and~~ then it kind of moved into the corporate arena, and I don't know what ~~it—you~~happened after that. I know, it was getting reiterated~~, and that wasn't part of – well, the~~. I was involved in the first set of comments, I don't remember being asked for the second set of comments for the August version. And it kind of – it never re-emerged, if I'm honest with you.

Now I can remember talking to Angela Oxley about that, and I remember Angela saying to me, 'What's happening about this report?' and I

1 said, 'Well we haven't had it back to the division,' and I didn't know whether it
2 was going to the Board, because I think the Board commissioned it. And I
3 didn't know what was going on with it, to be honest with you~~, but we did –~~.
4 ~~there~~ There was an agreement that we proceed, because there was, from a
5 professional perspective, the midwifery service and the obstetric service had
6 some issues with some of the content of it. But I remember a discussion
7 around, 'Well, okay, the contentious issues ~~that~~ might be 10% or 15% of it, but
8 let's progress with the difference of it.'

9 But it was not progressed in the way that I think it should have been
10 progressed. In other words, where's the action plan? First of all, received by
11 the Board, the action plan, how the reporting mechanisms and the delivery of it
12 would be up through the organisation through the governance structures. That
13 was not clear.

14 DR WALTERS: So you didn't feel that you owned it anyway?

15 MR CANT: Well I felt we owned the elements of it that we felt we could make
16 changes in, but in terms of some of the actions, I've done all the actions, and
17 we made progress on the actions. But the report just kind of – I don't know
18 what happened to it. That's my honest...

19 MR BROOKES: Can I just be clear, it's a point of clarification. From the first draft
20 you saw, how much did it change?

21 MR CANT: Not dramatically, it was more the language, and how – describing – I
22 think they changed things like – they were thinking about naming the associate
23 medical director. It didn't say he needs to go, but it was very blunt. I can't
24 remember the exact wording of it. And then that was changed to succession

1 planning. It was using different language to mean the same thing.

2 MR BROOKES: So it didn't fundamentally change from initially to...

3 MR CANT: No, although there wasn't – I don't know where the acknowledgement
4 took place of some of the elements of it which were not seen to be applicable.
5 You know, there was a bit of – quite a bit of the report, and they said, 'There's
6 the report.' And then the service came back and said certainly lots of it didn't
7 apply or were factually incorrect. I don't think those factual corrections ever
8 really changed, if I'm honest with you. Things like the domino service wasn't
9 thought to be appropriate ~~throughout~~ by the Head of the midwifery service, and
10 they'd said that they didn't think it was ~~– the midwifery staff said~~. There was
11 thing about a disclaimer at Helme Chase, that there was a disclaimer if you had
12 your child then that would be at your own risk. That didn't exist. You know,
13 things like that, which weren't actually true.

14 MR BROOKES: And they were still in the final report.

15 MR CANT: To the best of my knowledge they were.

16 PROF MONTGOMERY: To the best of your knowledge; you didn't see the final
17 report, you only saw the early one, or...?

18 MR CANT: I don't think I saw the final report.

19 MR BROOKES: It was not widely circulated.

20 MR CANT: No.

21 PROF MONTGOMERY: And can I just go on for clarification, which is that you
22 talked about progressing the actions from the report, and then you talked
23 separately about your expectation of an action plans. So there wasn't an
24 action plan that you saw...

1 MR CANT: No, there wasn't

2 PROF MONTGOMERY: ... or the background report, but you had a number of

3 things you picked up from the report.

4 MR CANT: Yes, myself and Angela picked up a number of things. I picked up the

5 capital development end and worked on – and started working on the business

6 case. So Angela did and I did take actions forward, but the actual ~~– there was~~

7 ~~an~~ action plan ~~done, but it~~ wasn't done until about February of the following

8 year. And then that became the action plan that the internal audit reviewed in

9 the May of that year.

10 PROF MONTGOMERY: And you saw it at that point?

11 MR CANT: The final report I never saw. I think I can say I didn't see the report after

12 I saw the first report.

13 MR BROOKES: So just on that, the action plan was produced in April, which was

14 then ~~[inaudible]~~reviewed by Internal Audit audit in May of the same year.

15 MR CANT: The action plan started, I think, from memory, in February of 2011. I

16 think it started then, and I think it coincided with Angela leaving, Angela Oxley

17 leaving. And the director of nursing following it up with one of the matrons. So

18 it was February – I think it was February time, February/March 2011. And then

19 everything that should have formally happening previously started to happen in

20 terms of pulling together the evidence and demonstrating the change.

21 DR WALTERS: So who actually pulled the action plan together?

22 MR CANT: It was Sue (Knowles), and I can't remember her surname right now, but

23 she was the matron at Helme Chase.

24 DR WALTERS: Right. Did you get the impression then that sort of the action plan

was done slightly before the internal audit came to look at it?

MR CANT: It was done, but was it done as a consequence of that report? Well I don't know which came first.

DR WALTERS: Right.

MR CANT: I honestly don't know which came first.

DR WALTERS: Okay.

MR CANT: But...

MR BROOKES: They're surprisingly close together, that's all.

PROF MONTGOMERY: Strange coincidence.

MR CANT: No, I don't disagree, but I don't know what was – I don't know what came first, and I don't know what prompted the internal audit. I don't know who commissioned it, and why the commissioned it then.

DR WALTERS: So did internal audit come to ask you about...

MR CANT: Not me personally.

DR WALTERS: ...the implementation of the action plan?

MR CANT: No, I don't recall that.

DR WALTERS: Did that strike you as odd?

MR CANT: Yes. I think it was heavily based on discussions with the head of midwifery. It must have been the new head of midwifery because she came at that time, and the matrons, but not – I don't recall...

DR WALTERS: Is that because the action plan and report was quite service-wide, wasn't it? It wasn't just a midwifery action plan.

MR CANT: It was wider than midwifery, yes. There were issues of leadership, medical leadership. There were issues of – issues between the staff groups.

There were issues around – there were some provisional issues, I would say, issues around midwifery supervision. There were issues around the facility, which was the one that I picked up. So – no, it wasn't purely on a governance or a clinical...

DR WALTERS: So you weren't incorporating it as part of your internal divisional governance process or anything like that?

MR CANT: No.

DR WALTERS: Did you feel you ought to have done?

MR CANT: Yes, with hindsight. But in that first year, divisional governance was very embryonic. I mean there wasn't a divisional governance group, and I formed a group ~~and started to –~~ but it was really embryonic, and that's the best way I can describe it. But at the same time, the report – I didn't know where – you know, I didn't – I don't know what the Trust response to the report was from a corporate perspective. And I didn't know why it was not – if we contrast it with subsequent reports, it was very clear how that was taken forward. But with that particular report, I don't know what was behind it.

And it then – I mean if the report came out, and the final report came out in the August, I was thinking I was leaving at the end of September. When September/October, Angela was indicating that she was going to leave, and my deputy was off sick – or had just left, there was a lot going on. There was a lot to keep a handle on at the same time, and we always have a CNST review in the beginning of 2011. So there was a lot...

DR WALTERS: So you went to have discussions with your boss on a sort of, 'How's it going?' obviously I don't want to ask about the financial position and

1 [inaudible] or anything like that, and did they say, 'And what about governance
2 issues or...'?

3 MR CANT: No.

4 DR WALTERS: So was that ever raised?

5 MR CANT: No, because, again, I hadn't worked in an acute Trust. This was my first
6 role within an acute Trust. Prior to that I'd been a community PCT services,
7 and I had nothing to compare it with in an acute Trust, but the governance,
8 those issues were primarily down the director of nursing route through the
9 nurses, or through the medical director at the – I had very few conversations I
10 can recall with the director of ops on governance.

11 DR WALTERS: So did your – in your responsibilities in your job description, did it
12 allude to safety and governance?

13 MR CANT: It alluded to it, yes. I think it's everybody's responsibility, but it was
14 never part of my discussions with Steve ~~or....~~.

15 DR WALTERS: Right, okay.

16 MR CANT: I discussed the capital build with him because that was – early
17 indications were that was going to be in the millions, and I'd started this piece
18 of work with the multidisciplinary team and their estates and so on and so forth,
19 and then I was giving indications this could be about £5 million, but – he was
20 certainly <u>not</u> involved in that discussion around clinical – so the clinical issues
21 and the Fielding Report, I don't recall having any conversations with him about
22 it.

23 DR WALTERS: So the one issue in the Fielding Report which really stood out to me
24 was this issue of slow access to theatres out of hours for crash sections. Was

1 anybody talking about that?

2 MR CANT: Not to my knowledge. And it's an interesting point, because it takes me

3 back to your last point around this being wider. That was wider than women

4 and children's as well, and I'm not aware of surgery being involved in that

5 discussion. You know, surgery would be providing that service, and I'm not

6 aware of them being involved in those discussions. And I'm not even sure if

7 they would have had sight of the report, if I'm honest. But I don't know who it

8 was circulated to.

9 DR WALTERS: And before we get onto [inaudible] job, can I...

10 PROF MONTGOMERY: Before we do that...

11 DR WALTERS: I'm just about to give you the opportunity.

12 DR KIRKUP: Too keen, Jonathan.

13 PROF MONTGOMERY: That particular issue about the surgery and the estates;

14 we're trying to understand when it emerged, and you told us a bit about – quite

15 later on, [inaudible] all the surgery and discussions about the estates planner.

16 When the team came, you were interviewed by them, were you, as part of

17 that?

18 MR CANT: Which team, sorry?

19 PROF MONTGOMERY: The Fielding Report.

20 MR CANT: Yes, I was.

21 PROF MONTGOMERY: And were any issues that they thought were immediate

22 issues discussed? I mean were you the person they would have discussed

23 that with?

24 MR CANT: No.

1 PROF MONTGOMERY: Who would they have discussed that with if they were
2 concerned about things?
3 MR CANT: I would have expected – I don't know, but I would have expected they
4 would have had that with the chief executive as a commissioner of the report.
5 It certainly wasn't with me.
6 PROF MONTGOMERY: But if there was something that emerged on the ward day-
7 to-day, and they noticed something they needed fixing quickly, it might have
8 been a clinical issue or something else, who would they...
9 MR CANT: What happened – sorry?
10 PROF MONTGOMERY: If they'd seen something, supplies that had run out on the
11 day, who would they have liaised with, who helped them find their way around
12 the unit?
13 MR CANT: They would probably have raised it – they were escorted in ~~– you know,~~
14 ~~it sounds a bit –~~ they were shown round the unit, and that would have been by
15 the matron and the head of service. And if they'd highlighted anything, that
16 would have been dealt with, but in terms of...
17 PROF MONTGOMERY: Would you have expected in your role to have known that
18 something like that had been raised?
19 MR CANT: Yes.
20 PROF MONTGOMERY: And do you remember whether anything was raised?
21 MR CANT: Not to my knowledge. I don't remember having anything coming directly
22 from their tour of the unit straight to me, no.
23 PROF MONTGOMERY: Okay, that's really helpful. I've got a couple of other
24 questions, but I think I'll stick with that. You talked about conflicting reports

1 coming through in 2010. One of them was clearly the Fielding Report.
2 MR CANT: ~~No, but I was just~~ I'm trying to describe – I'll go back to me plunging in
3 the pool and coming back up again and trying to make sense of the
4 environment and things I'm hearing and seeing, and trying to use that to get an
5 understanding of the Trust, the service and so on. And clearly I came into the
6 Trust after there'd been the significant incidents, and – so there was that
7 relatively recent history. And then we came into the ~~2000~~ 2010 and – sorry if I
8 just have to think about the years because a lot happened, particularly in the
9 latter years. But if I go to 2010, we'd got the – you know, CQC registered the
10 Trust, the Trust registration process. Then there was a CQC visit to the Trust,
11 and that said we were compliant across six indicators, so I'm getting some –
12 ~~you know, you [inaudible] about a~~ assurance; we're getting assurance coming
13 back that things are improving.
14 And then we had the patient survey, the ~~Pick a~~ PICKER Patient survey,
15 which identified that, from memory, we were in the top 20% of Trusts nationally
16 in relation to patient experience across most of the indicators. So we were
17 picking up some good stuff that, for me, felt positive. And that was building
18 over the first year of my tenure, if you like, and then going into the second year,
19 until the inquest in June 2011. And that's when things changed very
20 dramatically.
21 PROF MONTGOMERY: So the conflicting reports is that you got these things kind
22 of giving you some confidence that you were getting on top of things, and
23 feeling a bit less unclear. And then in 2011...
24 MR CANT: Yes, but I think we got CST Level 1 in the February. There were a

1 number of positive things happening, which if they hadn't been happening
2 would have been of great concern. If the CQC said in 2010, 'You're failing on
3 six,' or 'you're failing on three,' it would be a major concern. That would have
4 been a huge ~~—that would have—~~but that didn't happen. That was a positive
5 indicator.
6 MR BROOKES: Can I ask just alongside those? I understand that you've got your
7 clinical leads for midwifery. Were they at any stage coming to you and raising
8 concerns about the quality of the service and the safety of the service that was
9 being provided at Barrow?
10 MR CANT: No.
11 MR BROOKES: Not at all?
12 MR CANT: They had concerns about some of the legacy of the previous 18 months.
13 They had – oh, there was another thing I need to – sorry, you've reminded me,
14 it was the Birth Rate Plus Report as well, I need to mention that, which came in
15 that year as well. So they – we were talking about the challenges that we were
16 still facing in Barrow in particular, but there was nothing escalated to me of the
17 gravity.
18 MR BROOKES: So you were never given an indication at any time that the service
19 was unsafe?
20 MR CANT: No.
21 MR BROOKES: You were never given an indication that there were major concerns
22 about the staffing levels?
23 MR CANT: Other than – there was Birth Rate Plus, yes. I'm familiar with that, and
24 we had a shortfall, and – something else just came into my mind and I was just

1 thinking, but – and there was some concern about the practice of some of the
2 obstetricians and gynaecologists, more from the midwifery perspective. This is
3 where you've got this, but not getting the same message necessarily from the
4 associate medical director, who was an obstetrician gynaecologist, so there
5 was a bit of a difference.
6 But there was also some escalated concerns about midwives. There
7 wasn't concerns, but there were – I didn't – in terms of my own value set,
8 nothing came at me that made me think, 'Good grief...'
9 MR BROOKES: That set the alarms off.
10 MR CANT: No. Because if it had – you know, that would – I'm a clinician by
11 background, so I would ~~have – I'd not have –~~ not have and don't turn a blind
12 eye to anything. So if somebody had come up and said, 'We've got real
13 concerns here about something,' I've not ignored it. So I can't recall – I think it
14 was just the day-to-day managing and keeping the service on its feet was the
15 challenge, and keeping it staffed and keeping, you know, bank and agency,
16 and keeping everything – keeping it going.
17 PROF WALKER: Can I just follow up on that bit? There's this question of midwives
18 say commenting on the practice of obstetricians and gynaecologists. Was that
19 to the point of minor disagreements or whatever, or things which were major
20 safety factors that they flagged up that there's a safety issue?
21 MR CANT: I'm trying to think of a – no, I don't remember anything, a major safety
22 issue in relation to...
23 PROF WALKER: I suppose more of a personality or interaction?
24 MR CANT: Well there was some – oh, it's the wrong word to use, but there were

1 some interesting personalities in the team, and – within the obstetricians and
2 gynaecologists. And they were all very, very different, and I think that – and I
3 think some of it was personalities, I think, yes.
4 PROF FORSYTH: In relation to paediatricians, of course you had the Mitchell
5 Report, which we haven't actually seen yet, but then you also had the Craft
6 Report, which again highlighted some issues around medical staffing as well as
7 other things. Were you involved around that time?
8 MR CANT: Yes.
9 PROF FORSYTH: So what was the response to the Craft Report, and did it have a
10 similar journey to that of the Fielding Report, or were you able to [inaudible] to
11 act upon it?
12 MR CANT: The reason I'm just pausing, because I'm going back actually to the
13 Mitchell Report in my mind, but if we – because the Craft Report wasn't till
14 2012, I think, so it's quite well on.
15 The Craft Report was – you know, I think the [inaudible], it's in about
16 the December or the January, and then the report took five or six months to
17 come back. So I thought – you know, I was asking the PCT for that report and
18 saying this is – because at the time, as a service, we were right in the eye of
19 the storm. We really were, and we needed that report back [inaudible]. When
20 it came we did a response to that. There was an action plan, but we did a
21 response as well back to that report. And it also got absorbed within the
22 Central Manchester piece of work as well, so it became an additional
23 addendum to that piece of work as well, so yes.
24 But interestingly, when I went to the Trust – back to the Mitchell –

1 that's why I want to go back to the Mitchell Report. The Mitchell Report was
2 commissioned initially, from my understanding, about early 2009, by
3 Morecambe Bay. And then Cumbria PCT then commissioned a similar piece
4 of work for the community and for North Cumbria Acute, so this was a whole
5 economy. They eventually had three – there was three reports, as I
6 understand it. And then at that time, for a brief spell, it appeared that children
7 were coming into focus as a priority within Cumbria, and tipping into
8 Lancashire, but it was a brief spell, I have to say, because the enthusiasm to
9 take that piece of work forward from a commissioning perspective and from the
10 senior leads wasn't there, because that was the other part of my job,
11 remember. We couldn't move it forward, there was just myself and Paul
12 Gibson.

13 But what I did, and I think it's important I say this, I had the opportunity
14 to increase the staff. One of the recommendations of the report is actually to
15 significantly increase the staffing at Barrow. I think there were five consultants
16 when I went there, and within a few months we'd increased it to six by doing –
17 partially on equity, because inequity between Lancaster and Barrow was stark.
18 And it was there for everybody to see. And I – because I, as I said to you
19 earlier, and this was a corporate role, and because I had shared responsibility,
20 I could live with that disparity when there was two new consultant posts
21 assured that one went to Barrow, as part of building that service up. But my
22 hands were tied behind my back in terms of what you had in here. We had no
23 money, we were in a deficit position, but I did manage to make that one
24 change, which is like a 20% increase, not insignificant. But it doesn't take us to

1 the 10 Consultant Cell, which was ~~part of~~ what Andy Mitchell was suggesting.

2 And then in the Craft Report, Campbell Craft Report, they talked about

3 a [inaudible] unit as well, but they also said I reality, and I think – I mean

4 absolutely get this, in reality that's going to be very hard to do. One, it's going

5 to be very expensive; two, it's going to be highly inefficient; and three, the

6 quality – I used my worst case for the quality of the consultants we might

7 attract, might not be what we need. So then ~~he talks~~ CAMBELL/CRAFT about

8 going to ~~late~~ an 8 to late service, and then shifting – and then you get into a

9 real interesting view of the world in Barrow, and we would have needed whole

10 system support to take something forward. We'd have needed the

11 commissioners on side, it would have been a massive – and I'm not saying it

12 shouldn't happen, but it's not something you can do as a division running a

13 service. You need massive support for something like that because there

14 would be a lot of resistance internally and externally.

15 PROF FORSYTH: I think you've left an organisation out, but we'll go back down to

16 the divisional level in terms of the relationships you were talking about. The

17 relationship between the paediatricians and obstetricians, and in particular

18 around the maternity unit, how did you feel that worked?

19 MR CANT: I don't think it was optimum, in terms of the working relationships. I

20 found the paediatricians, again, a very disparate group of clinicians, who

21 weren't very unified.

22 PROF FORSYTH: There's only three of them, as I've got.

23 MR CANT: No, they went down to three with two suspensions. They certainly went

24 down by two, whether they went down a further one, I'm not sure, but two,

1 there were two suspended at one point.

2 PROF FORSYTH: Are they still working in the region?

3 MR CANT: I have no idea, sorry. I've left and I don't really know. With hindsight,
4 looking back, was this very functional, were they all working really well as a
5 multidisciplinary team? I'm not sure that they were, that's all I can ~~—~~ say you
6 know.

7 PROF FORSYTH: Okay, so there was sort of – a bit divisive within themselves.

8 MR CANT: Very.

9 PROF FORSYTH: And the relationship between the obstetricians and the
10 paediatricians and...

11 MR CANT: I don't think – I think probably, you know, again, this is – I can't validate
12 this. I think probably the interrelationships within themselves were worse than
13 the relationships between themselves, if that makes any sense. Particularly in
14 paediatrics, there were some people who really did not get on with each other
15 at all. Chalk and cheese, just – you know, and it'd play out in tantrums and all
16 sorts of...

17 PROF FORSYTH: So who was in charge of the paediatricians?

18 MR CANT: The paediatricians, it was [Owen Gott?] was the clinical lead for
19 paediatrics. And Owen ~~got into — he~~ was appointed in 2010.

20 PROF FORSYTH: He was based in Barrow?

21 MR CANT: No.

22 PROF FORSYTH: He's in Lancaster?

23 MR CANT: Yes, which is a...

24 PROF FORSYTH: Were they disparate just in Barrow or were they disparate...

1 MR CANT: No, Lancaster was a different group of – they worked cohesively, yes.
2 When we went to advert for a clinical lead in terms of building this divisional
3 structure, there was one candidate from Barrow and there was one candidate,
4 from memory, from Lancaster, and the one from Lancaster was appointed.
5 And this is – sort of really signals to me when I started, to realise that – the
6 significance if you were from Lancaster and you were going to have any
7 involvement in Barrow, it was going to be really, really difficult. Because Owen,
8 you know, experienced a great deal of difficulty, as indeed his predecessor,
9 Paul Gibson, had. They weren't easy to work with on any level. I hate to say
10 that, but that's true.
11 PROF FORSYTH: Okay.
12 MR BROOKES: I've got a question about your management line. I'm hearing a very
13 different set of conversations going on in terms of the management line, which
14 is about money. Is that a fair assessment? That there was a clear need to hit
15 your cost improvement targets and performance targets, and that was not
16 necessarily the sum total, but the priorities that were within that discussion, is
17 that a fair assessment?
18 MR CANT: That can be evidenced by the monthly performance meetings that were
19 held with the division every month. So that would have been my previous view
20 of the world. If you look at the performance meeting notes for any of the
21 divisions, including women and children, they were around – I think you start
22 with money, you go onto the ~~[inaudible]~~performance targets and so on. The
23 quality was a part of that discussion. And the measurables are in money, it's
24 measurable. The targets are measurable; big focus on what you can measure.

1 And I have to say, I agree very much with you. In my professional life, that is
2 my experience in the NHS. It's not very much different at the moment, there's
3 still a big focus on money, and you feel the heat, you feel the pressure for that,
4 you really do, and it's a real challenge.
5 MR BROOKES: But there's a difference between – I agree with that.
6 MR CANT: Good, I thought it was just me.
7 MR BROOKES: I've been a performance manager, so I know what it's like. I agree
8 with that, but at the same time there is a reality check about properly
9 constructed and deliverable cost improvement programmes, and, 'We'll take
10 15% off this organisation irrespective of whether it can do it or not.' What I'm
11 trying to get a feel for, where it was in that kind of spectrum.
12 MR CANT: Well, it changed over time. Up until I got to the Trust, the Trust had
13 traded its way through cost improvement because of income. I don't want to –
14 you know, do more, get more money, we'll offset that against – then that dried
15 up rather rapidly, and then it became about true cost reduction. And that's
16 when the screw started to turn, and that's when it got very tight.
17 In my role, I made a plea ~~plea for why am I – you know~~, if I've got this
18 challenges in this division, 'You need to grow this division', why am I being
19 squeezed on cost. You know, I need to grow this division. ~~I can't – any~~Any
20 economies I can make in efficiencies, I wanted to reinvest, not to make my life
21 easy, but to make the division's substructure what it needed to be, to be fit for
22 purpose.
23 MR BROOKES: And you weren't allowed to do that.
24 MR CANT: No.

MR BROOKES: And that was despite your discussions with your line manager in terms of...

MR CANT: Yes. Because I talked about 'I need a governance ~~laid~~lead, I need this, I need administrative support,' which Dame Fielding picked up, because I said it to her. I said, 'Can we have a bit more admin to work with, to...' I mean Angela and I at some point, and I can remember the late evenings working down to patient level ~~and writing – you know,~~ we had no –service manager so we're doing that level of detail to make sure we ~~don't~~ did not breach. We're not just delivering the target, we're actually down on the PTL. And then the next thing, we've got the whole picture – I'm supposed to be developing the strategic future of paediatrics in Cumbria. It ~~really didn't – you know, it~~really didn't square. I couldn't do it.

And then the screw tightened year one, year two, and then year three, interestingly was when we were right in the middle of the storm, and it relaxed a little bit. I have to say in year four it fairly ramped up again. And that – you know, it really did, because I was – you know, I think when I left the Trust it was – we'd a CIP (cost improvement target) target of £1 million ~~or £1~~. – it wasn't insignificant, it was significant, the amount of money on a £20 million budget. In fact Morecambe ~~paid~~ BAY TRUST. had a 13% cost improvement target. I mean – you know, when you do – what they were supposed to find versus, I think it was – that's the level we were talking about. ~~That does not – you do not – you~~You cannot not feel the pressure of that.

MR BROOKES: Absolutely, I understand.

MR CANT: You cannot, it's all around you.

MR BROOKES: And that would mean there's a step change, isn't there? It's not salami slicing your costs, a little bit here, a little bit there.

MR CANT: No, but that's interesting, because then from a general manager's point of view, it changes how you will approach this, right? It says to you, 'You can't approach this. This is not about skill mix ~~or round~~around the ages, this is fundamental change is required here if you're going to run a Trust on that level.'

MR BROOKES: And was that recognised?

MR CANT: Do you know – I don't know. ~~It was said – and you –~~I said it you know, other people you talk ~~went~~ to who might actually relate this back to me, I said it in public places. You know, I've said it in big gatherings, I said, ~~'Look, when...'~~ because every autumn ~~it~~ the CIP (cost improvement plan) would be like the precursor to Christmas. It'd be the downer before Christmas. You know, here we go, let's see how you're going to get your million quid together, whatever it's going to be, it would be a real – and I would say to those big gatherings exactly what I said to you (that fundamental change is required), because that's exactly what I believed, but I have to say, the politics of that scale of change are still being played out in Morecambe Bay, I know they are. And that's five or six years later. Huge challenge ~~– I mean~~and not insignificant – huge challenges.

But the other thing I'd just like to plea is – I realised quite quickly that Morecambe Bay, and I'm sure you all realise this, but Morecambe Bay is providing services across three sites for the highest rural population, which involves those people who are providing that service. It's not like working in a hospital on a single site with a very dense population where everything is —on

1 one site you know, if you want to go to a meeting you walk across there and up
2 the stairs. Morecambe Bay, you drive 30 miles to somewhere. It's –
3 everything is – and also, the income – and I'm not an accountant, and I don't
4 profess to be, for me the income doesn't square with providing services across
5 that geography. And therefore those are the battles that should be had – you
6 know, a Trust like it is about how do you adequately resource a service that's
7 across that sort of geographical location. And the only – and again, I'm sorry
8 it's not a plea, but you just need to look at North of Cumbria where I live, it's
9 exactly the same – not exactly, but a similar situation is being played out in
10 North Cumbria. And I'm not saying it's the same, I'm just saying there's similar
11 and there are various similarities between Whitehaven and Barrow. Huge
12 similarities. And why – and I've worked there for 30 years; why these things
13 have not been dealt with, you know, I really don't understand. Because you're
14 forcing people to save money in extremely challenging circumstances where
15 there's not much fat, if any.
16 MR BROOKES: Yes, thanks very much.
17 DR WALTERS: Just going back to the day job, so...
18 MR CANT: I have to say, that was part of the day job though. Sorry, I'm not being
19 sort of...flippant
20 DR WALTERS: No, no, but...
21 MR CANT: I understand.
22 DR WALTERS: It's not the day job, but the sort of sequence of events. So you've
23 got this job. Money's clearly the focus. In your performance meetings money
24 is the focus. ~~There's a building report, but actually it's not got a very high~~

1 ~~profile. You've got...~~ ?Fielding. Meaning unclear.

2 MR CANT: It didn't get the profile it should have had.

3 DR WALTERS: Yes.

4 MR CANT: Yes.

5 DR WALTERS: You've got some positive but weak signals coming from things like
6 patient surveys, CNST, and people within the division, if they are raising any
7 clinical concerns, they're not raising them to you.

8 MR CANT: No. But there's clinical concerns and clinical concerns, I think. Nothing
9 that would scare me, if you understand, nothing that I'd say, 'Oh, good God.'

10 DR WALTERS: So in your performance meetings, when you talk about money and
11 saving money and everything, do you raise this sort of quality conundrum there
12 at all with things specific that...

13 MR CANT: No, it wasn't in that forum. There was very much a distinction between
14 governance, nursing and medical leadership within the Trust, and operations,
15 finance, if I'm honest.

16 DR WALTERS: So rolling forward then to 2011, obviously then there's a bit more of
17 a flow of activity because you've got the Central Manchester Review.

18 MR CANT: I didn't – it's just when you said of limited significance, you didn't
19 mention the CQC, but I didn't take that as minimal, I thought that was pretty
20 significant.

21 DR WALTERS: Yes, I'm sorry.

22 MR CANT: Because – no, but I'd just like to mention, because I thought that was
23 significant. And then because it was even more significant when we came
24 back. That's why I looked at this.

DR WALTERS: Yes. But then there's a cluster of activity around 2011/2012, so does the focus of the sort of quality and safety agenda, does it increase at this point?

MR CANT: Yes.

DR WALTERS: Right.

MR CANT: ~~Exponent~~ Exponentially – like that, you know.

DR WALTERS: So just take us through the milestones of...

MR CANT: Well, the milestone was – can I say, there's another – I take your point about limited assurance, but there was another one, because the exec team – I just want to mention this – would go round the sites and round the departments as well, so they had a director of nursing and an exec with a non-exec, so there was another set of activity going on, on the shop floor. But that, as I say, limited assurance, but it was going on.

Sorry, what's your question? What happened was the day of Joshua Titcombe's inquest is when things changed dramatically – dramatically. It involved – clearly it was the Coroner's – you know, the inquest and the Section 43 letter to the Trust, but then within a week if not less we had unannounced visits, joint, from the NMC and the CQC. And that was interesting ~~– you know, when it happened we were – obviously, batch appointments, showing people around.~~? ~~We did all – of that happened.~~? Then there was a plenary session back at Lancaster, I recall, where they fed back. And the feedback didn't feel like the report felt, particularly the NMC one. They talked about the positivities of the service and they talked about quite a lot of positives. The CQC had issues of concern, they expressed that, but it didn't

1 feel like what then subsequently happened very quickly when the reports came
2 in and you had your major concerns and so forth.
3 And very rapidly. You know, we have very short deadlines to do. If it
4 was – it would be trivial to say, 'Did the light bulb come on, on quality that day?'
5 I wouldn't say it was like that, I just think it heightened awareness, and a shift
6 of focus that gradually increased.
7 DR WALTERS: And was this because it was the CQC, do you think? Or was it the
8 nature of the inquest?
9 MR CANT: It was the inquest and the ramifications and the publicity around that.
10 And then there was the – then the two reports coming together just – and then
11 we started to get more involvement from commissioners, taking more of an
12 interest maybe than they had done previously. You know, more people started
13 to want to know what was going on inside the goldfish bowl, in a sense.
14 Because in the past it almost felt that people were looking at the fish rather
15 than being in there with them. Do you know what I mean? So – and I felt
16 people were starting to listen and wake up to the fact that there were some
17 challenges here.
18 DR WALTERS: So what was the Trust's response to that, and how did that affect
19 life for you in the division?
20 MR CANT: It affected – well I'll come to me last, in a sense. It affected – but it
21 shifted a huge spotlight into maternity services, and neonatal
22 ~~[inaudible]~~services at Barrow, primarily, but not exclusively. Interesting, no
23 that's not the case. It shifted – it put a spotlight on Barrow, but for the first time
24 I think it put a spotlight on Lancaster, which was interesting, so back to the

1 point earlier that [inaudible] elitism, it's not the right word, but there was some
2 criticism of Lancaster which I don't think Lancaster was expecting.
3 And it – there was some clear actions of which were short terms – addressed
4 right away, and some longer term actions, in a nutshell, but we got on – it got
5 focus and an energy, and kind of pushed the money for this thing out the way,
6 just getting to this. You know, it's a bit like a pendulum. It – not the right way, I
7 know, but that's what happened and there was a focus on that, and then
8 started to address those concerns very quickly.
9 DR WALTERS: And what were the tangible changes and how quickly were they
10 brought about? Under your action plan, to exercise.
11 MR CANT: The only reason I'm hesitating is I'm just trying to distinguish action
12 plans, which actually took place at which time.
13 DR WALTERS: Yes, there's quite a lot of them.
14 MR CANT: There was. But some very rapid actions were taken, for example the
15 records that were found in the —Junior Doctors Room were shifted,
16 immediately, in less than a week. The – one criticism was an area that was
17 thought to be dusty or something in the corridor, so that was sorted. I'm not
18 sure how material that really was, in essence, but it was dealt with, and sorted.
19
20 The issue – I think the most significant issue that was addressed
21 rapidly, weekly, actually, was the issue of the distance from the labour suite to
22 the theatres. And somebody had a light bulb moment, and it was an individual.
23 I don't know who it was, but somebody said, 'Couldn't you just knock through
24 that wall, and go down through MAU?' That was a light bulb moment. And to

show you how – you know you're talking about how did the Trust respond to that? That was done. It wasn't that the capital plan, we're sitting at the capital planning meeting with, you know, going through, 'That was done.' We need it done, it's done. It was done. You know, the hole in the wall, done. Patient's transported down there and somebody else ~~said~~ suggested the need for curtains across ~~[inaudible]~~the corridor.

Positive things were moved forward very rapidly, and then there was also money spent on decoration, lighting in the labour suite. If – they all made a difference, but probably the most significant one for me was the one with the new route, rather than taking ladies down the corridor on trolleys in, you know, quite not acceptable circumstances.

DR WALTERS: Yes. So in terms of improving quality and safety, all those things make a difference, but there's a lot of other stuff, isn't there? Do you think there are any – did it bring about any fundamental change in relation to your practice?

MR CANT: That's not going to happen overnight.

DR WALTERS: No.

MR CANT: And I can't directly attribute that to the CQC and NMC. I can start to attribute that to the Central Manchester Report, when it was all – but these linked into each other, over quite a short period of time. So, I think the CQC had been the July, August of 2011 I think, and then the Central Manchester came in in November, so it's all very close together, and all started to create a bigger movement towards change.

DR WALTERS: So were you having to sort of report to the board and this sort of

1 thing?

2 MR CANT: ~~No. I – in the first – it's only the second today, the first time I went to the~~
3 ~~board – the~~The answer's yes, actually, but the first I went to the board was two
4 years after I'd been there, and that was in the September. 28th or 29th. The
5 end of September 2011, when we were asked by ~~DR KIRKUP~~the Trust
6 Chairman to come and talk about the capital plan for the ~~year next~~Maternity
7 Unit in Barrow.

8 Which, you know, I don't think would have happened – would have
9 happened, you know, that plan had been there from the previous year, to – so
10 that gives you the thing about the exponential focus. Come to the Board, talk
11 about the plan, we're doing it. It was that kind of... and similarly around that
12 time, this is where (– this is the third year) I think, this is once the money thing
13 changed, because they'd made some ~~[inaudible]~~additions with the workforce~~, it~~
14 ~~was like either [inaudible]~~. ~~It wasn't to a VCP, you know,~~Normally, you needed
15 to complete a VSP form, you got vacancy control form, put it through~~, –~~.
16 deliberate, ~~but like it wasn't like that,~~This was different you just get them, just
17 get on and do it, get seven~~...~~midwives and it was well actually get 13 midwives.
18 That was ~~the – where~~when the brakes came off the finances and for that, you
19 know, I think £15 million extra was spent in that year. Not just – can I just
20 qualify that, not just in midwifery, in outpatients and all the other challenges
21 that the Trust was facing at that time.

22 MR BROOKES: Can I just ask, before that point, how visible was the board, the
23 chief executive, director of nursing, the medial director, involved in the issues
24 that were related to Morecambe Bay?

1 MR CANT: See, when I...

2 PROF MONTGOMERY: Panel, I'm [inaudible].

3 MR BROOKES: So you put that in the log of the Chair and execs as well.

4 MR CANT: Well the – I mention the non execs in the visits on the wards, so that

5 happened. No, I can't say. I can't say they were. I know the chief executive

6 was heavily involved with Joshua Titcombe and James Titcombe.

7 MR BROOKES: I knew that's different from previous [inaudible].

8 MR CANT: It is different, but I – it was very – I know – but I just think...

9 MR BROOKES: I'm aware of that.

10 MR CANT: ...I know that was – but in terms of involvement on the ground, if I was

11 to do – I mean I don't want to pick – I'll put them in order, but I'm not here to

12 talk —about individuals you know, ~~I'm [inaudible] individuals,~~ topics, but in

13 terms of visibility, it would probably have been – you said Chair, didn't you? It

14 would be – if I was to do it from the most visible downwards, it would be the

15 director of nursing followed by the chief executive, followed by the Chairman, I

16 would have thought, but I have to say they're not hugely visible, but in that

17 order. Is that...

18 PROF MONTGOMERY: Not the medical director at all?

19 MR CANT: I didn't mention the medical director. And I think that's...interesting.

20 PROF MONTGOMERY: That's interesting.

21 MR CANT: I mean, I was involved with the medical director. Well, I wasn't involved,

22 I was trying to push the medical director on the problems I was having with

23 some of the doctors. Because they were taking years to sort out. Good grief,

24 we're trying to run a service here. Two doctors suspended. How can I –

especially when you've got critical mass on the ward, that is at critical mass. So I mean, I'm going back five years, so I'm trying, you know, to be fair to everybody. But I guess if I didn't mention the medical director, that's because he wasn't in my mind.

PROF MONTGOMERY: Thank you.

PROF WALKER: Can I ask just briefly on when the Fielding Report came out and the Manchester Report came out, did this conclude their conclusions, were you surprised by the conclusions? I think you questioned it, the Central Manchester Report you've got the reports and the recommendations didn't quite match or something, but I wasn't - not quite sure what...

MR CANT: Did I say that?

PROF WALKER: It was said in – you said, 'Identified a lack of correlation between your report and the conclusions drawn,' in our meeting of the maternity risk management meeting. But I'm not going to hold you to that, okay, so I'm asking you, were you surprised by these reports? Or did they highlight things you felt were there beforehand?

MR CANT: It highlighted – well, it brought together everything that had gone past in the previous few years. Some of the things I clearly new about, like the – the initial report. ~~And I was supposed to be involved in that in year one, but couldn't be. I had to leave in year – I must mention that when I got my substantive role, I couldn't obviously continue with that [inaudible] role. I need to mention that. So that stopped, as far as I was concerned.~~ Meaningless I think the thing that got me about the report, if I come to it, was that there were some factual ~~accuracies~~ —inaccuracies within the report that I'd not felt – I felt we should

1 have the opportunity, as a service, to comment on, and we weren't allowed to.

2 PROF WALKER: Okay, but did you feel, when the reports came out, did you feel,
3 'Good gracious, I never knew about this', or did you feel, 'I've been saying this
4 for years, and now I've got report evidence to help support me do things.'

5 MR CANT: Yes. Yes, in terms of the latter. There were things that would obviously
6 help the cause in terms of making us a focus for improvement within the
7 organisation. I did feel, however, that they were – I felt they were overly
8 critical. Is that still part of the same answer? Do you mind? I felt they didn't
9 recognise the embryonic nature of what we were trying to do in some ways,
10 because if we touched – these things – some of these issues had been
11 ~~barrelled~~ around for 20 years.

12 They – you don't build a strong governance overnight, you know, I just
13 brought a new management team together, I'd just got a new
14 ~~governess~~governance lead. ~~I'd actually been [inaudible]~~which I had been
15 trying to do for 18 months. I had to regroup, create a new governance team
16 and start from scratch again, so I was trying to – and I didn't feel that got the
17 recognition ~~that, you know, this is~~. There were green shoots of positivity here,
18 you know, they're going in the right direction. Whereas it was a bit –
19 governance [inaudible] are inadequate.?

20 Okay, but there's, you know, the Core clinical division – sorry to make
21 a point – didn't have any governance arrangements until I set that meeting up
22 prior to Central Manchester~~,~~ review ~~and –~~. I didn't set it up from Central
23 Manchester coming. I'd already done it with women and children, family
24 services. This was the next generation with the ~~nurse~~ new division merged. It

1 was happening.

2 So yes, it was helpful, it brought focus. It felt particularly damning in its

3 – in all its criticisms, and I felt some of the points within it – going back to

4 something I said earlier – hadn't been triangulated ~~to be —~~which would have

5 given more validation in a sense. It was – when you looked at some of the

6 detail beyond the actual report, there was a risk log. So it was actually what

7 one person said, and that seemed to inform something. And I'm not saying

8 that's not a true thing. ~~I'd~~ I would just like to have seen it validated. But this

9 was – to be fair, they had three days to do a very – well, to come into the

10 organisation, and they need to pull together a lot of evidence and information in

11 a short period of time, so I accept that.

12 DR KIRKUP: Okay.

13 DR WALTERS: To really have to tie up with this [inaudible].

14 MR CANT: [Inaudible].

15 DR WALTERS: Did the gold hand experience achieve anything extra?

16 MR CANT: Yes, because it brought the outside world into the team.

17 DR WALTERS: Yes.

18 MR CANT: That's, you know, the CCG's – that's right? Yes? The CC – the PCGs,

19 whoever, they were in – they came right into that. Then they extended links

20 into that, and we got a recognition and the involvement of the scales of

21 challenge that we're facing and more support than we'd had previously.

22 DR WALTERS: So a final question from me, in that all this stuff is really all about

23 systems and processes you have in place to make sure your outcomes are not

24 worse than anybody else's, in terms of survival, morbidity, of mothers and

babies. Was that discussed? About whether this Unit was worse, in terms of survival and outcomes of mothers and babies at all?

MR CANT: No. And I say that quite emphatically, because I can remember it was in the October of 2011, I remember dealing with it with I think it was myself and Sasha, were phoning into a conference call, and it coincided with an opportunity, it was quite an interesting experience, it coincided with the Conservative Party – you know the [inaudible] week that the parties have, it was clearly a lot of political pressure. You feel it coming right into the room, and we were linked into calls only up to the department, the ~~SHF~~SHA, ~~and I can – and~~ Professor John Ashton, and the reason – I ~~won't say public health, you know,~~would not say I am an expert. In public Health Professor John Ashton was part of that conference call and so on, and I can remember then thinking, we're reacting, rightly so, to a lot of things that we are aware of, but where are we in the scale of perinatal mortality?

I never had any benchmark back to ~~– you know,~~ to say, ~~I hadn't seen it and I didn't discuss it to say that you're an inlier, outlier, whatever~~that our perinatal mortality was high (outlier). Nothing at all. And I remember thinking that, on that day. ~~I think it was because a minister was involved in it.~~I have no recollection of this sentence So it got me thinking where is that piece of – well surely somebody's doing it. I have to say I have read one piece since, as part of my preparing for this, which was interesting. But I'm not a public health expert, but I'm sure you've got it, but it's the report commissioned by Cumbria, and I've done it as part of my preparation for this, commissioned by Cumbria, to look at between 2002 and 2008. And it's really interesting, that it says that

the perinatal mortality in Cumbria was – and please don't – I'm not trying to talk as a public health professional, I'm not, but it says that it was at 5.6 per 1000 population, and that northwest is 8.1 and that England, all England, at 7.9.

I tried to square that, I don't know – I need an expert in that field to look at, but that type of information, I never heard that discussed in all the time that we were pre- post- ~~[inaudible] Tickham[?] and~~ the previous case incidents. Or at any time, when I was in the Trust. I just thought that was an interesting report. I don't state it for any other reason than its interest – I wouldn't like to comment on its – you know, whether it says things were better than they were or not. I'm not saying that at all. I'm just saying, interesting piece of information.

DR WALTERS: Okay.

DR KIRKUP: Shall we [inaudible].

PROF MONTGOMERY: I've got a few, I'll try and be really quick. I'll – there are a whole series of things that came together in 2011. Were they dealt with as a series of separate issues that had action plans, or was there some collated action plan?

MR CANT: Let me just tell you something. I'm glad you mentioned this, because it's important, because I feel quite strongly about this as well, so why this - I'll probably pick this up in a minute somewhere, but when we had the – Central Manchester was the all encompassing that brought everything together. That's a good thing, right? Because we, as a small division, couldn't cope with the amount of stuff that was coming at us. It just was like overload.

That helped bring it together, and it helped, as far as the organisation's

1 concerned, to get the focus round the size of the problem, and then additional
2 resources came in to help us with it, and I don't know if you'll pick this up, but I
3 want to say this because I feel strongly about it. We didn't handle the taking
4 forward of that report very well from a practical point of view. Again, if you ask
5 people they'll say that I did say this.
6 It coincided with the organisation bringing in a program management
7 office, PMO office around everything that was going on in the organisation. I
8 mean A&E, outpatients, everything that was not right was part of the PMO.
9 And the PMO came in from PWC – I'm not knocking anybody, but they came in
10 and they came in with the ~~wrong way~~their way, and it was their way or no way.
11 And their way was to use a specific way of doing the action planning around
12 the Central Manchester report .
13 We, - and I can remember doing it – we, as a service , actually started
14 off doing an action plan ourselves, before, which was, as you'd expect, you
15 know, what are the issue? What are the actions? Who's accountable? What
16 they need to be done by, etc. That got binned, and it came to you that this is
17 the PMO way of doing things, and then they brought in a person ~~who's~~
18 ~~populating~~whose job it was to populate this for example, and we lost the detail
19 and some meaning. By the time - we ended up with something that we
20 couldn't work with– it was like a Chinese…whispers.
21 MR BROOKES: There was no ownership.
22 MR CANT: It was like a Chinese whisper. It didn't – couldn't relate it back to the –
23 then it became a micro-management of all the little issues on that risk log that
24 you've seen of the – all those things. So we ended up with – there was the 15

1 topics, and then there was 100 actions, and then there were another – well, it
2 went up to like 1300, you know, total sub-actions. Again, we got into the point
3 where we couldn't see the wood for the trees. When you go back to the report,
4 the actions are fairly straightforward. They're actually involved in the report,
5 and that's what we had in our ~~–~~initial Divisional Plan. you know, that's what we
6 should have ~~got~~stuck with. With a bit more leeway we could have made a
7 smarter piece of work quicker. Because what then happened is, and I just
8 want you to know this, what then happened is that when Central Manchester
9 came back a year later to review our progress, we - first of all I believe that the
10 evidence and information was sent to them late, but secondly, when they got it,
11 they were completely deluged. Because they'd got far too much stuff that was
12 not – it was not sure, but it was – you couldn't see the wood for the trees, and I
13 think that – so when they did the further review, what I'm trying to say is, we
14 were more compliant than they thought we were, but they couldn't tell because
15 of what we sent them. Do you understand what I'm saying?
16 And then, in the beginning of 2013, a further action was done in
17 response to their request – I just want to say that a further one was done that
18 found we were working, you know, that there was an agreement that we were
19 more compliant~~, but we'd completely drowned them in, you know, the minutes~~
20 ~~of a meeting that took place in, you know, or some – we could have done that~~
21 ~~much smarter than we did. But it was – I have to say, you have to recognise,~~
22 ~~this was an organisation which was still walloping [inaudible] around in terms of~~
23 ~~chaotic – a group of epic totality. I understand that. I think we got squashed a~~
24 ~~little bit, in that I think we could have –~~This is meaningless ~~with a bit more~~

1 ~~leeway we could have maybe made that a smarter piece of work quicker.~~

2 PROF MONTGOMERY: This one's a yes, no answer.

3 MR CANT: Sorry. I promise.

4 PROF MONTGOMERY: You describe really quick response to the CQC access to
5 theatre's issues, and someone had the bright idea you could just knock the wall
6 through and go through. Was that the first time that that access question had
7 been discussed?

8 MR CANT: Yes.

9 PROF MONTGOMERY: Thank you.

10 DR KIRKUP: Okay, thanks.

11 PROF MONTGOMERY: There's other areas of interest, but nothing at this time I
12 think.

13 DR KIRKUP: Okay. Is there anything else you want to say to us? Thank you very
14 much for your help.

15 MR CANT: Thank you very much. I appreciate it.

16 [Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Monday, 24 November 2014

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

Before:

Dr Bill Kirkup CBE – Chairman of the Investigation
Professor Jonathan Montgomery – Expert Adviser on Ethics

MIRANDA CARTER
VICTORIA WOODHATCH

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1 DR KIRKUP: I'm Bill Kirkup. I'm the Chair of the investigation. I apologise that we're
2 a few minutes late starting, owing to the vagaries of the railway service from
3 Carlisle. Sorry about that. I'll ask my colleague to introduce himself to you.
4 PROF MONTGOMERY: I'm Jonathan Montgomery. I'm professor of healthcare law
5 at University College London. I also chair the health research authority and in
6 the past I've chaired a couple of provider trusts, PCTs and [an SHA when
7 there were 28?].
8 DR KIRKUP: You will see that we're recording proceedings. We'll produce an
9 agreed record at the end. You may also know that family members are invited
10 to be present as observers at the interviews. As it happens we don't have any
11 this morning, but they may listen to the recording subsequently. You'll also
12 know we've asked you to hand in any mobile phones or recording devices, just
13 to emphasise that we don't want anything to go outside the room here until
14 we're ready to produce the report with everything in context. Any questions
15 from you about the process? Okay.
16 I'll start off just by asking if you could each outline when you started with
17 Monitor and what you've done since then, and then I'll hand over to Jonathan.
18 So who would like to go first?
19 MS CARTER: I can go first. So I'm Miranda Carter and I've been with Monitor for 10
20 years. So I joined Monitor pretty much when it started in February 2004 and
21 I'm still there now, and I head the functional area of Monitor that looks at FT
22 applications as well as FT transactions.
23 DR KIRKUP: Thank you.
24 MS WOODHATCH: And I'm Victoria Woodhatch. I started – I've been at Monitor
25 five years. I started in the assessment function, and I am now in the

1 compliance function.

2 DR KIRKUP: Sorry, I missed the least bit. You were in the...?

3 MS WOODHATCH: Compliance function.

4 DR KIRKUP: Compliance. Right, okay. Thank you. That's very helpful. Jonathan?

5 PROF MONTGOMERY: Can I just check, may we call you Victoria and Miranda, or

6 is that – is that okay?

7 MS CARTER: That would be fine with us.

8 PROF MONTGOMERY: Okay. Victoria, when did you move from assessment into

9 compliance, just so we're understanding.

10 MS WOODHATCH: Not quite sure, because it –

11 MS CARTER: Was it 2011 I think?

12 MS WOODHATCH: Maybe 2011.

13 PROF MONTGOMERY: Okay. So you were still in the assessment bit as

14 Morecambe Bay went through the assessment process? That's the crucial

15 thing for us to understand.

16 MS WOODHATCH: Yes [inaudible].

17 PROF MONTGOMERY: Thank you. That's really helpful. We just need to

18 understand the processes that went through and how material was produced

19 to support the board to boards, how you interacted with the trust. So we'll

20 have a few things that are prompted from what we've read elsewhere. It's just

21 trying to get to the bottom of understanding what the process was. So I think

22 what would be most helpful is to, sort of, take us through the timeline, and we

23 only need to know about Morecambe Bay, but if you tell us a bit about the

24 context it may help us understand that. So once you know an NHS trust is

25 seeking to get through the – on the Monitor system, can you take us through

1 what Monitor does once it knows that.

2 MS CARTER: So, sorry, you want the generic process rather than the process for

3 Monitor?

4 PROF MONTGOMERY: If you could. I don't think we need to separate them. We

5 need to understand both, but if you can take us through Morecambe Bay, but

6 if it diverges from what you would have expected elsewhere, explain that.

7 MS CARTER: So we get involved with an aspirant NHS trust only when we receive a

8 letter from – going back to the original part of when Morecambe Bay was

9 considered, that would be from the Secretary of State, confirming that it was

10 ready to be considered by FT status.

11 PROF MONTGOMERY: So by that stage it's been looked at by the SHA, it's been

12 looked at in the Department of Health –

13 MS CARTER: Yes. It had gone through an SHA assurance programme, so they

14 have certain domains that they look at. So they would be working out whether

15 from their view they've developed that organisation so they think it's ready to

16 become a foundation trust. It then goes through a process – at the time went

17 through a process at the centre and a recommendation made to the Secretary

18 of State, and then the Secretary of State would write to us. And then at that

19 point we'd – so we receive a letter, saying, 'Yes, it's ready'. And then at the

20 time Morecambe Bay was considered we had a number of applications which

21 would be referred to us at any one time, so I can't actually remember how

22 many there were, but there was a process that needed to go – we went

23 through to determine when their start date would be, because we couldn't start

24 all of them at the same time. Now we do get less coming through each month

25 and normally we'd start them straight away.

1 So I think, if I remember correctly, they came through at about the end
2 of ~~two thousand -- right at the end of 2008~~ February 2009, and they were
3 scheduled to start their first application in March 2009. So we write to them
4 once we've received that letter. It says, 'We confirm we've received your – the
5 letter from the Secretary of State. You now need to submit to us what we call
6 the integrated business plan', which is the document which basically sets out
7 their stall: their strategy, their finances, governance arrangements and why
8 they believe they can be ready for foundation trust status. And we also ask for
9 their constitutions, so you're probably familiar from your previous roles about,
10 sort of, setting out governance arrangements, and then that formally starts
11 their application. And then we receive those documents and we send out a
12 more detailed letter about their timeline and additional information requests.
13 So –
14 PROF MONTGOMERY: So just if I can come back to that bit, how much do you see,
15 if anything, of the process the SHA has been through and the documentation
16 submitted to the Department?
17 MS CARTER: We don't see that.
18 PROF MONTGOMERY: So if anything was from that it would have to be in the IBP
19 for you to know about it. So anything that had been raised in those questions
20 –
21 MS CARTER: Yes, but also we do speak to the strategic health authority as part of
22 the process. – Clarification the IBP doesn't specifically refer to the SHA
23 assurance programme. Ref note 1 below.
24 [Note 1- from Autumn 09 we began receiving a letter from DH which outlined
25 the key issues at the time of Secretary of State approval. This was not in place

1 for the first assessment but we did receive an updated letter in Sep 2009
2 before the final authorisation decision]

3 PROF MONTGOMERY: Okay. I don't think we've quite got to that bit yet, have we
4 though? I think I interrupted you. That's great. And the IBP, how much does
5 it have – what's the balance between quality issues and financial profiling? All
6 the ones I've seen were focussed on finances and best case, worst case
7 predicted. So what data would you expect to see in that about the quality of
8 services?

9 MS CARTER: Well, they would need to set out the service lines that they have.
10 They would set out their strategy and their service developments, so there
11 would be things in there. I think they would talk about their current position
12 with, I think at that point, their quality of service rating and use of resource
13 rating within there. And I would say it's evolved over time such that, as you're
14 probably aware, following Mid Staffordshire all the work around quality
15 governance –

16 PROF MONTGOMERY: We understand what's happened since, so we obviously
17 need to understand the time on – principally. So you'd see anything that was
18 – so you'd see the use of resources ratings, you'd see any Healthcare
19 Commission ratings. Would you expect to see anything in those around
20 complaints and the handling of complaints and the pattern of complaints?

21 MS CARTER: Well, we would ask for that as part of the assessment process, but –
22 I've just remembered, sorry, this document isn't supposed – it's not a
23 document this thick that –

24 PROF MONTGOMERY: No, I understand.

25 MS CARTER: – covers everything. And the other thing I would say is we worked

1 closely with the Care Quality Commission. The Care Quality Commission has
2 an organisational risk profile, so we would have seen that, which has a lot of
3 data within it. That's not within the IBP.
4 PROF MONTGOMERY: But you wouldn't have had – that's helpful. I'd like to come
5 back later on that, because I think it would be helpful just to clarify it, to take
6 stock of what you get from each of various organisations so we can be clear in
7 our mind what comes through. Do you do any – did you have any on
8 investigations that you do around quality issues, independently of those
9 organisations, or do you work through them?
10 MS CARTER: So just to be clear, sorry, if you take when we first assessed them and
11 identified maternity concerns, at that point we didn't do work on quality
12 governance. When we looked at it the second time around we did work
13 around their arrangements to manage quality and performance within their
14 organisation.
15 PROF MONTGOMERY: Okay. So if we can – I sort of interrupted you, I think.
16 That's really helpful and there are some things you've already flagged up
17 which are helpful for us to understand. So we've got to the stage where you'd
18 got the IBP in, and then you were writing back with some questions to follow
19 up from the – is that –
20 MS CARTER: No, we then send out a letter saying, 'This is when we're going to kick
21 off your assessment, and to help us we need to request further information
22 from you'. And typically we ask for things like direct evidence to support risk
23 and performance management. We arrange a kick off meeting with the trust
24 and we go up to see the trust and explain the process and what it's going to
25 look like, and arrange a whole programme of interviews within the trust and

1 with external stakeholders. And then we go out on visits and doing interviews,
2 and we would also ask for follow up information as we go through the process.
3 So once you start looking, you've got a line of enquiry, you might want to see
4 some more information as a result of that, so we keep a log of all the
5 additional information we require. And the process takes – well, currently it
6 takes longer, but at the time around three or four months to pull everything
7 together.

8 PROF MONTGOMERY: Okay. And then does that all get pulled together into the
9 pack for the board to board meeting? That's a, sort of, summary level
10 meeting.

11 MS CARTER: Yes, yes. So we try – I'm not sure how familiar you are with it, but do
12 you know the board to board pack would have an executive summary, and
13 then it will have different areas within it? So within that pack, just if we've
14 taken the theme of quality, one of the learnings we've had from Mid
15 Staffordshire was we needed to look at other performance indicators in more
16 detail. So the pack would have clearly articulated what the staff survey says,
17 what press survey says, what internal – sorry, what patients' surveys were
18 telling us, and looking at complaints and looking at serious untoward incidents.
19 So I would say that the first time we looked at that organisation our review into
20 serious untoward incidents highlighted the concern that there were five out of
21 12 which related to the maternity.

22 PROF MONTGOMERY: And there was a specific question prompted at the first
23 Board to Board about that, yes.

24 MS CARTER: Yes, because of our learnings from Mid Staffordshire and the fact that
25 we needed to pull that information together. And I think the other thing I would

1 say is that the other bits of quality we look at – so we looked at the mortality
2 and also how they were performing on targets and standards as well.
3 PROF MONTGOMERY: Okay. Thank you.
4 MS CARTER: So that was an additional bit of information that our board would see
5 as well.
6 PROF MONTGOMERY: Okay. So if we can then, sort of, focus that down on the
7 first phase of the Morecambe Bay application, so leading up to the May 09
8 Board to Board. Can you take us through what the lines of enquiry were that
9 emerged? We'll have an incomplete record from the papers we've been
10 [picked up?], but there are clearly a whole number of meetings that you were
11 involved with in pulling that up. So it would be really helpful to have an
12 understanding of what your lines of enquiry were, and what you discovered
13 which led into, sort of, focus on a series of questions at the Board to Board.
14 MS CARTER: So, sorry, across the whole assessment?
15 PROF MONTGOMERY: Well, we're actually interested in the quality bit, but we're
16 also interested in the balance, because one of the things that has been said to
17 us is that the whole thing is driven by finance not by quality. So it would be
18 helpful to understand what your perception of the issues was on that, and that
19 hasn't been about Monitor particularly, but it's part of the general picture.
20 MS CARTER: Yes, yes, okay. Which way to describe – big topic, so –
21 PROF MONTGOMERY: Well, start with the – you clearly got into – you identified the
22 five SUIs, so take us through the bit around that to start with, and then we can
23 see whether we need to broaden it.
24 MS CARTER: So I've been looking back over the files to do this, so I think in – so I
25 think we kicked off the assessment in February 2009. We're collecting all the

1 data, in about April 2009 pulling together the data. The manager at the time,
2 we had listed out – and the trust was very open with us, had given us the
3 serious untoward incidents. And of those 12 we – because of – I hope I'm not
4 beating a drum about this, but we were very focused on it given what had
5 happened in Mid Staffordshire. We were trying to identify whether there were
6 trends, not the individual SUI itself but were there trends. And I remember
7 Victoria and I going into a meeting with our boss at the time and saying, 'Well,
8 there are five here that relate to maternity', and my boss saying to me, 'Well, is
9 that normal, Miranda? What do you think about that?' And we said, 'Well, we
10 don't actually know'. You could look at the five and you could make a case
11 that they might not easily be connected, it could just be unfortunate, but we
12 didn't know, so we were told to go and speak more to the SHA and the CQC
13 as well.
14 So we spoke to the SHA and my understanding is that they were aware
15 of the five SUIs, but I don't think the CQC were at the time. So when we
16 spoke to the manager at the CQC, we said, 'Look, we've identified this, is it a
17 concern?' And I think at the time they said, 'We hadn't picked up that they had
18 that trend'. And that's when we asked them to go away and give some
19 thought about that, because I think we were very clear about the Care Quality
20 Commission having more experience in that area. They had an investigation
21 function that could trigger investigations, so they would have some thresholds
22 that they would use to determine whether or not an investigation was required.
23 PROF MONTGOMERY: This is really, really helpful. Do you remember who you
24 spoke to and when you spoke to them, so that we can try and pin down our
25 timeline?

1 MS CARTER: So I think we spoke to – it might have been Dawn Hodgkins. I have
2 got a timeline. I'm sure it was submitted as part of the application, so I can – if
3 you want me to look at it I can tell you.
4 PROF MONTGOMERY: I think it would be helpful to pin down, because we need to
5 compare what we get in the documents with what other people remember.
6 And you've raised a question which obviously we're asking all the way
7 through, which is how do people judge whether these things are connected,
8 part of a trend or not.
9 MS CARTER: So I don't know if I've got anybody's names here, so on the... I think
10 the – I'm fairly sure the CQC assessor at the time was a lady called Dawn
11 Hodgkins.
12 MS WOODHATCH: I think that's right.
13 PROF MONTGOMERY: Okay. Thank you.
14 MS CARTER: On 15 May we spoke with the CQC first to raise concerns on the
15 SUIs. We had another call on 18 May. And I think on 20 May is the call that I
16 went on with Victoria and the manager from Monitor. And at that point I think
17 they – sorry, it says here, 'Another SUI series submitted to the SHA by the
18 trust. They confirmed the confirmation that the fourth serious untoward
19 incidents had been received, and they'd also received a complaint from
20 Mr Titcombe, which raised concerns around maternity services.
21 PROF MONTGOMERY: So by that stage they're aware of at least four of them on –
22 that's –
23 MS CARTER: So these SUIs happened, I think, if I remember –
24 MS WOODHATCH: They happened at the end of two thousand –
25 MS CARTER: Yes, some of them. So certainly Mr Titcombe's son was at the end of

1 2008.

2 PROF MONTGOMERY: And the SHA, do you remember who you spoke to at the
3 SHA?

4 MS CARTER: I don't remember at that particular time. I know on the 22nd – is it 22
5 May? I spoke to Angela Brown.

6 MS WOODHATCH: Angela Brown, yeah.

7 PROF MONTGOMERY: And this all around the question are there five unconnected
8 incidents –

9 MS WOODHATCH: 22 May was Angela Brown

10 MS CARTER: What is the significance of the five was the question.

11 PROF MONTGOMERY: Yes. So what was Angela Brown's view, do you
12 remember?

13 MS CARTER: Angela Brown. Oh, sorry, I have to correct myself. It says, 'They
14 were not aware of all five SUIs because some of them might be reported
15 directly through to ~~[inaudible]~~ the PCTs. The SHA have considered the
16 timeliness of internal reporting'. PCTs are responsible for managing SUIs now
17 is what they were talking about. 'Average confidence about the reporting of
18 concerns, and they went – then talked to us about their processes that were
19 looking at the SUIs. The SHA did not view the maternity services at UHMB as
20 unsafe, but recognised there's room for improvement. New management
21 have worked to move consultants on from accepted practice, a change in
22 nursing director has really driven this forward. The SHA takes reassurance
23 from the fact they performance managed – the PCTs internally performance
24 managed the trust'.

25 [The file note dated 22 May 09 states that Angela Brown was not aware of all 5 SUIs

1 but this could be that the SHA team assess on a case by case basis to

2 determine whether they are recorded on Steis system or to CEMACH (who

3 collect information on peri-natal deaths)]

4 PROF MONTGOMERY: So that's principally around the process of where

5 responsibility fits. There's an assessment of safety. Is there anything that –

6 either in the notes or that you recall about this question of was there a trend?

7 It's obviously a key question for us to understand. Are there five unconnected

8 incidents that happened to be in maternity, or is there some form of pattern?

9 And you'd obviously asked that question on – so we're trying to get to the

10 bottom of what other people thought at that stage, whether they were also

11 asking that question.

12 MS CARTER: So it's difficult for me – so the CQC decided not to investigate when

13 we sent the information to them. The SHA were looking at the action plans to

14 come out from SUIs. This is something that I'm not sure if I'm recalling

15 correctly, but I'm not aware that the data from ~~GMACH~~ CEMACH highlighted

16 this organisation as a concern. So I feel I can't – as to what conclusions to

17 draw, but I think you could draw a conclusion that people didn't feel that there

18 was sufficient evidence at that time to say that the trust wasn't doing what it

19 should be doing, learning the lessons.(see clarification note below)

20 [an email from Miranda Carter to Bill Moyes 26 June 2009 stated that the

21 investigations team have not identified Morecambe Bay as an outlier in terms

22 of maternity morality, no have they any indication from CEMACH (who collect

23 information from every hospital on all perinatal deaths using a specific

24 notification form), that the trust is an outlier.

25 PROF MONTGOMERY: I guess what you've described, and you're describing what

1 people told you, so we fully understand that, and we have to do the same, we
2 have to try and piece together from what – putting aside the benefit of what we
3 know people have said now, what was apparent to people at the time. I think
4 what you're describing is there was a focus on the following through of SUIs
5 and the action plans. There was a focus on, 'Are we performance managing
6 the system appropriately?' being described to you. We're trying to get to the
7 bottom of how they asked themselves the question that you clearly started
8 with, which is, 'Should we be treating this as a pattern or should we be treating
9 them as separate processes?' And I think what you've described, but I want
10 to check whether this is your perception or not, I think you said your
11 perception was that they were focussing on making sure each of the SUIs had
12 been appropriately responded to. You haven't described a discussion about
13 whether there were any common features to them.

14 MS WOODHATCH: Discussions with the trust? We're talking about discussion with
15 CQC.

16 PROF MONTGOMERY: Well, any discussions, because you clearly had one
17 amongst yourselves, because you've described that. You were asking that
18 question and you reasonably said, 'How do we get to the bottom of that?' We
19 ask what the CQC think, what the SHA... We were trying to understand
20 whether your perception was that the SHA was asking itself that question or
21 had asked itself that –

22 MS CARTER: I think at the time I think we were still unclear whether there was
23 greater concerns as a result or not, which is why we delayed the application.
24 So even though the CQC said to us they were not investigating, they did – it
25 didn't yet meet the criteria for investigation, they needed to understand

1 whether the Ombudsman was going to take the case for investigation, I think
2 the whole reason why we delayed that application because it just wasn't clear.
3 We weren't sure we had a definitive view on whether or not this was a more
4 serious problem.
5 PROF MONTGOMERY: Okay. So that makes a bit of sense. And what you're your
6 understanding of the discussions between the CQC and the Ombudsman?
7 You said the CQC was uncertain about whether the Ombudsman was going to
8 take the –
9 MS CARTER: So I wasn't involved at all with any of the – this isn't an area that I
10 handled directly – of any of the discussion in between the CQC and the
11 Ombudsman. I did speak to the Ombudsman, Harriett Clover, at the time,
12 because I wanted to understand the process, because I remember the team
13 raised with me that the Ombudsman was involved. And they said – they told
14 me that – I just needed to understand what their process was. I wasn't trying
15 to challenge it, I just wanted to understand what was going on, and they said
16 to me they were still collecting evidence to determine whether or not it made
17 the criteria to be investigated. And I think they were looking to take some
18 clinical advice as to whether or not that needed to be investigated further. And
19 I think because of what happened on Mid Staffordshire we were very aware
20 that if there was a risk that an organisation might be thinking it needed to
21 investigate a trust around the quality of care, we couldn't authorise a trust until
22 we knew what the outcome of that was. So we spent quite a bit of time trying
23 to work out timelines, and I know Victoria did a flow chart for me about what
24 might happen, when we might get conclusions. So what happened then was
25 that the application was delayed and we said, 'We can't reactivate it until we're

1 clear that the CQC has got a clear position on this trust'. And I don't know if
2 I'm going on to other questions, but then there was a –
3 PROF MONTGOMERY: Keep the flow. We may need to go back for some of the
4 things, but – yeah.
5 MS CARTER: So then we did follow up the CQC, because they said, 'Look, this is
6 going to go back to be managed at the regional level'. And the way the CQC
7 worked at the time they'd have regional risk panels, and they'd have
8 conversations. So we went on a number of calls between May and I think
9 August, September time, to try and understand what was the CQC's position,
10 because, ~~being very selfishly~~ on my side, I just wanted to know what their view
11 was. And it wasn't very clear between concerns or not concerns, and I
12 needed to do – be fair on the trust, but I also needed to be fair on what the
13 CQC was doing.
14 So we sort of got back from the SHA – sorry, from the CQC, that 'The
15 trust is putting action plans, but we still have concerns, and we need to
16 understand the outcome of' – there was some work around the core
17 standards, I think, that was going to happen. But I remember Alan Jefferson
18 at the time saying to me, you know, 'This is red rated for us at the moment'.
19 They did comment that, you know, there were action plans in place and also
20 commented that the Charles Flynn review, which was done, you know – I think
21 people from Liverpool Women's had gone in and said, you know, 'The
22 maternity service at Barrow is fit for purpose but we're not sure the lessons
23 have been learned', so it remained as concerns.
24 So then I stood back, because I thought, 'Well, this isn't something
25 that's going to resolve in two or three months, this is...', and I spoke to

1 Amanda Sherlock, who was the deputy director of operations at the CQC, and
2 she said, 'Miranda, realistically this is not going to resolve, you know, we're
3 now going through the whole process of registration and we'll need to wait
4 until the outcome of registration to determine what our – that this has been
5 resolved in our view'.
6 PROF MONTGOMERY: What was your expectation about registration, because you
7 can have registration without conditions, registration with conditions, it could
8 be deferred, or... What did you think their thinking was at the time?
9 MS CARTER: I think it's very unfair to ask me that, because I think I'm not the
10 judgment of how to apply their regulations.
11 PROF MONTGOMERY: I'm not asking about what they should do; I'm asking what
12 your perception was of their thinking.
13 MS CARTER: Well, at the time in August, with the concerns, I'd say, well, that
14 seems that that must give some indication that they might have some
15 concerns here for registration.* see clarification below
16 [* (provided to investigation) The file note of the conversation with Alan Jefferson
17 dated 31 July 2009 say- on registration, it is also likely that there will be some
18 'requirements' attached. These will be less formal than 'conditions'. Being
19 registered with 'requirements' is not going to be uncommon for trusts, however
20 there will be different levels of seriousness of these requirements.]
21 PROF MONTGOMERY: But did they give you any indication of what their thinking
22 might be? I mean, we know, for example, that Alan Jefferson has written at
23 various stages indicating expectations that this would probably end up in the
24 use of some of those powers, so what were the expectations that they put on
25 to you?

1 MS CARTER: I don't – I hadn't –

2 PROF MONTGOMERY: So I'm not asking your judgment of what they should do,

3 simply asking what they seemed to be saying.

4 MS CARTER: Okay. So I don't think I had a clear position from them. I don't think

5 they were – gave me a view one way or the other.

6 PROF MONTGOMERY: Okay. And what – there's a particular issue we're trying to

7 understand, which is what does the CQC mean by red risk rating, and I

8 wondered what your perception –

9 MS CARTER: I think we wanted to know what that actually meant.

10 MS WOODHATCH: We didn't know the answer to that ourselves.

11 PROF MONTGOMERY: Did you try and get to the bottom of it?

12 MS CARTER: Yes, and I think that might be why [inaudible] keep contacting us to...

13 So, again, one of the learnings from Mid Staffordshire is trying to understand

14 what the view was of the regulator that was looking into quality. And on their

15 organisational risk profile documents they had a tab within that which had – I

16 think it had two scores if I remember correctly. One is about confidence in

17 management and the other one was about level of concerns, and there was a

18 colour scheme within there, the way they rated those, so red, amber, green.

19 And at the time our, sort of, criteria was you couldn't authorise if – they need

20 to be less than – they need to be minor concerns and ~~high~~_*-confidence. And

21 so therefore seeing – Alan Jefferson telling me in a letter that it was red rated,

22 I then needed to try and understand, well, where does that – where can I see

23 that in the organisational risk profile. I'm not sure if it was updated actually, so

24 we were just trying to understand what that meant.

25 And I think in fairness to them as an organisation, they were an

1 organisation that has been set up and, you know, this was information they
2 would say, 'This is for internally how we utilise it'. So I'm not even sure how
3 they had – how clear the criteria were, which is why I pushed back to
4 understand – 'I need to understand, when you said a concern' – so the letter
5 from Cynthia Bower to Bill Moyes, it talked about having concerns, so the
6 reason I went back is I needed to understand. Because I knew they had
7 gradations: they had minor concerns, moderate concerns, major concerns. So
8 I didn't know where it sat within that, so that's what I was trying to understand.
9 [* The risk rating requirements from the CQC at the time was that an applicants rating
10 as per the organisational risk profile was no worse than minor concerns and
11 the regulators confidence in the trust's ability to meet regulatory requirements
12 is at least confident, in addition the CQC must not be undertaking or planning
13 to undertake an investigation.
14 PROF MONTGOMERY: And we're also trying to understand, and one of the
15 questions is the pace at which trusts can change from being red rated to being
16 registered without conditions*. And we've heard different views on what red
17 rating indicated. And at one end of the spectrum, if I can put it like a
18 spectrum, it's that you remain red rated while there are open questions that
19 need to be followed up, so that the red rating wouldn't, in itself, necessarily tell
20 us anything about the quality of the trust. It would only tell us about the
21 absence of information. And at the other end of the spectrum there's a – well,
22 red rating must mean that there are grounds for concerns. So when Monitor
23 was assessing, the CQC ratings, I mean, would you be treating it as there's
24 just more information to be gathered, or would you treat it nearer the end of
25 the spectrum that says, 'This is a flag for us that tells us something's wrong'.

1 [* Note the risk rating moved from red to amber in August 2009 registration occurred in April 2010.]

3 MS CARTER: So I think it's – so absolutely we'd treat it as a flag, that something was wrong, but if – just to set out the – we'd already made a decision to delay at that point, so –

6 PROF MONTGOMERY: Yes. No, I understand that.

7 MS CARTER: It was in a funny status with us, so we weren't really actively trying to follow on, to – you know, we needed to understand, well, when, given the concerns, when do you think that – because I had... You can imagine, the trust were confused by what was going on, and they were asking me about timelines, so I was just trying to work out what a timeline might be. And then it was clear that, look, given the concerns, they're needing some time to see how action plans embed through. This wasn't going to be two or three months, so I then stood back from that.

15 PROF MONTGOMERY: I think I fully understand that, and I think I understand, you know, the Monitor process has been until you're satisfied, you know, it's not proven, irrespective of how good or bad it is, it's not proven, but we're trying to get an understanding of how the system as a whole understood and received messages from what the CQC was doing. So you said the trust was confused. Do you have an – can you help us with what you thought the trust though the red rating meant.

22 MS CARTER: So I don't think the trust knew the CQC's rating.

23 PROF MONTGOMERY: No, that's fine. That was hidden from them.

24 MS CARTER: Because this was an internal rating that we were aware – I think, you know, it wasn't an external judgment, and so the reason why the CQC – the

1 trust was confused is I guess they wanted to understand, well, 'We understand
2 you haven't got the requisite assurance from CQC, but what do we need to do
3 next' –
4 PROF MONTGOMERY: To give it to you, okay.
5 MS CARTER: – 'to deliver on that'. So I would say to them, 'You obviously need to
6 speak with your CQC people as well to understand'.
7 PROF MONTGOMERY: And were you ever able to have three way discussions on
8 that with yourselves, the CQC and the trust, so that you could help people get
9 to the bottom of what was going on?
10 MS CARTER: I don't think we did do.
11 PROF MONTGOMERY: No. Could you have done? Did that happen in other
12 places?
13 MS CARTER: So certainly we do it now, and it's really good. It happens now. I
14 think theoretically I could have pushed to do that, but –
15 PROF MONTGOMERY: But it wasn't common practice and –
16 MS CARTER: Well, this is very – it was very unusual, this – exactly where we were
17 on this one.
18 PROF MONTGOMERY: Unusual because you had to suspend, or –
19 MS CARTER: Yes.
20 PROF MONTGOMERY: Yes.
21 MS WOODHATCH: And because we raised the concerns with them, not the other
22 way round.
23 PROF MONTGOMERY: Yeah. So usually you'd have expected quality issues to be
24 flagged up to you by the CQC with the assessment, but you had to take this to
25 them. That's helpful. Can I go back to the SHA, the conversations with the

1 SHA?

2 MS CARTER: Yes.

3 PROF MONTGOMERY: We know later on in the picture that there seems to be a
4 pretty robust view that these five events were not connected, but we're having
5 some difficulty tracking down at what point that view emerged. So you were
6 speaking with Angela Brown in May 09.

7 MS CARTER: Yes.

8 PROF MONTGOMERY: And what you described on that was discussions which
9 were principally around them getting assurance the system was operating
10 properly, that they were checking on the follow through of action plans. Do
11 you have any sense of that stage whether they'd already formed a view that
12 these events were – didn't have common themes or...

13 MS CARTER: So I don't – so it's very difficult, because this is five years ago and I
14 haven't got it written down on this piece of paper. See note below.

15 [I sought clarification from Amanda Sherlock regarding the change in risk rating as
16 per her email dated 24 August 2009 "At the most recent NW risk panel,
17 concluded, mainly of the uncertainties have now been resolved: the series of
18 Seriously Untoward Incident reports have turned out to have no common
19 thread; the SBA inspection has revealed only minor concerns; The recent risk
20 panel decision to reduce the risk from 'red : to amber' was appropriate in the
21 circumstances."]

22 PROF MONTGOMERY: I understand.

23 MS CARTER: I guess the only sound bite I can remember is – and I think this – I
24 don't know. It was about the central data held on ~~CMACH~~ CEMACH did not
25 flag this trust as an outlier, and that – I think that people might have been

1 taking some evidence from that.

2 PROF MONTGOMERY: Yeah. And was that also consistent with your – I mean,

3 we've heard from a number of places that Morecambe Bay was not really

4 particularly different from other – you know, on the SHA's radar. There were

5 no particular features of it that were odd, and yet you've identified something

6 which is odd because you suspended the process, so you've picked up

7 something that doesn't seem to be apparent to other parts of the system, so

8 we're trying to understand that. So –

9 MS CARTER: Well, I don't know if we –

10 MS WOODHATCH: I don't –

11 [Cross-talk]

12 MS CARTER: We didn't know the answer, so I would feel slightly – what's the right

13 word? So I wouldn't want us to be sat here saying, 'We were perfect in our

14 knowledge and we spotted something someone else didn't'. I think we just

15 felt, 'We don't understand this. Is it an issue or not?' And I think we would

16 have – I think the position at the time, we were looking to take advice from the

17 SHA, who have a broader perspective, and the CQC about whether – what

18 they thought on that. And the sound bite from me is what Stephen Hay said to

19 me. He said, 'I just – do you know?' And we said, 'We don't know'. I mean –

20 PROF MONTGOMERY: So what went into the – so take us through the thinking

21 about the board to board, because you've raised this as a particular question

22 for the board to board so that you could put it to the trust about what the

23 question is. So what was the thinking about raising that in the meeting? What

24 was the purpose of raising it? How did it help your process, because you had

25 Bill Moyes ask specifically about it, and I assume that that would be you

1 flagging that up.

2 MS WOODHATCH: ~~Just a~~ A typical part of the process ~~is~~ at the time was for the

3 team to have areas to probe ~~that we called it, which could be –~~ which would

4 cover, ~~you know –~~ Board awareness

5 MS CARTER: So to be very clear, so we wouldn't have been asking that question to

6 test from a clinical point of view what the right answer was. The focus of our

7 thinking would have been, 'Are you as a board, are you aware of these SUIs,

8 and how are you treating it? Have you thought about whether or not it's a

9 trend? What are you doing about them and, you know, have you got an action

10 plan to deal with them?' And the one thing I would say is that we've

11 experienced other organisations who may not be outward looking or may not

12 require external reviews to come in and have a look at things. But from our

13 understanding of how the trust was investigating, particularly, well,

14 Mr Titcombe's – well, the sad situation of Joshua, was we got evidence to say

15 that, you know, they'd invited the medical director from Wrightington, Wigan

16 and Leigh and another lady with maternity experience to come in and look at

17 what had happened. Then they'd also requested Charles Flynn to do a piece

18 of work and were inviting Liverpool Women's in to come and have a look at

19 the issues.

20 So from a governance point of view, and an organisation, is it just

21 keeping itself internally and not trying to learn from it? I think some of the

22 rationale for the questioning at the board to board would be 'How seriously are

23 you taking this, and what steps are you taking to get assurance that it is not an

24 underlying issue you need to deal with.?' So I think that would be where the

25 noise would be coming from.

1 PROF MONTGOMERY: That's really helpful. So in a sense that's entirely
2 independent of the actual quality question?
3 MS CARTER: Yes.
4 PROF MONTGOMERY: The actual quality question you'd be looking for assurance
5 from the CQC and the SHA.
6 MS CARTER: Yes, and that's – I know it's sometimes –
7 PROF MONTGOMERY: No, I understand.
8 MS CARTER: Sometimes people say confused about [inaudible], so that's how we
9 think about it very clearly. It's about, from a governance and leadership point
10 of view, 'How are you thinking about this as an issue?'
11 PROF MONTGOMERY: And do you recall what the view was on the board's grip on
12 that [inaudible] as a result? I mean, the record is very succinct, shall we say,
13 about the answer from the Chairman, but you were there, so –
14 MS CARTER: So I think they came across in a credible way, that they'd taken it
15 seriously and they were trying to, through inviting external people, learn from
16 it. But, I mean, I can't remember exactly how I felt at the board to board
17 meeting.
18 PROF MONTGOMERY: Okay, that's helpful. So the product of that is that you still
19 don't have enough confidence when you take all the evidence together, so you
20 suspend the –
21 MS CARTER: Well, the product of it was, I think, obviously given a clear direction we
22 need to have a view whether or not this trend is concerning, whether the CQC
23 might need to investigate. So that's why, you know, the things happened post
24 board to board.
25 PROF MONTGOMERY: So at the point then when you suspend consideration of the

1 application, are you specifically saying to the CQC, SHA, PHSO, that, 'We will
2 not restart until you give us this assurance'?
3 MS CARTER: Yes. So there's a letter which went across which said that.
4 PROF MONTGOMERY: And is it your impression that they accepted that response?
5 We're trying to understand how the systems meshed together, because it then
6 seems to go a bit woolly about who's being proactive about it. I think you've
7 described a very clear position, which is, 'We don't have the answer, we can't
8 get the answer ourselves, but there are people who can, and therefore we
9 need to wait until that answer comes back'.
10 MS CARTER: Yeah. Sorry, your question is whether or not –
11 PROF MONTGOMERY: I'm trying to understand how, if you like, to use your phrase
12 about the board, how seriously does – do the other parts of system take the
13 need to resolve that question, because you've done that at a time when the
14 CQC's got a red rating, the PHSO is considering what to do about it, and is
15 this a – did it go quiet or did you get the feeling that they're actively trying to
16 find the answer for you?
17 MS CARTER: I think that I got a steer from the CQC – well, the letter says that they
18 were not going to investigate, and they were going to wait until they
19 understood the outcome from the PHSO, whether or not that was going to be
20 investigated. And unless – they were going to – you know, the SHA were
21 going to do its action plans and they were going to monitor the action plans.
22 So my sense was they were – they wanted to check that the action plans were
23 embedding before they took an updated view. So they weren't planning to go
24 back in and retest anything straight away, so they needed to understand what
25 happened with the Ombudsman. SHA, you know, continued to manage on

1 the action plans and then, as I said, I think the conversation with
2 Amanda Sherlock suggested that, you know, they would then need to consider
3 this all as part of registration, which would have been six months later.
4 PROF MONTGOMERY: So reflecting back on what sounds as though it may have
5 been said is that there were two slightly separate decisions. There was the
6 decision about whether to make an investigation, and the powers of the CQC
7 were changing at that point, so there's some discussion about who is best
8 placed to do that. I think what you've described is that Amanda Sherlock is
9 indicating that the focus is going to go into the registration process and
10 gathering data for that, because they're not going to investigate at least until
11 they know the PHSO's –
12 MS CARTER: So they wouldn't – it didn't meet the criteria unless the – and they
13 then needed to see about the PHSO. They needed to confirm. No further
14 data came through, so [it?] did obviously say if something else came through
15 that it could re-look at it, but I think – sorry, I think – no, I think I'm trying to get
16 across that the CQC needed to understand how the action plans were
17 embedding before it could take an updated view.
18 PROF MONTGOMERY: And, I mean, the SHA has a role in getting people, aspirant
19 FTs through the processes, and supporting them doing that. Were you having
20 discussions with the SHA on what they might need to do in order to help
21 Morecambe Bay restart? Or does it sort of go quiet [inaudible]?
22 MS CARTER: No, it went quiet.
23 PROF MONTGOMERY: Okay.
24 MS CARTER: I think we stood back at that point, saying, 'Look, it needs to work its
25 way through with the CQC and the SHA. We need to wait until they feel it's

1 ready'.

2 PROF MONTGOMERY: And were there other trusts in a similar position or was

3 Morecambe Bay the – suspended applications, yes.

4 MS CARTER: On – okay. On quality issues – so, I remember Medway. At the time

5 we didn't authorise them because we were concerned about mortality and,

6 you know, that was an example where we weren't sure that the trust was

7 externally getting people in to look at what they should be doing. So I think it

8 wasn't the only trust that I'd been involved in that had some quality issues.

9 PROF MONTGOMERY: Did Medway just fail and have to restart?

10 MS CARTER: So that actually went to a decision and the board said no. The reason

11 this one's slightly different is because it was – didn't go to the board meeting.

12 It was prepared as if it was going to go to the board meeting, but when we got

13 the letter back which said, 'This is the situation', we said, 'We can't put it in

14 front of the board because we don't have the CQC assurance'. So knowing

15 that they would –

16 PROF MONTGOMERY: So that's the difference between failed application and a

17 suspended – is that the right language? You suspended the application?

18 MS CARTER: Yes. So a formal – so a deferral would be a board decision. A

19 suspended one is when it hasn't gone to the board because we have evidence

20 to say we know it doesn't meet the test.

21 PROF MONTGOMERY: Okay.

22 MS CARTER: And it didn't meet the test because it didn't have the CQC assurance,

23 and we required a letter from them.

24 PROF MONTGOMERY: Okay. So you started answering the next question then,

25 which is about how it restarts.

1 MS CARTER: Yes.

2 PROF MONTGOMERY: So just take us through what needs – what does the trust
3 need to do to restart it or do you – or does the trust do nothing and you wait
4 until you've got information?

5 MS CARTER: So this one I would say was slightly different because it was a
6 suspended rather than a formal deferral, but we made it clear with the trust
7 that we needed to get the assurance it met the CQC bar before we could
8 reactivate. When we were informed by the CQC – because at the time a
9 whole lot of trusts were going through registration, so we were having
10 conversations with them about who was going to be registered with and
11 without conditions and actually Victoria and I had another one that was
12 registered with conditions.

13 MS WOODHATCH: With conditions, yeah.

14 MS CARTER: So they couldn't restart.

15 PROF MONTGOMERY: And was Morecambe Bay one that was flagged up as likely
16 to end up with conditions, or –

17 MS CARTER: We didn't –

18 MS WOODHATCH: There was no preview of –

19 MS CARTER: No.

20 PROF MONTGOMERY: Thank you.

21 MS CARTER: So it had received that. I then, I think, had conversations with the
22 CQC lead at the time, who was Sue McMillan, to try and understand what the
23 current view was on their organisational risk profile, to just make sure that
24 whilst there were registered without conditions was that gradation okay. See
25 note below.

1 [In Sue MacMillan's letter to me ~~dates~~dated 16 April 2010 stated that 'the registration
2 assessment of the Trust did initially identify concerns but further information
3 was sought and we were satisfied that the Trust was taking appropriate
4 actions to address those concerns and that the evidence indicated overall
5 indicated compliance. One remaining minor concern in relation to Outcome 13
6 (staffing) will be addressed through issuing of an improvement letter.']
7
8 PROF MONTGOMERY: So that's after the registration decision CQC's taking, yeah?
9 MS CARTER: Yes, I think it was mid-April time.
10 PROF MONTGOMERY: Okay.
11 MS CARTER: And I remember going back and forth a few times, saying, 'Look, just
12 to be very clear, we've set out this bar so they can't – we can't authorise them
13 if – they've got to be no worse than minor concerns'. So I needed to check
14 and then got the confirmation back and that enabled us to start the –
15 PROF MONTGOMERY: And did you get a sense of how the CQC had shifted from
16 the stage where they had a red rating, they seemed to be thinking that it was
17 quite possible that – they seemed to be indicating to various people that they
18 would be contemplating conditions, and then when it comes to it they don't
19 feel they need to put conditions on. So what was the account of that shift
20 given to you?
21 MS CARTER: Yeah, I didn't challenge them on that.
22 PROF MONTGOMERY: Okay. So you were just told by Sue McMillan, after the
23 registration without conditions, about their current level of concerns.
24 MS CARTER: So I had the registered without condition, then I also probed into what
25 their organisational risk profile said and what conclusions that had. But to be

1 fair as well on everybody, I think the view was – did oscillate quite a lot during
2 that time between July and August. It wasn't really – to me it wasn't clear
3 whether the –
4 PROF MONTGOMERY: Is your sense that it oscillated in the sense that individuals
5 were unsure or that there was a difference of views amongst the team?
6 MS CARTER: Well, it was the fact that centrally it said concerns and then later – I
7 had a red rating and –
8 MS WOODHATCH: But we didn't know the significance of –
9 MS CARTER: And then I think it went down to amber rating.
10 MS WOODHATCH: That's right.
11 MS CARTER: It went down to amber rating. So I think when they'd completed their
12 review of the core standards I think it went back down to amber rating, I think.
13 I need to – I might need to check that point for you. See earlier Clarification, in
14 August 09 the trust moved down to amber rating follow N.W. risk panel
15 meeting on 10 August 2009.
16 PROF MONTGOMERY: So I was asking you about what the process was to restart.
17 So you've spoken to the CQC and you've satisfied yourselves that they are
18 now – I don't know what the right phrase is – below or above the threshold,
19 yes?
20 MS CARTER: I've got an email [Clarification I also received a letter dated 16 April
21 2010 from Sue MacMillan] communication for that, and then I spoke with the
22 trust, and I sent the trust the letter to tell them that they need to reactivate and
23 the information they needed to provide to us.
24 PROF MONTGOMERY: So if I was sitting in the trust I haven't actually had to do
25 anything in that process in relation to the Monitor application, that it's

1 suspended. I'm working with the CQC, I'm sorting out –

2 MS CARTER: Well, and with the SHA on the action plan.

3 PROF MONTGOMERY: And you haven't asked for anything different from the trust

4 direct to open up the application again. You're just keeping in touch with –

5 MS CARTER: They need to refresh their business plan and things like that, all their

6 submissions.

7 PROF MONTGOMERY: So that's a little bit like the letter – after the letter of the

8 Secretary of State. So you write to them saying, 'This is the point at which you

9 should' –

10 MS CARTER: Yes, so they'd satisfied the condition that caused the application to be

11 delayed, so then we –

12 PROF MONTGOMERY: Okay. Thank you. Can I ask you about where the

13 commissioners, PCTs, fit into your – into the process more generally and in

14 particular what, if anything, they raised with you as part of the Morecambe Bay

15 application?

16 MS CARTER: So they are a key stakeholder that we speak to as part of the

17 application process, and we talk to them both on financial sides and also what

18 they think about the trust and on quality, so that's how they fit into the process.

19 So we would have spoken to them at the time of the original application and

20 we spoke to them again on the second application.

21 PROF MONTGOMERY: And do you expect – so one of the questions we're asking

22 is were any questions flagged up to you by the PCT? We've asked the PCTs

23 about this as well. So what's your perception of the concerns, if any, that the

24 PCT had, and if they did have any how did they express them to you? Was it

25 in meetings, did they write to you?

1 MS CARTER: So we had meeting notes from speaking to the commissioners, and I
2 think that they had, sort of –
3 MS WOODHATCH: They had some areas –
4 MS CARTER: Some areas of concern and some areas which they thought that the
5 trust was doing well at. So they were concerned about discharging
6 outpatients.
7 MS WOODHATCH: The demand management assumptions.
8 MS CARTER: Yeah, and the finances.
9 PROF MONTGOMERY: Sorry, I didn't quite catch that.
10 MS WOODHATCH: Demand management assumptions.
11 MS CARTER: So at the time this was about, you know, underlying demographic
12 growth was 4% and that the –
13 PROF MONTGOMERY: And you must have heard that from pretty much every
14 commissioner in the FT application process.
15 MS CARTER: Well, and that demand that – so there was, I would say, from my
16 reading of it, it wasn't – you know, I don't think it was the cosiest of
17 relationships between the commissioners and the trust. There was noise
18 around who was right on whether demand management would work, so that
19 was definitely an influence, and there was some concern around quality. And
20 we asked Tony Halsall at the time about his response to some of the letters
21 from [~~Janet Seochung~~?].Janet Soo Chung
22 PROF MONTGOMERY: [inaudible].
23 MS CARTER: And we also spoke to the CQC to say, 'Look, there are some
24 concerns here as well', and we shared the correspondence with the CQC.
25 PROF MONTGOMERY: And did you think they'd seen it already?

1 MS CARTER: The...?

2 PROF MONTGOMERY: The correspondence that you shared with them. Had they
3 already –

4 MS CARTER: I don't know the answer to that.

5 MS WOODHATCH: I don't think they commented on that at the time. We just were
6 sharing.

7 PROF MONTGOMERY: So if I could just relay back what I think I've heard from that:
8 that you had from those discussions evidence of some tensions between the
9 PCT and the trust. You had some evidence of tensions between some of the
10 personnel that were there, but clinical issues that were raised were not
11 maternity issues, they were around discharges, they were around demand
12 management schemes.

13 MS CARTER: Yes.

14 PROF MONTGOMERY: So would it be right to say that that actually didn't mark out
15 Morecambe Bay as a particular flag for you around maternity care, because
16 those would be consistent –

17 MS CARTER: It didn't flag a concern on maternity care.

18 MS WOODHATCH: No, not maternity *per se*, and we were ~~very~~ – you know,
19 sensitive to that, given the history. And when we raised those issues with the
20 trust the trust were aware of those issues and were able to show us the
21 correspondence they'd already had around those issues, which showed the
22 issue being raised and their response, and then we read those.

23 MS CARTER: And the other thing to say, even though – so we did have – the letter
24 that Alan Jefferson wrote us about it being red rated, within it, it did say
25 maternity services were fit for purpose at Barrow. So it's very – it's quite – it

1 was difficult.

2 PROF MONTGOMERY: Yeah, we're just trying to understand –

3 MS CARTER: Not, no, I don't think we –

4 PROF MONTGOMERY: – how these signals are understood in the system, and

5 you've been really helpful on that. I mean, I guess what I was trying to tease

6 out in relation to the relationship between the PCTs and commissioners would

7 be the difference between did it in the end lead you to say, 'Well, the PCTs,

8 you know, have lots of issues but they're fundamentally happy to sign off their

9 commissioner support for the application'? So there's something about when

10 they have to say yes or no, [because a former?] PCT check, you know, there's

11 a set of concerns you have, and then there's a point at which you have to say,

12 'Does that mean you're not supporting the application or not?' And I think

13 what I've heard you describe is a group of – a set of discussions on which

14 discussions were raised. But I haven't quite been clear whether in the end the

15 PCTs were saying to you, 'We don't think it should progress', or whether they

16 were saying, 'Well, we've got our views and that's for someone else to

17 decide'?

18 MS WOODHATCH: I don't think it – it was more that we said that we would – where

19 there were quality issues we would then pass them on to the CQC, which is,

20 you know, what we did, and we did follow up with the trust and we followed up

21 with the CQC.

22 PROF MONTGOMERY: So you don't – your sense is not that the PCTs were raising

23 quality reasons by which this didn't reach the bar, so much as they were

24 raising issues that the system needed to address, and then you passed on to

25 the appropriate people. And you're still in the stage of saying, 'Does it or not

1 meet our bar?', but you're going to wait for the CQC's assurance on quality.

2 MS CARTER: So I think we took a judgment of where we thought demand
3 management, you know, would sit, and I think that eventually the contracts
4 were signed. So there's a bit when you have to take a judgment and you do
5 triangulation between a number of parties, because quite often you have slight
6 disagreements between what the commissioners want to deliver. And so we
7 delayed when we thought demand management came in, so we would have –
8 you know, and I think that would be explicit in our pack around how we'd made
9 the judgment on that.

10 I think on the quality side I think we've – you know, we felt that we had
11 discussed it with the CQC. It wasn't flagging on maternity. We'd seen the
12 trust's response, so in the absence of hearing anything different we didn't
13 believe that altered the quality bar. And we did send our minutes of our
14 meeting back to the PCT to say, 'Look, we are about to take our decision, you
15 know, if there's anything else you want to raise with us please let us know', but
16 – you know. That's one thing we did, but we didn't hear anything back.

17 PROF MONTGOMERY: That's very helpful. So I think we're now getting to the
18 second board to board.

19 MS CARTER: Yes.

20 PROF MONTGOMERY: And in terms of the key issues for the trust at that stage,
21 has maternity, sort of, receded a little bit in terms of –

22 MS CARTER: Yes, because – so, you know, if you ask us how we felt about it at the
23 time, so we – you know, they'd done the external reviews, the SHA had been
24 looking at, you know, how those were implemented. The CQC had effectively
25 given us what we needed to reactivate the application. They also did a

1 responsive review into Maternity services at Furness General Hospital -on 29
2 June 2010 – which came out positively. So you get to a point where, you
3 know, you have to say – well, we felt that they, from the information we had,
4 that they had dealt with the maternity issues. So we didn't, I think, probe it
5 significantly at that point.
6 PROF MONTGOMERY: I can understand that. So, you know, you've raised early
7 on, you've pushed it to the other people to confirm, you've got apparently a
8 clean bill of health coming back and you move on to other things at that stage.
9 So maternity has faded out of the – by the time you're looking at the actual
10 authorisation, the maternity issues feel as if they've been checked and you've
11 got assurance back on those things.
12 MS CARTER: Yes.
13 PROF MONTGOMERY: And how much noise is there coming to you both at this
14 stage from James Titcombe and the other families? If we're going to talk
15 anything about cases we need to move to a private session, but I don't know
16 that we need to know about individual cases at this stage. Bill?
17 DR KIRKUP: So long as we're not going into any clinical details it's fine.
18 PROF MONTGOMERY: Yes. So I'm trying to understand what sort of –
19 MS CARTER: I don't think Mr Titcombe was writing to me during the second
20 application. He wrote to me at the beginning of the application and then I think
21 when the coroner's report happened.
22 PROF MONTGOMERY: So that wouldn't really have had any impact on the
23 authorisation stage, because it's both earlier and later. Is that –
24 MS CARTER: So I think it had some impact on first one, but it – at the point when
25 we were reactivating I didn't hear.

1 PROF MONTGOMERY: No. And just to check, the impact it would have is it puts
2 questions in your mind that you need to have answers to, yes?
3 MS CARTER: It was, you know, quite – the case of Joshua Titcombe was extremely
4 sad, and it's always very, very difficult when you're dealing with that sort of
5 situation because you – unfortunately you have to stand back and go from a...
6 You know, if the CQC have looked at it, if we think, on governance, they have
7 responded to it and are learning, you have to make a judgment at the end of
8 the day, but, you know, that it's an incredibly sad situation.
9 PROF MONTGOMERY: So correspondence from a family, in this case Mr Titcombe,
10 would have flagged a question and you'd have to satisfy yourself that the
11 question's adequately answered. What about the Ombudsman's decision
12 making? How does Monitor take that into account?
13 MS CARTER: So we were informed by the PHSO that they were not going to take
14 that for investigation, and that it was – so that meant that we didn't need to do
15 anything further.
16 PROF MONTGOMERY: And what's your understanding from that information of the
17 reason for them not investigating?
18 MS CARTER: To be honest, I didn't probe them significantly on what that – how
19 they'd reached that decision. It wasn't clear at the time whether they thought it
20 would or wouldn't, so...
21 PROF MONTGOMERY: And we're trying to get to the bottom of clarity about both
22 why they decided that and how they represented it, but one version of that is
23 that they – even if things had gone badly wrong, they couldn't add any value to
24 it by investigating after the event, because they couldn't find enough out.
25 MS CARTER: Well, they might – I don't know, but might they say, you know, 'If

1 actually what's being done is what we would expect to be done, what's the
2 benefit of further investigation?' I don't know.
3 PROF MONTGOMERY: So what would be your – if Mr Titcombe raises, 'I'm
4 unhappy with the way this has happened', it raises a question for you to say, 'I
5 just need to satisfy myself it's still appropriate for Monitor to go forwards'.
6 Would the PHSO saying, 'We're not going to investigate', is that the end of it
7 for you or does it raise any questions about trust governance? Because if
8 what they've said is, 'The trust is doing the things that we recommend them to
9 do', you still have a question: are they doing them effectively, is the
10 governance loop being closed? Because if, you know –
11 MS CARTER: Yes, but – so I don't know if we're in the hypothetical at the moment,
12 so one of the things that we brought in following Mid Staffordshire was the
13 review of quality governance that within that there is a question about how
14 does an applicant respond to risks identified, put in robust action plans and
15 close the loop. But I think that we're clear that we don't do investigations of
16 individual cases.
17 PROF MONTGOMERY: No, I understand. I'm just wondering whether – so let me
18 put a question back, sort of in my mind as a possible area you might need to
19 be thinking about recommendations. Now, if the Care Quality Commission
20 say, 'We're not going to investigate this, because under the current legislation
21 we don't investigate this type of case', so it doesn't tell you anything about the
22 case itself, it says it's not their jurisdiction, and if the PHSO says, 'We're not
23 going to investigate, not because we don't think anything went wrong but
24 because we don't think we're going to add any value to it', then it's quite
25 possible there's still a governance problem in the trust that you don't yet know

1 about, because it hasn't been investigated by the CQC for jurisdictional
2 reasons, and it hasn't been investigated by the PHSO for jurisdictional
3 reasons. And I'm wondering whether there are certain senses in which that
4 might say, 'So we need assurance somewhere else'.
5 MS CARTER: I don't think the CQC didn't look at it for jurisdictional issues. I think
6 they said it didn't trigger their criteria for investigation. So having looked at the
7 type of SUIs they were and what was going on, they did – it didn't trigger a
8 review. So I'm not sure they were saying it wasn't their jurisdiction. So my
9 view on it is that actually with the CQC's new inspection regime, which goes
10 into service lines more deeply and covers alongside a more embedded
11 approach to governance, that, you know, the broad governance concerns or
12 issues would have been looked at.
13 PROF MONTGOMERY: Thank you. I think then I'd like to ask about the KPMG
14 report, you know. So we now move to the benefit of hindsight, if you like. So
15 you've taken us through. I'm very grateful to you avoiding the benefit of
16 hindsight as you take us through that, but if we then step to looking back and
17 asking, as we need to ask: what could we learn from this that might have
18 helped us pick things up? So what were the reflections you shared? We've
19 obviously seen the outcome of the KPMG report, but your views that were no
20 doubt represented to them about what should we learn from this?
21 MS CARTER: So one of my main reflections is about our relationship with the CQC
22 and understanding – both of us understanding the work that we do. Because I
23 think it's – in our management response we need to be much clearer about
24 what assurance we have on issues, and whether or not it might need a joint
25 review or jointly commissioned review I think would be really important. I think

1 it was – I feel personally very sad about Morecambe Bay because it's
2 happened at a time when, you know, the CQC was setting up, we were still
3 trying to learn all the lessons from ~~Morecambe Bay~~ Mid Staffordshire and
4 embed quality governance.
5 And, you know, I think that it's – you know, our relationship with the
6 CQC now is a lot better. We are more established in the way we look at the
7 governance of quality, so what my reflections as well would be was around
8 some of how we got to they just met the criteria on quality governance was we
9 took as some of our evidence that they had satisfactorily dealt with the
10 maternity issues. So you would say, 'Well, this is a management who had a
11 difficult situation, they' –
12 MS WOODHATCH: Appeared to have resolved it to the satisfaction of, you know,
13 CQC and other stakeholders, so that put them in a positive light in terms of
14 forward delivery and forward problem solving.
15 MS CARTER: Yeah, because one of the things we say is that it's not – you know, we
16 recognise if there's any trust that thinks it doesn't have an issue then I've got a
17 very, very big concern. You know, trusts will have issues and what we need to
18 understand is they deal with them and respond to them in the right way. And
19 so we took some evidence that they had done that, so that's one of the
20 reflections that I gave back to KPMG.
21 PROF MONTGOMERY: So in a sense having a problem and dealing with it is a plus
22 in terms of your ability to assess, because you can see how an organisation
23 reacts to the stress of something having gone wrong, whereas if you had an
24 organisation with fewer quality concerns you wouldn't know one way or the
25 other how they were doing.

1 MS CARTER: Yeah, but not that on it its own, so I wouldn't want you to take away
2 that it's actually much better to have a really serious issue and solve it than it
3 is to have a bunch of smaller issues.* See Note below I wouldn't want to take
4 – but, you know, there were other things this trust was doing, so if we looked
5 about the information they were putting in around Guru, which was a tool
6 which was real time performance data, ward to board, certain indicators they
7 were putting in place, and nursing and midwifery quality assurance tools. So
8 actually there was evidence they were doing some more stuff about trying to
9 seek out more information to help them improve as an organisation. So it was
10 a fine balance, but we said, 'Well, look, they've solved that and they are
11 moving forward. They're doing work in this area'.
12 [* just to clarify it wouldn't be possible tito be authorised if the issues identified meant
13 that it didn't meet the minimum requirements for quality. Now this is at least a
14 good rating from CQC and no planned or ongoing investigations.
15 PROF MONTGOMERY: The evidence in hindsight from about 2012 shows us that it
16 didn't go ward to board, that it didn't connect.
17 MS CARTER: Because we were very early in the process you see, so I think –
18 PROF MONTGOMERY: Yeah, no, I understand. So the question is do you think
19 there was any way – is there anything that could have flagged that up early,
20 because there may not have been, it may have been that it's only –
21 MS CARTER: Well, we were taking a view, weren't we, at a time when they were
22 just implementing, so the other bit – and if I think now about how we look at
23 quality governance, and we get challenged, 'Are you being too risk averse?'
24 Monitor is saying, 'We need to see some embeddedness of your new
25 process'. So I think that is something we've learned from that point of view.

1 PROF MONTGOMERY: Do you think or do you have a view on whether Morecambe
2 Bay would get through the current procedures, if in 2010 when you were doing
3 it you were applying current safeguards? So I guess the question –
4 MS CARTER: Sorry, if I did – if I was applying my process as it is now to them then,
5 not them now.
6 PROF MONTGOMERY: Yeah. I might ask you that separately, but –
7 MS CARTER: I think – well, I don't. You wouldn't expect – I think the process would
8 pick up concerns. And I think, both from the CQC position – I don't think
9 would be them doing their inspection. And I think in terms of our accumulated
10 knowledge, being able to calibrate across a number of quality governance
11 assessments would enable us to make that judgment which side of the line
12 they were on, and they were just on the line –
13 MS WOODHATCH: It was very marginal, yeah.
14 MS CARTER: – which is what, I think, this paper said.
15 PROF MONTGOMERY: So this is a related question but it's a different question. I'm
16 trying to get my head round whether – what that describes as your processes
17 pick up more things but the bar stays at the same point, so what you're saying
18 is, 'We'd be clearer that they missed the bar', or whether the bar has changed,
19 because some people have argued the bar has changed.
20 MS CARTER: I think it might be a bit of both to be quite honest with you. So I think
21 our process is much clearer, but I think if you ask anybody whether or not our
22 bar on quality has changed, I think with Francis, with the requirements now, I
23 think probably unashamedly the quality bar has risen.
24 PROF MONTGOMERY: Okay. I think the last bit for me, and it goes back to the
25 point when the authorisation goes through. You've described for us how your

1 processes have changed in response to Mid Staffs. Presumably everybody
2 else is also reflecting on how their processes should change at that stage, so
3 the SHA, while they're still in existence, NHS England as it's emerging.
4 MS CARTER: So the TDA now takes on the role of the SHA.
5 PROF MONTGOMERY: Yes. So we want a bit of a sense of what sort of
6 discussions are being had, because you described what you're doing to adapt
7 to that, and we know quite a lot about that from the KPMG report. We're
8 beginning to, sort of, piece together thinking elsewhere about what should
9 they be doing, so whether it's the process that goes into the Secretary of
10 State, whether it's the SHA into TDA, can you –
11 MS CARTER: Tell us a little bit how I think they're changing?
12 PROF MONTGOMERY: Well, how they were discussing that with you, because I
13 guess we're trying to understand – it's a muddled picture for us.
14 MS CARTER: Okay, sorry.
15 PROF MONTGOMERY: Because everybody is trying at the same time to respond to
16 the needs, to think very carefully about what more they can do around the Mid
17 Staffs process. And so we understand that what's now NHS England was
18 thinking about how it could use the medical directors and the SHA –
19 MS CARTER: Oh yes, the medical directors forum on applications.
20 PROF MONTGOMERY: Yes. So clearly lots of people have tried to improve the
21 focus that they've got on what's going on. So the medical directors at the
22 SHAs are having a look at this to – how does that feed into your process?
23 MS CARTER: So this is difficult for me because I think quite a bit has changed in the
24 last – to what it is now, but certainly one of the learnings from Mid
25 Staffordshire that the SHAs and the approval process for referring to us was

1 saying, 'Well, we now will discuss each application, we'll get the medical
2 directors in from the trust and the SHA to take a view on an application before
3 it's referred on to Monitor'. So there is definitely that step in the process which
4 was enhanced. And I think Bruce Keogh was leading that.
5 PROF MONTGOMERY: And do you remember when it started? Would this trust
6 have been part of that?
7 MS CARTER: So I have to tell you I'd have to go back and check that point. I think it
8 may have just missed it, because my memory is September 2009 is when we
9 issued the joint ~~[MAU?]~~ Memorandum of Understanding with the CQC, the
10 [quality bar?] and things like that, and I think it came in from then, so – point of
11 clarifications from my notes I understand that Medical Directors review was
12 implemented around November 2009. As Morecambe Bay received Secretary
13 of State approval in February 2009 I don't believe it went through this process.
14 PROF MONTGOMERY: So it's suspended at that point.
15 MS CARTER: Yes.
16 PROF MONTGOMERY: So it is an application in, but it's –
17 MS CARTER: I think some of the learning may be around – it went through a
18 process when it – and then does it need to be re-signed off or something
19 before.
20 PROF MONTGOMERY: Okay. So if – one of the things we were thinking is that it
21 was better to think of it as a new application as opposed to a resurrected, if I
22 can use that phrase, application. I think I'm right in thinking this is possibly the
23 only one that's quite in that category within your remit and others have either
24 been deferred –
25 MS CARTER: We have required that applicants go back to –

PROF MONTGOMERY: Go, without collecting £200.

MS CARTER: Back to go, yes. So there's actually the trust that I was talking about earlier with Victoria, one – Kent and Medway Social Care, which was one of the ones which was registered with conditions and had a long period and kept asking for more time, and we said, 'No, go back'. And I think it is something that we're reflecting on at the moment to say, 'Let's just be clear', and particularly I think it's probably pertinent now as well because we've moved from the SHA process to now the TDA process, so it could be an applicant that has – went through the old SHA process, has been delayed and maybe the TDA might want to reconfirm that it's happy.

PROF MONTGOMERY: I mean, I guess that it seems slightly strange to me, and I've tried to understand whether it's fair that it feels strange, that you have an application which has been – the review of which by Monitor has been suspended because you haven't yet got the answer on the quality questions that are in your mind, and so that happens in May or thereabouts. September ~~you have~~ the DH had a new way of looking at quality questions involving the medical directors as part of the SHA assurance programme *, and it doesn't seem to be used in relation to this one. And if there are lots of them then I think that's easier to understand, but this feels as though it's a – if not unique it's very unusual that you have something that hasn't been sent back at the beginning and it is in there, and that would seem to be a resource that you might expect to have been used as part of this.

[* Please note that the medical directors review was implemented as part of the SoS gateway process. It was not a Monitor process. As the trust already had SoS approval it didn't at that point go back through.

1 MS CARTER: I'm not sure I've – I don't think I've got the same view actually, so I
2 think that... So let me try this: so the process with the medical directors was
3 brought in ~~in~~ around September, so anything new would have gone through
4 that process. I don't think Morecambe Bay would be the only applicant that
5 was delayed or deferred that didn't go through the medical directors process,
6 so I think that's fair. And I think that there is some – this clarity of status,
7 because they've already been referred to us and we've had this process – if
8 you look at the guide for applicants it talks about, 'If you are deferred you can
9 stay with us as long as the problems are solvable within 12 months, so we'd
10 expect you to reactivate within 12 months'. And this trust did reactivate within
11 12 months so you could argue about whether or not that was the right thing.
12 PROF MONTGOMERY: And so by that stage there's limited SHA or Department of
13 Health involvement, or TDA involvement, because it's in your –
14 MS CARTER: But the SHA – we did speak to the SHA again.
15 MS WOODHATCH: We spoke with them again, ~~saying~~ in the second half ~~we spoke~~
16 ~~with,~~ as we did with ~~[inaudible].~~ the PCTs
17 MS CARTER: And we've got notes for speaking with them to say, 'How do you feel
18 about how they're going on the application'.
19 PROF MONTGOMERY: Just refresh our memories on how they did feel.
20 MS CARTER: I can't remember, but there's a quote about them being in their quality
21 journey six and seven out of 10 versus two or three out of 10 two years ago,
22 you know, improvements on that. So the PCTs at the time said, 'Sound
23 clinical services, some very good, particularly at Lancashire. Some services
24 are excellent, but Barrow probably not as good, with one or two exceptions.
25 General surgery is good, elderly care is good'. Have we got the SHA here?

1 We'll have the SHA here but, you know, the picture was... There's some
2 concerns about how strategic they were going forwards, but not relating to
3 quality.
4 PROF MONTGOMERY: The quality picture was essentially reassuring that they are
5 above the bar and moving in the right direction. Is that what you –
6 MS CARTER: Okay, so, 'The trust board' – 'The SHA's view on the trust board has
7 not changed. It feels it engages well with North Lancashire PCT. Cumbria
8 PCT is concerned it's not fully reflecting closer to home. Some concerned
9 about how they interact, but the SHA have not experienced any difficulty in
10 dealing with the nursing director and medical director. Quality of services'...
11 So we did talk to them about the baby death at Furness: 'Ongoing discussions
12 with the [baby?]. The SHA is considering the results of the external review. It
13 feels that this review served its purpose. The SHA are now looking for actions
14 for improvement'.
15 PROF MONTGOMERY: Does it say which external review did they mean there?
16 MS CARTER: Not in our notes, no. 'Dame Pauline Fielding has undertaken a
17 review, Birthrate Plus, staffing levels, and the trust now knows what additional
18 staffing requirement it has'.
19 PROF MONTGOMERY: Date of that note is?
20 MS CARTER: 17 ~~March~~ June 2010. Should be June (as corrected in my letter)
21 PROF MONTGOMERY: Okay, so 17 ~~March~~ June –
22 MS CARTER: Okay, so here we go: 'Overall, in terms of –
23 PROF MONTGOMERY: Sorry, just to check this, because this is quite important in
24 terms of piecing together. You've just described that the Fielding Report, the
25 existence of the Fielding Report, ignore the outcome, but the existence of the

1 inquiry was known in March?

2 MS CARTER: I'm not clear from this note whether that's right though, because it

3 talks about the Birthrate Plus, so we thought this was the Birthrate Plus report.

4 PROF MONTGOMERY: Which is a different report.

5 MS CARTER: Yes. So I think there's a –

6 MS WOODHATCH: Staffing gaps, yes.

7 MS CARTER: Unclear from this note.

8 DR KIRKUP: But you're mentioning Dame Pauline Fielding though, so, yeah, there

9 must have been some knowledge of her review by –

10 MS CARTER: Well, the note makes it – reference to the Birthrate Plus.

11 PROF MONTGOMERY: But also uses her name.

12 MS CARTER: Yes.

13 PROF MONTGOMERY: Okay, that's helpful. I mean, there's a difference between

14 seeing a report, which wasn't available at that point, and knowing that there

15 was a report coming to be seen, and we're trying to piece together who knew

16 what about [inaudible]. So at – in those discussions the fact that

17 Dame Pauline Fielding had some connection with the trust was known, albeit

18 in a confused way. I fully understand the confusion.

19 MS CARTER: Yeah, I think – so all I can say is I think the team understood that to

20 be the Birthrate Plus report.

21 PROF MONTGOMERY: Okay.

22 MS CARTER: And this: 'Overall, in terms of where the trust is on its quality journey,

23 the SHA would give it a six out of 10. Three to four years ago this would have

24 been two to 10. The trust actively engaged in the SHA's Energise for

25 Excellence in care. The trust nursing director is keen to keep the trust moving

1 in the right direction. She's done well with team leaders and has worked
2 closely with the SHA'.
3 DR KIRKUP: Sorry, just while we're on that one, I'm interested in the date that the
4 SHA was giving the trust six out of 10 on quality.
5 MS CARTER: It was the same date. i.e June 2010
6 [Cross-talk]
7 MS CARTER: – meeting notes. So this is – you know, this is the conversation with
8 the trust and saying, 'What do you feel about where they are on quality?' So
9 whether they'll remember saying that I don't know.
10 PROF MONTGOMERY: So that's a meeting – who –
11 MS CARTER: That's just a meeting note.
12 PROF MONTGOMERY: Yes, but between who – I thought it was with the SHA but
13 you just described it with the trust.
14 MS CARTER: It's the SHA.
15 MS WOODHATCH: It's the SHA.
16 PROF MONTGOMERY: Who was there from the SHA?
17 MS CARTER: I think you would have had this. 17 ~~March~~ June 2010. Mark Thorne,
18 [Peter ~~Keye~~Keogh?], Martin Clayton, Angela Brown, Sam Simpson,
19 Karen Campion.
20 PROF MONTGOMERY: Thank you.
21 DR KIRKUP: Thank you. Okay. I want to pick up one or two loose ends, at least in
22 my understanding, so apologies that I'm probably going to dot about a little bit.
23 You talked about the trust notifying Monitor of the five incidents five out of 12:
24 12 overall, five related to maternity or close by. What part of the process were
25 you at when the Trust notified you? I mean, had you [inaudible]?

1 MS CARTER: So we requested that information from the trust, didn't we? We asked
2 for a list of serious untoward incidents as part of our data request.
3 DR KIRKUP: That's a standard part of your request?
4 MS CARTER: Yes.
5 DR KIRKUP: Okay. And what you got back was the 12.
6 MS CARTER: Yes.
7 DR KIRKUP: And over what timescale did you ask?
8 MS WOODHATCH: That was in the first part of the assessment.
9 MS CARTER: So it's probably in the last –
10 DR KIRKUP: Yeah. Sorry, I'm not being clear. Did you ask for them over the last
11 year or the previous financial year?
12 MS CARTER: I'd have to go back to the data request list. It's either a year or two
13 years.
14 DR KIRKUP: Okay. When you had conversations with the CQC, were you dealing
15 with predominantly the central part of the CQC organisation or predominantly
16 with the regional part, or did it change?
17 MS CARTER: Predominantly with the regional, and I would have conversations
18 centrally. So the team would do regionally on the assessment and I would do
19 the central conversations with – Amanda Sherlock is who I used to speak with.
20 DR KIRKUP: Right. Were you content that the messages from the different parts of
21 CQC were consistent with each other?
22 MS CARTER: Well, I know that Amanda used to speak to the regional team before
23 she'd have a conversation with me, so...
24 DR KIRKUP: But when you compared notes internally, were there times when you
25 said, 'Well, I don't quite understand that: the central part is saying this, the

1 regional part is saying something slightly different'?

2 MS CARTER: I don't ~~[reflect?]~~ recall thinking on that, no.

3 MS WOODHATCH: I don't recall thinking that.

4 DR KIRKUP: Okay. When you spoke to the regional people, was that mostly Alan

5 Jefferson initially?

6 MS WOODHATCH: Alan and then Dawn mostly. On the actual assessment it would

7 have been Dawn.

8 DR KIRKUP: Okay. And at that stage you've described, I think, that he was giving

9 messages that indicate a fair amount of concern about Morecambe Bay as a

10 trust and its quality.

11 MS CARTER: Sorry, I think we spoke to Alan Jefferson after the delay.

12 DR KIRKUP: Right, you didn't speak to him before?

13 MS CARTER: No, because we spoke to the regional team before.

14 DR KIRKUP: Right. Alan Jefferson was the regional team. He was the –

15 MS CARTER: He was the director –

16 DR KIRKUP: Yes. That's –

17 MS CARTER: – wasn't he?

18 DR KIRKUP: That's right. Sorry, let me clear: when did you speak to

19 Alan Jefferson?

20 MS CARTER: I think – sorry, I need to check with my notes, but I don't think we –

21 once we – we spoke with the regional team about our concerns on maternity,

22 they escalated it up, they told us they weren't – it didn't trigger an

23 investigation, but they had the, you know – sorry, they didn't give us the

24 assurance we needed. We delayed it and then when we had further

25 conversations about what the process was going forward, we did speak to

1 Alan.

2 [*for clarification I contacted Alan Jefferson by email requesting a discussion on the

3 SUIs during the first assessment he referred me back to Dawn, as he had no

4 current information on the issue. My letter to the investigation clarifies all the

5 contact with the Regional Director.

6 DR KIRKUP: Yeah. So you spoke to him twice, or in two different phases.

7 MS CARTER: I spoke to him after – so over a couple of months, I think. Over the

8 summer of 2009 is when I had most conversations with Alan Jefferson. It

9 wouldn't necessarily have been part of our process to speak to the regional

10 director during the process.

11 DR KIRKUP: Okay. So you spoke to him when the concerns were first raised, when

12 there was the question of a central investigation.

13 MS CARTER: No.

14 DR KIRKUP: No?

15 MS CARTER: We spoke to Dawn, who was escalating it internally and having

16 conversations internally with CQC. You know, she was our main point of

17 contact. She referred it onto the investigation team, but at all points I would

18 have been having monthly calls with Amanda Sherlock about what was going

19 on as well.

20 DR KIRKUP: Right, okay. I still am struggling slightly to understand that you thought

21 that the message you were getting from CQC was consistent between the

22 regional part and the central part, because that's not what comes across. The

23 regional part are expressing concerns, the central part are not investigating,

24 why the difference?

25 MS CARTER: Sorry, this is quite confrontational. I think that the CQC have a

1 process that they go through to work out whether or not they should
2 investigate, so it has to meet certain criteria. So you can have concerns at a
3 regional level and it not trigger the concerns for investigation, because we did
4 ask why it wasn't going to – you know, to see the process for escalation, so I
5 think at the time of the – you know, of the delay; I wouldn't have been aware of
6 any difference of view because my understanding of the way the CQC worked
7 – I wouldn't imagine that – I mean, I'd have to go back to all of our notes of
8 speaking with Dawn, but Dawn would not give me a view that wasn't
9 consistent with what her regional director was saying to me.
10 DR KIRKUP: No, it's – I'm obviously not explaining myself adequately. It's not the
11 gap between Dawn and the regional director, it's the gap between the regional
12 director and the central – Amanda Sherlock and her team. That's what I'm
13 trying to explore.
14 MS CARTER: To be clear, Alan Jefferson's view of red rated risk did not come
15 through until August. The QRP, I think, if you looked at the time, would not
16 have had a red rated risk on it.
17 DR KIRKUP: Yeah, sure.
18 MS CARTER: So I guess what I'm trying to say is at the time when we did the delay
19 I don't – so you said to me 'I failed to understand how you couldn't have
20 concluded there was a difference between the regional and the centre', but I
21 would say at the time we delayed the application I'm not sure there was a
22 difference between what the region thought and the centre thought, because
23 the risk rating was not red at that time.
24 DR KIRKUP: Okay. I'm not trying to polarise in quite such stark terms. You're over
25 interpreting a bit, I think. I'm trying to –

1 MS CARTER: No, no, because I feel very sensitive, because I feel like you're saying
2 to me, 'You should have drawn a conclusion' that I didn't think I could have
3 drawn at that time.
4 DR KIRKUP: No, no, no. I'm trying to understand what your view is of the regional
5 organisation, what they're saying, and the central organisation, what they're
6 saying. And on the face of it, to me, they seem to be saying different things,
7 so I'm asking for your help in trying to understand you reconciled that.
8 MS CARTER: But I think maybe the reason we're having a difficulty on this is about
9 the timing. So I don't – so, you know, I found in my relationship with Amanda
10 Sherlock she was very open with me, and my understanding was she would
11 have a communication with the regional team before, you know – she would
12 ask for an update from the regional team before she'd have a discussion with
13 me.
14 DR KIRKUP: Okay. And your understanding of the reasons for the red rating by
15 Alan Jefferson when it did come through, which is later, you've explained.
16 What lay behind it?
17 MS CARTER: I think it was clear from the letter he wrote to us that they were
18 uncertain at that time whether there were broader concerns, and they wanted
19 to see how the application had proceeded. [inaudible] if I've got it here. So in
20 his letter on 29 July it says, 'We've received a copy of the management review
21 of the trust maternity services from Charles Flynn. This raises a number of
22 concerns about their operation, including poor communication between
23 maternity, obstetric, paediatric services, poor relationships, inconsistent
24 practice between maternity at different trust sites, shortcomings in the
25 interdisciplinary workings. The trust maternity services have been

1 benchmarked against those at Liverpool Women's Hospital and it has been
2 confirmed that the arrangements at Barrow are fit for purpose. Mentorship
3 has been offered by the Liverpool Women's Hospital to assist in the
4 development of better interdisciplinary working. The trust is to formulate an
5 action plan in response to the findings of this management review. We are
6 concerned that there appear to be systematic features to some of these
7 findings, so we've left it to continue to be rated at red. A further North West
8 Regional Risk Panel will be held on 10 August and the trust will be discussed *
9 again. It seems unlikely that our concerns will be fully resolved by this time'.
10 [* note Alan's letter to me dated 13 August 2009 provided an update of the 10 August
11 risk panel and the move to an amber rating. I sought further clarification of the
12 move down from Amanda Sherlock who responded to me on 24 August 2009.
13 DR KIRKUP: Okay, that's fine. I see what you're saying. Thank you. I'm interested
14 to pursue a little bit further the change in that risk rating by CQC that
15 happened over a relatively short period of time. It went to amber and then
16 very shortly afterwards to green. In the middle of that they were registered
17 with no conditions. What was your understanding of the reason for that
18 change?
19 MS CARTER: I don't think I've got anything more to add than I've said already, in
20 terms of it was six months, they took a view of what the rating was and as --
21 you know, I didn't challenge them significantly on how that rating had
22 changed. And we went through our process and spoke to others as we went
23 through the authorisation process, and other, you know, risks around
24 maternity services didn't flag.
25 DR KIRKUP: Again, I'm asking you for help in my understanding here. You've read

1 out a fairly typical extract of an external review. They had two or three, as you
2 pointed out, and they've pretty much all come to the same conclusion: that
3 there are some systemic issues of culture and communications and failure of
4 team working. Were you surprised that those sort of findings could be
5 resolved within six months?

6 MS CARTER: I don't think that – you know, so at the – you know, the CQC's letter
7 from Cynthia at the time was, 'They're putting in place action plans and those
8 need to be continued to monitor', so I don't know how I felt at the time. I just
9 felt that this – the trust had put in place action plans, it had other people come
10 in and look at them, the SHA was looking at how the action plans were
11 unfolding and a decision was made by the CQC about whether it met the
12 conditions for authorisation. But I guess, you know, in terms of our role, you
13 know, we weren't going to – we weren't suggesting that we should re-perform
14 what others had done.

15 DR KIRKUP: No, I understand that, but was part of your role not to challenge what
16 people were saying? For example, in the Board to Board meetings you would
17 typically challenge what people were telling you.

18 MS CARTER: Yeah, but I think you could say that, you know, we did our process
19 and we did look at the governance's quality as part of our review to add into
20 what we were looking at.

21 DR KIRKUP: Yeah.

22 MS WOODHATCH: I think we did also ask the CQC about the registration process,
23 because we had another trust [in a similar timeframe?] that had been
24 registered with conditions, and we understood that that Trust had been
25 through a ~~so we did ask had there been~~ calibration process as part of

1 registration [inaudible] –* per letter from Sue Mac Millan dated 16 April 2010
2 they did identify concerns at registration but (CQC) sought additional
3 information was sought and we were satisfied that appropriate actions were
4 being taken.
5 PROF MONTGOMERY: What was the answer?
6 MS WOODHATCH: That there had been calibration and that they'd gone to –
7 MS CARTER: They weren't central, I think, in terms of...
8 DR KIRKUP: Were those the sorts of findings on reviews of trusts that you were
9 used to dealing with, you were used to seeing, problems of clinical failures in
10 communication and team working and, you know, relatively deep seated
11 systemic problems, was that –you've mentioned one or two other trusts that
12 were suspended or deferred.
13 MS CARTER: I think – so obviously we've had experience of Morecambe Bay and
14 other trusts that I mentioned, but no, I wouldn't say that I'd had, you know, a
15 lot more on the quality side at that point.
16 DR KIRKUP: Okay. Did you detect a change of approach from the CQC regional
17 team when you were dealing with them when Sue McMillan replaced
18 Alan Jefferson?
19 MS CARTER: No.
20 DR KIRKUP: Was that not the period when there was a fairly rapid change in the
21 assessment of Morecambe Bay?
22 MS CARTER: Sorry, which period of time are you talking to me about? Between
23 April and – sorry January and April when they got –
24 DR KIRKUP: Between February and May of 2010. He left –
25 MS CARTER: I guess at the time – you know, I didn't seek to challenge the state of

Comment [RP1]: The interviewee wanted this section deleting

1 assurances from the CQC. Sue McMillan was very helpful to me. She told
2 me that they were going to do a responsive review of maternity, which I
3 thought was good, and I thought indicated – and I knew very clearly we
4 wouldn't take a decision until they'd done that responsive review of maternity.
5 So maybe at that point in time, yes, they'd got the registration without
6 conditions, and we were going to have evidence through a responsive review,
7 a focussed review on maternity before we took our decision, so I – you know,
8 at that point that's how we understood it. So we didn't feel that they were
9 completely stepping away from maternity services, because they had
10 highlighted they were going to do a responsive review. So if your question –
11 so I didn't get a sense that Sue was not – I think, you know, they recognised
12 that they wanted to look into maternity before giving us the final view, before
13 authorisation I think.
14 DR KIRKUP: Okay. When you had conversations with the trust, I don't mean as part
15 of formal meetings, but when you were having regular telephone contact with
16 them, would that usually be the chief exec?
17 MS CARTER: Me personally would be the chief exec.
18 DR KIRKUP: Okay. Were there other contacts that were going on as well?
19 MS WOODHATCH: Yes, so we would be – when we were doing trust visits we
20 would be – they had – a lady there helped us ~~kind of~~ organise the meetings
21 and so we would – and we'd run through ~~that~~ a structured programme~~d~~ of
22 meetings, so we would meet different ~~[inaudible]~~ representatives from the trust
23 at meetings.
24 DR KIRKUP: Right.
25 MS CARTER: So we would have spoken with Jackie Holt, Peter Dyer, the finance

1 director, and we'd meet the divisional teams as well.

2 DR KIRKUP: Yeah, but in terms of progress –

3 MS CARTER: Oh, sorry, you weren't –

4 DR KIRKUP: – and conversations where you described about what happens next.

5 MS CARTER: Well, you probably had – what was the name of the lady who did the

6 FT application? She would have had a lot – Jo Borthwick?

7 MS WOODHATCH: Jo Borthwick? That was their lead there.

8 DR KIRKUP: Okay.

9 MS CARTER: And I did have a conversation with the chair directly when we delayed

10 the application, around the timing, because we wanted to see more [inaudible]

11 we spoke with [Eddie?] to –

12 DR KIRKUP: Okay. I guess I'm particularly interested in the conversations you did

13 have with Tony Halsall, especially around the idea of the external reviews.

14 Can you recall how they were described to you and what the origin of the

15 external reviews was?

16 MS CARTER: I can't recall directly. My sense was he was quite open about the

17 reviews that were going on.

18 MS WOODHATCH: I think – I mean, I don't recall the detail either. Again, I think it

19 was in the context of discussion around the five SUIs. He said, you know, 'I've

20 got some external people in to look at this as well'. So it was in that context.

21 DR KIRKUP: Okay. Was that in the context also of what you describe as what do

22 we need to do next to progress this application?

23 MS WOODHATCH: We never told them they had to do external –

24 DR KIRKUP: No, no, I wasn't suggesting –

25 MS CARTER: Because these were happening at the time before we –

1 MS WOODHATCH: They predated the start of the assessment.

2 DR KIRKUP: Well, some did. Some might not have. Okay. You described some of
3 the points that reassured you that they were looking seriously and that they
4 were making changes and so on. Can I just play them back to you and just if
5 you could confirm or otherwise or comment on them. The first one that you
6 said, I think, was that the incidents were unconnected, and that wasn't your
7 decision, that was somebody else's, but we're not quite sure where, but that
8 was – that played a significant part in the thinking: they were clinically
9 different, the mode of death was different and so on. You mentioned it a
10 couple of times earlier on.

11 MS WOODHATCH: I said that's the question we asked the CQC. We said, 'These
12 are the facts of five incident different cases. We don't know – this raises a
13 question in our minds that we can't answer'.

14 DR KIRKUP: Yeah. I'm sorry, I'm obviously coming across badly this morning. I'm
15 not trying to catch you out here. I'm just wanting to confirm my understanding.

16 MS CARTER: Yeah, but I don't think that we said – I don't think we know for sure
17 whether or not they were connected or not connected.

18 MS WOODHATCH: We didn't know.

19 MS CARTER: We said, 'There are five, this looks like a trend in maternity. We need
20 to know whether you believe there's a problem with maternity'. So I don't think
21 we – so the way you've read that back to me is saying that we had made a
22 view – so I might have represented to our board –

23 DR KIRKUP: No, no.

24 MS CARTER: – that those weren't unconnected.

25 DR KIRKUP: The un-connectedness of the incidents was a significant feature of the

1 CQC's reassurance of you that this wasn't a systemic problem.*

2 MS CARTER: And, sorry, can I just check for my understanding, so were you saying

3 that because I said that didn't trigger their criteria for investigation or

4 something else that they've said to you?

5 [* Clarification Amanda Sherlock's email datesdated 24 August to me stated at the

6 most recent NW risk panel, concluded, many of the uncertainties have now

7 been resolved, the series of Seriously Untoward Incident reports have turned

8 out to have no common thread. NW risk panel is attended by CQC. My

9 confusion at the time of the interview was that I didn't recall the detail of this

10 email, and I interpreted the question originally as though I amade the

11 conclusion they weren't connected, which was not the case.]

12 DR KIRKUP: You mentioned it two or three times as being a significant factor in the

13 level of concern that was held or was not held.

14 MS CARTER: I don't – you see, I don't think I've said that. I think I've said that we

15 weren't sure about whether or not they were connected. The CQC decided

16 that they didn't need to – it didn't trigger the need for investigation. I think my

17 understanding at the time was that Seematch CEMACH didn't highlight them

18 as an outlier.

19 DR KIRKUP: Yes, I'm just coming to that as well, but I'm pretty clear from my notes

20 that you used the term that the incidents were unconnected at least twice.

21 MS CARTER: But, sorry, I said that they were not – I'm really confused now.

22 DR KIRKUP: Not that it was your conclusion that that was a significant –

23 PROF MONTGOMERY: My memory is that you told us that you raised that as a

24 question, are they or are they not connected, and I think you told us that you

25 got reassurance that they were not connected from the CQC and from the

1 SHA.

2 DR KIRKUP: Yes.

3 MS CARTER: Do you think I said that?

4 MS WOODHATCH: Well, the first part, I think that's what we asked the CQC and
5 then we –

6 PROF MONTGOMERY: But you seem to have then proceeded through your
7 process on the basis that you've received assurance that these are not
8 systemic problems. If you'd had that question and you need an answer to it
9 and you hadn't had an answer to it, how could you have progressed through
10 the process? It's clearly an appropriate question for you to seek assurance
11 on.

12 MS CARTER: I just... So I think by inference, the fact that CQC gave us the
13 clearance, they must have felt that they were not sufficient to conclude the
14 maternity services was not fit, is what I think.

15 DR KIRKUP: Okay. The second point that you made was about it not being an
16 outlier on ~~Seematch~~ CEMACH. Could you just explain where that view came
17 from?

18 MS CARTER: So my – I don't have a note of a call or a meeting in that scenario, so I
19 don't know whether that was something that might have been said at – on the
20 call with the SHA, or whether it was a conversation with CQC. So I don't know
21 if you have data about what it said, what ~~Seematch~~ CEMACH said, but – *

22 [*According to my email to William Moyes on 26 June 2009, I reported that the
23 investigations team had not identified Morecambe Bay as an outlier in terms of
24 maternity morality, nor did they have indications from CEMACH (who collect
25 information from every hospital on peri-natal deaths using a specific

1 notifications form) that the trust was an outlier.]

2 DR KIRKUP: Okay, but the important point is that was fed back to you as a
3 significant factor.

4 MS CARTER: I think it was one piece of information that came through.

5 DR KIRKUP: Yes, okay. And the third thing that I think you mentioned was that
6 there had been external reviews commissioned, and that was reassuring
7 because the trust was opening itself up to external reviews.

8 MS CARTER: I think the point was – so for example I gave the case on Medway
9 where, you know, on mortality they'd done an internal look at it. So a trust
10 where you could see that they had people externally coming in was more of a
11 positive.

12 DR KIRKUP: Okay. Now, I wasn't quite sure about this one. Did you say also that
13 the unconditional registration from CQC was a point of reassurance?

14 MS CARTER: Well, because it's our – the requirements to be authorised is you have
15 to be registered without conditions.

16 DR KIRKUP: Without conditions?

17 MS CARTER: Yes.

18 DR KIRKUP: Okay, so that was significant.

19 MS CARTER: Yes.

20 DR KIRKUP: Okay. And finally, I'm not sure how –

21 MS CARTER: And also the minor concerns at the point that we reactivated was
22 significant.

23 DR KIRKUP: Yes. I'm not quite sure that –

24 PROF MONTGOMERY: So if there'd been a condition you wouldn't have
25 authorised?

1 MS CARTER: No, correct.

2 PROF MONTGOMERY: You might still have refused to authorise even if they'd been

3 registered without conditions.

4 MS CARTER: Yes.

5 PROF MONTGOMERY: If there'd been more than minor concerns.

6 MS CARTER: Yes. So, for example, Kent and Medway was registered with

7 conditions, therefore could not be considered.

8 DR KIRKUP: Okay. Thanks for clarifying that. The one which I don't think you were

9 explicit about but which came up several times in the conversation was the

10 PHSO decision not to investigate. Can you explain how that did or didn't fit

11 into the thinking?

12 MS CARTER: So I think it's more of a negative. So the fact that it was – that there

13 were, I guess, no concerns flagged from the PHSO, given that they were not

14 investigating the incidents. So what our reaction might have been if the

15 Ombudsman were investigating I think we would have questioned, because I

16 would imagine, given the way the CQC letter was written, which said 'We can't

17 confirm until the outcome of the PHSO investigation', if they then investigated I

18 would imagine that the CQC wouldn't have given us a view at that point. So

19 again we wouldn't have been able to authorise, but that didn't play out, so it

20 didn't cause that issue.

21 DR KIRKUP: Yes. Okay, that's helpful clarification. Thank you. And I think the very

22 last thing that I wanted to raise, you were talking about what was different

23 now. One of the things that I guess is different now is that you've got a – do

24 you call them a medical director? I'm not quite sure what he's called.

25 Hugo Mascie-Taylor. Would that make a difference now?

1 MS CARTER: It's very interesting you raise that. So I think it's fantastic we've got
2 Hugo with us, and I think actually the fact that our quality governance
3 associates have senior operational experience makes a difference, and that
4 came in place a couple of years ago. But, you see, some of these issues
5 were very – you know, quite deeper down into the organisation. So I definitely
6 think it's better. Whether just Hugo on his own would have stopped the
7 application I don't know the answer to that question.
8 DR KIRKUP: No, but rather than being entirely reliant on people to interpret what
9 they were telling you, would he not have been able to give you a reality check
10 on that, or maybe challenge some of the things that were being said?
11 MS CARTER: I mean, it's very clear from the KPMG review saying we need more
12 clinical experience, so we could have – whether it came from the medical
13 director or, you know, we said in this, you know, we might require, you know,
14 further review, I think.
15 DR KIRKUP: Yeah, okay. Anything else? Is there anything else you would like to
16 tell us? You don't have to.
17 MS CARTER: I don't think so. I think, you know – I guess I'd like to close in that,
18 you know, I think we were very keen to do a lessons learned, and that's
19 something that David Bennett immediately said, you know, 'We need to look at
20 this because we authorised them so recently, and the reason we deferred
21 them in the first place we need to look at it so we' – we did take this really
22 seriously. And I think one thing I've learned, I think, there's always room for
23 improvement in what everybody does. So I welcome, you know, that this is
24 being looked at again to see whether or not there's more stuff that can be
25 done.

1 So I certainly wouldn't want to give an impression that I didn't feel like

2 that. And there's an awful lot of information we have to draw and conclude

3 upon. You still need to do that balance in terms of where do you – you know,

4 how do you balance the risks and burden of regulation versus picking up

5 issues. So it's a tough challenge and we need to have a mindset where we're

6 always looking to improve. So I hope, even though we might have had some

7 – in this meeting I hope that's very clear that we do want to learn from this.

8 DR KIRKUP: Yeah. No, it is. Thank you. That's appreciated, and thank you for

9 coming.

THE MORECAMBE BAY INVESTIGATION

Wednesday, 17 September 2014

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

Before:

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

MICHAEL CHESHIRE

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

1

2 MR BROOKES: Welcome. I am Julian Brookes. As you can see

3 Bill Kirkup, unfortunately cannot be with us today. He has

4 asked me to Chair this session. We will start with saying

5 who we are. I will ask you for the record to say who you

6 are. There is a little bit of housekeeping and then we will

7 start.

8 (Following introductions by the Panel

9 and housekeeping matters)

10 MR BROOKES: For the record, please.

11 DR CHESHIRE: I am Dr Michael Cheshire, previously Medical

12 Director at SHA North West.

13 MR BROOKES: Welcome.

14 PROF MONTGOMERY: Can we start by getting the date

15 right when you were in this part of the world and the scope

16 you had at the SHA?

17 DR CHESHIRE: My contract started on 1 December 2009, for

18 the first. We then moved office and Christmas intervened so

19 by the time I had a desk and bits and pieces it was well

20 into January. During the first six months until the end of

21 July I only did two days a week at the SHA. The other three

22 days were in London as Clinical Vice-President at the Royal

23 College of Physicians. I did weekends on-call, about every

24 three or four, in acute medicine at Manchester Royal

1 Subsequently when the term of office finished at the
2 College I visited four days a week from the SHA -- 1 August
3 at one a day week in CMFT doing acute medicine primarily at
4 weekends. That happened probably every fourish-weeks for
5 about 24 hours. Again I was quite busy.
6 That contract then continued until we were supposed to
7 be abolished in the end of March 2012 and I was asked to
8 continue until it completely finished at the end of
9 March 2013.
10 During that time, when I started at the SHA, there was
11 quite clearly Dr Ruth Hussey who was ~~had been~~ the Senior Medical
12 Director, and she was part and parcel of the establishment
13 when I arrived. I started to pick up things within the SHA
14 that were required of me, but we did not set any formal
15 objectives until March/April. I looked through my notes and
16 I cannot find what they were but I can find and I have
17 brought with me, if you wish, an appraisal summary from
18 October 2010, which explains what I was doing at that time.
19 My primary requirement was to get on top of the major
20 trauma work, which we had done nothing about even though it
21 had been extant for about six months. I had to work to get
22 myself a project manager and things of that sort.
23 I also had to develop the work on revalidation, which
24 had not started; the dementia work, which had not started;
25 and a range of other issues, which included finishing off

1 the previous work with clinical pathway groups; the voice of
2 the SHA as far as doctors were concerned; communication with
3 all the medical directors in our region. I had a view over,
4 which I think is relevant -- there are lots of other things
5 in the papers I have got -- but a view over quality, but no
6 direct responsibility for Foundation Trust development.
7 That was clearly under the managerial responsibility of the
8 Director of Finance. There was a big team that ran that.
9 From late 2010, Caroline Shaw, who was at that time the
10 Chief Executive of Christie Hospital, joined us to run that.
11 My contribution was to be involved with the quality and
12 safety team, which was responsible to Jane Cummings, and to
13 work with them to assess quality and safety as it turned up
14 in various places.
15 My other responsibility was to take the papers and the
16 decisions that had been taken by the SHA to Bruce Keogh's
17 group of medical directors once a month in London.
18 For those first six months I intermittently attended
19 the meetings and subsequently I attended them regularly
20 until we were clustered, at which time my role ceased in
21 that regard but that is well beyond, I think, the time you
22 are probably going to ask questions about.
23 I had a broad role on a part-time job and on a less
24 part-time job and believe that I tried my best to do those.
25 MR BROOKES: Okay.

1 PROF MONTGOMERY: Thank you very much. Maybe I could
2 start with the handover. You obviously arrive and it sounds
3 as though arrival is probably quite challenging, not much
4 time to find out what was going on. Is there anything
5 relating to this part of the world and Morecambe Bay Trust
6 that featured in your handover, or was it on the radar as a
7 concern at that stage?
8 DR CHESHIRE: I thought hard about this and I am just trying
9 to go over and make certain I do not mislead you. I don't
10 believe that is the case. It may -- if you find documents
11 to prove otherwise, I might be incorrect -- but I am pretty
12 certain that I was not part of that. The Joshua Titcombe
13 case had already happened, the SHA was well into that
14 process.
15 I have also looked through my notes to see was I
16 directly involved in FT accreditation. I clearly was
17 because I must have presented that to Bruce Keogh, I cannot
18 believe that I did not, but I cannot find a dominant note
19 and, at that time, we had a senior management team, on a
20 Monday morning, which I made sure I was always at, where
21 decisions about this sort of thing were made. We had a
22 discussion, we decided what was going to happen and then I
23 would, effectively, have my brief to go to see Bruce.
24 PROF MONTGOMERY: To the best of your recollection, by
25 the time you have got there, the SHA had thought it had

1 dealt with the Titcombe --
2 DR CHESHIRE: If they did not think they had dealt with it,
3 and I cannot say whether they did or did not feel they had
4 dealt with it -- they were certainly the people involved. I
5 was not asked directly to take part. I went through quite
6 carefully; it was not in my records of my job description;
7 neither was it in my appraisal, which took part in April --
8 not April, I am sorry, October 2010.
9 PROF MONTGOMERY: The Trust was not flagged up as one
10 where they had any particular concerns about medical
11 leadership
12 DR CHESHIRE: I think that is not true. "True" is the wrong
13 word. The Trust was clearly recognised as a Trust in
14 difficulty, as were many others in the SHA. I do not
15 remember that it was especially different. I think, from my
16 recollection, certainly from the occasional notes that I
17 have got, we were taking more note at the time of the
18 difficulties with North Cumbria and Carlisle than we were
19 with Morecambe Bay.
20 PROF MONTGOMERY: That is consistent, I think, with
21 things.
22 What could you tell us about the Medical Director at
23 Morecambe Bay and the quality of the leadership?
24 DR CHESHIRE: Pete Dyer. I had a lot to do with him in
25 revalidation and a lesser amount to do with him in Morecambe

1 Bay. He was a oral maxillofacial surgeon. I think he
2 probably still is. Very diligent, hardworking, easily
3 approachable. I always thought that if Peter was in a
4 situation where life got very tough, that he would find it
5 difficult to impose his he will and direction on others. That
6 is not to say that he did not try; he did, but I think that
7 he would have found that quite difficult.
8 PROF MONTGOMERY: Do you have any examples that led you
9 to that assessment of the character?
10 DR CHESHIRE: I think the best example would be to go
11 forward about a year and to -- in the situation we were in
12 where serious concerns were being raised about the quality
13 and safety of care at Furness General in maternity and
14 paediatrics. At that time, of course, they were a
15 Foundation Trust, and, therefore, the SHA Medical Director,
16 technically, had no input or responsibility to be involved.
17 Nevertheless, the Primary Care Trust Medical Director from
18 North Cumbria is Mike Bewick, and with the Primary Care
19 Trust Medical Director Jim Gardner, from Lancashire, I
20 believe they were both present -- if they were not then one
21 or other of them was. We sat in my office and talked to
22 Peter on the telephone and said, "You need to take this
23 seriously, when are you going to have an external review?" "Words to the effect of " – I have no exact record of this conversation"
24 The initial response was; "Well, that might be quite
25 difficult. I have talked to my Chief Executive, he does not

1 want to do that sort of thing", is my recollection, I do not
2 have...
3 DR WALTERS: Sorry, what point was this --
4 DR CHESHIRE: This would have been in the autumn of 2011.
5 It preceded the Central Manchester review that was
6 commissioned by Monitor. This was in advance of that, but I
7 could not tell you directly.
8 PROF MONTGOMERY: This is around the time then that the
9 risk summit was called?
10 DR CHESHIRE: It was in front of the risk summit. This was
11 the first time when Mike Bewick and Jim Gardner said, "We
12 have got a real problem; can you help?"
13 At that time, of course --
14 PROF MONTGOMERY: That came from the PCT, not from the
15 Trust?
16 DR CHESHIRE: It came from the PCT, not the Trust.
17 We sat in my office, very quickly, and had a telephone
18 call with Peter -- who I cannot recollect whether he was on
19 his own or there was somebody else with him -- but it was
20 very clear that they were resistant to this idea of an
21 external review. I do not know whether the resistance was
22 the Chief Executive, or his clinicians, or who it might have
23 been. I was very firm with him and said, "Broadly, there
24 are two choices. You either get it inflicted on you because
25 it is going to happen; or you invite one, which puts you in

1 a much stronger position and you may have some ownership of
2 the problem". He accepted that, following some toing and
3 froing. * My recollection not an exact record of the conversation.
4 PROF MONTGOMERY: What was the review to be about?
5 DR CHESHIRE: This was to go and find out whether it was
6 safe to continue with maternity services there.
7 PROF MONTGOMERY: Particularly on maternity services?
8 DR CHESHIRE: Yes. I found – I subsequently made some
9 telephone calls both to the Liverpool Women's and Children's
10 and also St Mary's and recruited the help of Dr Mike Maresh,
11 who was a very experienced obstetrician in St Mary's. My
12 recollection, broadly, is that I rang him up midweek and he
13 went up to Barrow on the Sunday and started work on the
14 Monday. So he was fantastically quick.
15 That review was owned by the PCTs and by
16 Barrow-in-Furness and, well, University Hospital of
17 Morecambe Bay, but particularly Furness Hospital.
18 He made some recommendations about partnership between
19 the small hospital and the Royal Lancaster. He made some
20 recommendations about numbers of patients. He made
21 recommendations about the strange way in which people moved
22 through the obstetric unit. He made sufficient progress to
23 give them some guidance as to what they should do now.
24 It was also a recognised that it is 46 miles to
25 Lancaster, or thereabouts. You cannot just stop providing a

1 maternity service in Barrow-in-Furness. That is a tough
2 call really. He was very helpful.
3 That then went -- the next I knew was a serious
4 incident had been called, which allowed the SHA to launch
5 their Gold Command. I went to the first meeting of Gold
6 Command, which, I believe, was chaired by Jane Cummings.
7 Subsequently that Chair moved to Gill Harris because Jane
8 left and Gill took over as NHS North Chief Nurse.
9 I was not required at any further Gold Command meetings
10 and I didn't attend any further Gold Command meetings. I
11 was no longer required to have any further interest in that.
12 It was with PCTs and with Steve Singleton, who, by that
13 time, was NHS North Medical Director, I was no longer on the
14 Board. I guess if I had been on the board --
15 PROF MONTGOMERY: Can I ask more about the emergence of
16 Gold Command because from outside it is a slightly strange
17 way of responding to the problem. Gold Command is usually
18 very focused and short --
19 DR CHESHIRE: Sure.
20 PROF MONTGOMERY: What do you recall about the
21 discussion about whether the Gold Command was the best way
22 of getting to grips with this problem?
23 DR CHESHIRE: I do not recall the great detail of it. That
24 is the first thing.
25 I thought about this long and hard, since I got my

1 original letter, of what happened. I effectively was told
2 that is what was going to happen. This was a foreign method
3 to me; I had not met it previously, but I did understand it
4 was the only way of an SHA taking direct control of an FT.
5 Therefore, a serious untoward incident needed to have been
6 previously recorded and reported and that was the incident
7 surrounding --
8 PROF MONTGOMERY: Was this an SHA initiative, or did it
9 grow out of the fact that the PCT Medical Directors said we
10 need some external help?
11 DR CHESHIRE: I suspect it was an SHA initiative. I am not
12 confident that was the case but I suspect it was. I suspect
13 that basically because I do not think that -- Mike Bewick
14 may well have known about it, but I would very much doubt
15 that Jim, with his very primary-care background, would have
16 known about this particular method. He might have done --
17 very, very able man -- but I doubt it.
18 PROF MONTGOMERY: One of the things we are learning
19 from this is how many different reports and inquiries and
20 things that are happening. You kicked off just before Gold
21 Command -- the piece of work. Was that co-ordinated with
22 the thinking about Gold Command, or are there two channels
23 that we need to support the Medical Director.
24 DR CHESHIRE: The review by Mike Maresh was to make sure
25 that we had actually -- we had not got a totally unsafe

1 service and to give some recommendations and make certain it
2 was safe while further things happened. So it was, in
3 effect, a life boat.
4 PROF MONTGOMERY: Yes. If you had different feedback
5 from that it might have been a different next step, but Gold
6 Command is the one that follows.
7 What about knowledge of the various previous reports
8 that had already been done by that stage? What were you
9 briefed about that --
10 DR CHESHIRE: I saw the Fielding Report that said there were
11 major problems and there were recommendations; some of which
12 had been implemented and some of which had not.
13 I do not remember the Fielding Report in detail; it is
14 a big long document and I have not read it.
15 PROF MONTGOMERY: Do you remember when you saw it?
16 DR CHESHIRE: It would not have been in 2010. It was more
17 likely to have been 2011. It was most likely to have been
18 when other issues, about obstetric care/maternity were being
19 raised, and then I was made aware. Tracking back then I
20 realise that there had been cardiology-made awareness
21 reports in the distant past as well; but that was the main
22 one.
23 The subsequent report by Grant Thornton on CQC things
24 post-dated that, so that was not part of my reading at that
25 time.

1 PROF MONTGOMERY: We are trying get a sense of what the
2 jigsaw looks like to people. You did see the Fielding
3 Report, but actually quite a long time after it was produced
4 and about the time you have other reasons for being
5 concerned.
6 DR CHESHIRE: I can't remember when it was produced, but I
7 think it was 2009/10, was it, or a little later than that?
8 I did not see it at the time.
9 MR BROOKES: Can I just -- clarification. The Mike Maresh
10 report; did it conclude that the service was safe?
11 PROF MONTGOMERY: Straightforwardly yes or no.
12 DR CHESHIRE: It did not conclude it should be shut. Now
13 that is not -- I am sorry --
14 MR BROOKES: Yes.
15 DR CHESHIRE: -- I am being very hair-splitting here. I
16 think he thought it was safe with some intervention but not
17 beyond repair.
18 MR BROOKES: Thank you; that is helpful.
19 PROF MONTGOMERY: That gets over taken by Gold Command,
20 which is the mechanism for making sure that things happen --
21 DR CHESHIRE: I am pretty certain that was the case. Gold
22 Command was commissioned by Monitor; that was a much more
23 formal set up.
24 PROF MONTGOMERY: Okay. One of the things we have been
25 trying to track down, and I want to check whether you can

1 shed any light on it, I suspect from what you said you might
2 not be able to do so, is the way in which the SHA reached
3 the conclusion of what the Fielding Report meant. At some
4 point in the process it is used as evidence that someone has
5 had a careful look at the cases at Furness General and has
6 concluded they are not connected. We are, of course, trying
7 to pick our way through whether they are connected or not
8 and what the connections are.
9 Two questions really. One is: Do you know who in the
10 SHA would have been asking that question, are these
11 connected; and do you have a view yourself?
12 DR CHESHIRE: I am trying to make an answer make sense. I
13 remember reading the Fielding Report. I do not remember
14 being in a room discussing it and its consequences. I might
15 have been, but I don't remember it. That is not a cop out,
16 that is a genuine "might have been" but I do not remember.
17 There were three senior people who potentially might
18 been involved. There was -- if you exclude the Chief
19 Executive Mike Farrar -- there was Jane Cummings, who was
20 the Chief Nurse; and Anne Hoskins, who was Associate
21 Director of, or Deputy Director of Public Health with a
22 particular responsibility for maternity and child services
23 and safe guarding. There was Ruth Hussey, who was the
24 Director of Public Health. I suspect that before I arrived
25 they were the people who were deeply involved. The only

1 other one would have been a Deputy Medical Director sort of
2 stand-in for some time, whose name I have forgotten and is
3 now a very able Medical Director down in London.
4 I am not aware that anybody else would have been.
5 There were a series of clinical leaders, none of them would
6 have been in that frame. I think that Jane's quality and
7 safety team would have been the team that would have been
8 the key determinant; it was a big and effective team. That
9 is my recollection.
10 PROF MONTGOMERY: Thank you. We have also heard that
11 the SHA had been called in to arbitrate on issues around
12 clinical commissioning strategies and the like, particularly
13 around paediatrics. Can you shed any light on that for us?
14 Would that have called in Medical Directors roles? We are
15 not quite sure when, in the process that was, but was the
16 Medical Director one that got involved in those --
17 DR CHESHIRE: I was not involved in the discussions about
18 the commissioning of paediatrics. I suspect that Anne
19 Hoskins may well have been. Anne -- a very able woman who
20 knows a lot about paediatric services delivery -- but I was
21 not directly involved in that. We had, as you probably are
22 aware, a series of reviews and shifts in services --
23 maternity and paediatrics -- those were not done by me; they
24 were done with Anne and with others and primarily before I
25 arrived.

1 PROF MONTGOMERY: I think I have got one other area.
2 That is around your understanding of the challenges of
3 medical recruitment and staffing in the area. Clear set of
4 issues around it being difficult to get people who wanted to
5 work at in Furness. Some issues around when on the
6 rotations – how experienced people were when they went out
7 there and clinical isolation --
8 DR CHESHIRE: I can give you, hopefully, some insight into
9 that. I mean, it is a highly-deprived area; the most
10 deprived in Cumbria. It is a small population of 69,000.
11 It is a young population. It is pretty static -- if
12 anything it is dropping; it is not going up. Background
13 context.
14 UHMB was part of the North West Deanery and it was
15 generally viewed as, my recollection, is that the junior
16 doctors in training and medical students were quite happy to
17 go to Lancaster, they got good teaching there, it was quite
18 distant but it was well supported, but they did not want to
19 go to Barrow because not only was it quiet – so it is not a
20 great deal to learn -- but there is not much to do when the
21 lights go out. Therefore, it was not a popular place. It
22 is also a very, very long way to drive. It is very
23 difficult to get to by train. So there social life got
24 fragmented substantially, so they did not like that. There
25 is the first thing.

1 The second one is that doctors in general, and there
2 are exceptions, like to be where it is busy; like to be
3 where there is training because you learn -- if you a teach
4 you learn, there is no doubt about that at all; they like to
5 be where there is a buzz; and where there is innovation and
6 things of that sort. Whether it was correct or not, that
7 perception, certainly the perception was that that stuff
8 does not happen there. Therefore it is difficult to
9 recruit. There's the first thing.
10 The second one is you are recruiting in a difficult
11 market. Broadly speaking there is not a surfeit -- or there
12 was certainly not a surfeit of obstetricians and
13 paediatricians of that sort so they had choice and they can
14 choose to go where they would prefer to go. They would
15 prefer to go to some of the big centres. They broadly
16 speaking prefer to be south than north -- plenty of evidence
17 to support that view as well.
18 So, I think, that fishing in that very big pool for
19 high-quality doctors is quite difficult for them.
20 The second one, of course, is that being a smaller
21 relatively quiet hospital, getting the finance to get the
22 numbers of doctors you need is remarkably difficult. That
23 is even difficult in a big hospital. I was reading
24 recently, looking at the statistics for Central Manchester
25 Trust, which is a big hospital, and you may say is

1 irrelevant, but in order to provide a 24-hour service in
2 their A&E department they have got 16 consultants. Well,
3 you stand no chance of providing a 24-hour service on the
4 sorts of numbers you could even afford to finance, never
5 mind recruit on that basis.
6 What I do know is that when -- I cannot tell you a lot
7 about obstetrics but I can move sideways about other areas
8 of clinical practice. When the major trauma work, which I
9 led in the North West, was being done, they needed to be
10 able to provide high-quality, lots of them, emergency
11 doctors at Lancaster. They would simply fail to recruit --
12 not simply failing to recruit because there are not a lot of
13 doctors, but that is the case, but nobody was interested.
14 The only way they could do that would be by getting
15 partnership with Preston, which is a much bigger, more
16 popular hospital. I suspect that the way to do this is to
17 have partnerships with big places with rotations, but they
18 are not that popular with doctors because you -- certainly
19 if you are in a technical speciality, if you are there you
20 know the kit; if you are over here, unless you have got a
21 really good organisation, you don't know the kit; you know,
22 that is when accidents happen.
23 Now, is that in any sense answering your question?
24 PROF MONTGOMERY: It recasts it really, I think. I
25 think that is what I understood.

1 In terms of the Medical-Director role, I mean that
2 creates a couple of worries, does it not? One is about
3 sustainability itself of staffing; the other is about the
4 lack of rotation and the awareness of what goes on in other
5 places. One of them happens, that we are picking up, is
6 that it is not just a geographically-isolated unit, it is
7 also a clinically-isolated unit and a bit of lack of
8 awareness. I wonder whether anything came out of the
9 trainees who did go, on the doctors who were there, raising
10 concerns about the understanding --
11 DR CHESHIRE: I think there was a flick of concern
12 repeatedly and often, but it never reached the level at
13 which the Dean said, "I hold my hands up, I am shutting it
14 down", which she ~~he~~ did in several places.
15 I mean, just as an aside, if you think this is a
16 diversion tell me to stop, but I worked in what I regard as
17 two hospitals under pressure when I was much younger. One
18 of them was an appalling unit -- I will not tell you where
19 or what it was -- but it was under threat of closure and it
20 could not get staff even way back in the '70s. They just
21 pulled stuff in, they stopped going out, they stopped taking
22 new ideas, the registrars that went there tore their hair
23 out in horror. Yet the staff there said, "This is the way
24 we do things". I also saw that in a hospital I had
25 responsibility for closing, where it was not a bad hospital

1 at all, it simply was financially non-viable; again
2 everybody started to pull in. I think that it is almost a
3 biological response to –
4 PROF MONTGOMERY: Given that we know that happens –
5 DR CHESHIRE: I am not surprised.
6 PROF MONTGOMERY: – how does the system watch out for
7 that? Given we know it happens, how does the system find
8 out whether it is happening in a particular place? What's
9 the responsibility of the system, whether it is the PCT
10 Medical Director, or whether it is the SHA Medical
11 Director –
12 DR CHESHIRE: Do you mean –
13 PROF MONTGOMERY: – given what we know about
14 recruitment, given what we know about isolation, is there
15 sucking-in of introspection? Does that put patient care at
16 risk? How does the system make sure that does not happen?
17 You talked about difficulties of recruiting but there is a
18 monitoring question as well.
19 DR CHESHIRE: I think that – do you mean how did it happen
20 or does it happen now?
21 PROF MONTGOMERY: How did it happen and any thought on
22 what we might make sure should happen?
23 DR CHESHIRE: When we talked through future Foundation Trust
24 status with Bruce Keogh and the other medical directors,
25 before we were collectively abolished, the things that we

1 had, by that time, come to realise very strongly, was that
2 the staff and the patient survey would tell you if something
3 was about to happen, even if it had not. It would always be
4 red if it had happened. In fact, to the extent that by the
5 time that became a fairly robust system, and it got more
6 robust during the time I was there -- not because of me but
7 it just was developed -- that we would kick back any FT
8 applications that had a red from the staff on it, or a red
9 from the patients.
10 PROF MONTGOMERY: If you work in an isolated unit and
11 you do not know what it is like elsewhere, you might well
12 say, "I am happy for my family to be treated here", because
13 I know no better, but that will be a thing to worry about is
14 it?
15 DR CHESHIRE: It would be a great thing to worry about. In
16 my experience, for what it is worth, I didn't see that
17 happen. In the fragile hospitals, the red came up quite
18 quickly from the staff. So the staff tend to know --
19 everybody knows; that is problem. My anecdote from the
20 Bristol Inquiry, which I have read about and I have heard
21 about, is 24 different inspectorate organisations knew about
22 this stuff, I guess there was not a shape for the
23 infrastructure to say, well, okay in that case this is what
24 happens.
25 I think that there is a lack of bravery -- this is a

1 personal perception -- that when things are not working,
2 well -- we are inclined to be charitable or not, because the
3 opposite is to be, what's the word -- incisively negative or
4 critical. That is often thought to be, well, not quite the
5 way to do things. Therefore, I think that only happened in
6 the last five years; I think we have got far better at
7 saying, "This does not work and needs to be changed and it
8 needs to be changed soon". Is that an answer or a reason?
9 PROF MONTGOMERY: I do not think it is an answer
10 because, I think, it is something we should be worrying
11 about. Carry on. It is something we all need to worry
12 about, which is if everybody knows that is the problem and
13 if we are not brave enough to get it right, how do we make
14 sure that systems can look out for that and correct it?
15 DR CHESHIRE: I do think I am right, you know. I think
16 there is -- if you really pick into a ward, or a department,
17 the staff will say, "We could have done that better"; they
18 know that.
19 PROF MONTGOMERY: We are ten years on from where we
20 start --
21 DR CHESHIRE: I am not making excuses; I am not trying to
22 rationalise it. I am simply saying that is what, I think,
23 happened.
24 DR WALTERS: Given that insight, what was your view
25 of the quality surveillance methodology of the SHA?

1 DR CHESHIRE: It was very detailed. When I arrived what
2 impressed was how much more detailed it was than the detail
3 that I was getting as a practising clinician in a hospital
4 down the road and how much more detailed it was than I was
5 getting as a senior officer at the Royal College of
6 Physicians. Therefore, the SHA had very detailed
7 information and it also had very skilled staff who collected
8 it and talked about it and communicated it to the hospitals
9 or units concerned.
10 DR WALTERS: I suppose with that reflection, how can
11 an organisation like Morecambe, with a hospital like Barrow
12 in it, how could that not flag on the system? What was
13 wrong with it if it did not?
14 DR CHESHIRE: I think that there is a big problem with
15 flagging once the Trust is a Foundation Trust. The
16 Foundation Trusts will say and have said that we are now an
17 FT and we are not managed by the SHA.
18 DR WALTERS: Did the surveillance system then rely
19 too much on self-populated information from an organisation?
20 DR CHESHIRE: I think there is the SHA data collection,
21 which went through AQA, which is the North West Quality
22 Observatory. There was the information that came from
23 Monitor. There was the information that came from the CQC.
24 Then, of course, there is information that comes from
25 Nursing Council, the General Medical Council, and all other

1 sorts of places. I was not involved in it, as I said, in
2 the FT success, whatever it might be called.
3 However, quite clearly, if you look back, all of the
4 negative features were there prior to FT status except on
5 the Furness and University Hospitals -- the Morecambe Bay
6 self-declaration to CQC, which seemed to be quite good. I
7 think the problem is that people get double-blinded by,
8 "Monitor says this, CQC says that, we have got this
9 information", and yet there is not a shape that says, "In
10 that case you, SHA, or you, Medical Director, are directly
11 responsible to put these things right".
12 I think that there is that real potential for there to
13 be a formal structure once that happens.
14 DR WALTERS: Do you think the problem is that with
15 organisations which are groups of small organisations, the
16 problem is that the indicators are smoothed out between
17 larger and smaller hospitals within that?
18 DR CHESHIRE: I think that is very difficult.
19 DR WALTERS: Is that looked at --
20 DR CHESHIRE: You would have to go to each individual
21 department certainly if you got a large hospital, knowing
22 that somebody has had a visit for a day and said, "You are
23 okay", means nothing. Going into a hospital for a day and
24 saying, "This is poor standard", again means nothing,
25 because every other department might be brilliant. So, I

1 think, they do get smoothed out; I think, it is very
2 difficult to -- it would be very easy to miss the important
3 red lights in that very large amount of data. The minute
4 you corralled it all into one score you have lost it.
5 DR WALTERS: What is your view on why it appears
6 suddenly that they have the worst HSMI in the Country? That
7 had not really been red flagged before --
8 DR CHESHIRE: No. The only thing I can assume is that we
9 had seen it and missed it. I do not know how we could have
10 done that. I do not know. I do not understand how that
11 could have happened. I thought long and hard about that
12 because I thought you might say to me, "Well, okay, Mike,
13 what were you doing? Were you asleep all this time?" Well,
14 I was not asleep, and I cannot give you a sensible answer
15 because I do not know.
16 DR WALTERS: What was the relationship, in the
17 sharing of the information, between the PCT and the SHA like
18 about quality issues?
19 DR CHESHIRE: Well, PCTs and SHAs. The SHA did not vary but
20 the individual PCTs would have quite different relationships
21 with the SHA. Some PCTs were very collaborative. Of
22 course, if you collaborate with me, I collaborate with you;
23 you get a good partnership. Others were less so.
24 The Lancashire PCT, my recollection is, work very
25 collaboratively. The Cumbria one was not so collaborative.

1 That is not to say they were antagonistic, but it was
2 definitely competitive. There was a view that they could
3 run the affairs if the SHA would go away for a while. At
4 times that is quite tense. I went to Cumbria on several
5 occasions with Mike and had some really quite heated
6 discussions -- with Mike Farrar that is. I think they
7 varied and they would start with personalities and then they
8 would go back into history. You would end up with a long
9 historical, "This happened, that happened, the other
10 happened".
11 Once it became obvious that the SHA was going to be
12 abolished, the PCTs were going to be abolished, the
13 relationships became very different. The first part was
14 that I, as a Medical Director in the SHA, had the
15 responsibility for appointing the new people to PCTs as
16 Medical Directors. Bruce Keogh asked us to make certain
17 that whoever we appointed would be capable of doing our job.
18 So we were appointing our successors.
19 Then the PCT's, I think, took much more control than
20 they previously had knowing that we were going. Also
21 knowing that they would probably morph into the CCG and all
22 that went with that. So -- what's the word... The
23 "relationship" changed.
24 Does that answer your question?
25 DR WALTERS: Yes. I suppose, I think, the thing that

1 raises that is that the PCT do not seem to have known about
2 the Fielding Report, so I suppose we are trying to tease out
3 whether that is because the SHA assumed it was the Trust's
4 role to tell them about it; or whether that was part of the
5 compact that the SHA had with the PCTs, that there would
6 have been sharing....
7 DR CHESHIRE: I think that was mentioned in the Grant
8 Thornton review. They could not figure it either.
9 DR WALTERS: Right.
10 DR CHESHIRE: It is 342 sides in that and it was quite a
11 read. I think that the subsequent judgment was; you did not
12 ask, and you did not tell me, and I don't know which was
13 which.
14 I never thought that the SHA was coy about its
15 information. It was more than happy to share. Having never
16 been in an SHA, before I worked in this one, I found it very
17 open, very communicative and very keen to do things.
18 I am not blaming anybody. I think that with so much
19 and so many different people in this larger arena, knowing
20 who is responsible for what at any particular time,
21 especially we had the White Paper, within how many months of
22 the election in 2010 -- the election was 6 May, I think we
23 got the White Paper by the end of July or the beginning of
24 July, and the relationships were off and they were changing
25 all over again.

1 DR WALTERS: When you join the SHA in 2009, at the
2 senior level, what were the big issues?
3 DR CHESHIRE: The biggest issue then was probably -- one of
4 the big issues -- was the FT pipeline. Huge pressure to get
5 Trusts to become FTs. There was very strong encouragement
6 and it was regarded as a sign of success to get them
7 through. I think that is why it was that the responsibility
8 of the Finance Director to do that because in the main there
9 people -- male or female who know how to get things done and
10 get them audited and get them on to paper. There was an
11 assumption that we would get large numbers through. We were
12 one of the SHAs -- London easily the biggest -- where there
13 were quite a number that were not FT, so we were under some
14 pressure to get that pushed through.
15 I do remember, it never occurred again, that there was
16 a huge problem with PCTs and their related Trusts not
17 completing their contracts and we had months of discussions
18 and chairing meetings, and I did a few and a lot of other
19 people did; we were trying to get completion of financial
20 contracts during that year, which was very difficult. It
21 was extraordinarily time-consuming.
22 We had the big review of the maternity and paediatrics
23 services with a move away from -- Salford and that went
24 through at that time.
25 Then we had the new stuff -- trauma; revalidation;

1 and a variety of other things.

2 I think that the biggest thing for me was the White

3 Paper because it stopped strategic thinking in its tracks.

4 Until then North West SHA had been very good at developing

5 new things; not all of them worked but, nevertheless, that

6 is the way with innovation. Talking to the Chief Executives

7 and Chairs that I knew fairly well, they regarded the SHA

8 approach as being supportive and developmental, rather than

9 top-down and do what you are told and they enjoyed that

10 approach. Of course, that stopped. That had been the habit

11 of the SHA and, I think, for a little -- well, what are we

12 here for? Of course we were there to wrap up once that

13 started.

14 DR WALTERS: It sounds then that an awful lot of

15 pressure on getting the finance through informed the

16 targets, to get Trusts through to FT. Then AQA would

17 probably -- slightly arm's length body that was dealing with

18 the qualitative --

19 DR CHESHIRE: Yes. Very effective at arm's length, yes.

20 DR WALTERS: You were saying you had a quality safety

21 and remit but not to do an FT. What did that consist of?

22 DR CHESHIRE: As my role developed and as I got to

23 understand it, which took me quite a few months, I was

24 involved in all the subsequent FT applications and would go

25 with the Quality Team to the hospitals, or the Mental Health

1 Trusts, that were putting themselves forward for FT. We
2 would go through their plans with a toothcomb. So I was
3 deeply involved in those.
4 I didn't manage it, I was there. One of the places
5 that I often found I was most useful was we would have
6 either a brilliant quality strategy that just did not fit
7 with a finance strategy -- could not afford it; or,
8 alternatively, a finance strategy, which everybody was proud
9 of, and a quality strategy had not been fixed. We often
10 were in the situation of saying; "I need a costed quality
11 strategy; I need to understand what that is". I think that
12 eventually became one of the important roles for me, but it
13 was not an important role when I started.
14 DR WALTERS: Thank you.
15 PROF FORSYTH: The issue that we are looking at in
16 maternity services, particularly focusing on Furness
17 General. Small unit; a thousand deliveries; a small number
18 of staff. Yet the Trust, the SHA, Monitor, Care Quality
19 Commission, Gold Command; have not been able to sort the
20 problem out. In retrospect, do you find that easy to
21 understand, or not easy to understand?
22 DR CHESHIRE: I think it is very easy to identify the
23 problems. I think it is extraordinarily difficult to
24 identify the solutions. The reason for that is that there
25 was a recent report on the Isle of Wight: Nowhere near

1 enough nurses; small, very elderly population; isolated from
2 the mainland, as it were, I know only by a small ferry ride
3 but that is the case. Cumbria has the same problem -- not,
4 Carlisle Hospital is the one I am talking about.
5 I do not know how they go in other parts of the
6 Country, but I suspect that these small hospitals need a new
7 and special way of looking at them. I find it difficult to
8 believe that on the current funding formulas, with the
9 current competitive requirement for staffing, and even more
10 important the fact that they are quiet so you are not going
11 to do too much. You will not spend a lot of time doing
12 nothing, but we need you to be there. We need to find a
13 different way and a much more imaginative way of supporting.
14 If we go to Furness General in particular, it is on an
15 isolated peninsular; it does get serious injuries; it does
16 get serious medical and surgical and maternity conditions
17 that need addressing there and then; it cannot just put
18 people in an ambulance and send them away.
19 I do not know what that solution is. It clearly has to
20 be partnership. It clearly needs to be some incentive.
21 They have got to have education and training embedded in
22 what they do. They must have that. You must go there for a
23 reason apart from providing a clinical service.
24 I think we have got locked into a small way of thinking
25 of this, rather than a big way. I could probably write an

1 essay on it and you, at the end, would say you have not got
2 a conclusion and I would not have done.
3 It cannot close. It is needed. It is where it is,
4 because the alternative for the population is too difficult
5 for them to imagine. At the moment I do not know --
6 PROF FORSYTH: There needs to be a place for mothers to
7 have babies in Furness but what about the risk assessments?
8 I mean, it is really trying to balance the risk versus the
9 benefits. The risk of having mothers delivering there and
10 the risk of having to transfer. I mean, being a
11 paediatrician, particularly I am interested in the Special
12 Care Baby Unit there. That is a level one unit, it should
13 not be caring for any sick babies at all and should be
14 transferred out. I see that being a dilemma for all the
15 obstetricians in particular because they want to look
16 after -- this is looking after a complicated case, but then
17 they do not have the neonatal bed and support.
18 DR CHESHIRE: I completely agree with you. I would not want
19 my daughter or son and I would not want us, years ago, to be
20 giving birth to anything resembling high risk in such an
21 isolated area. I think that there is a tradeoff between
22 quality and safety and accessibility. For the population at
23 large, they understand accessibility very effectively; the
24 know that they have a local hospital. When we collectively,
25 as a managerial or clinical community, look at safety and

1 quality, I think most of us would recognise that very high
2 quality and safety -- certainly Jarman would say it is
3 directly related to the number of consultants we have in
4 hospitals and numbers of GPs per populations in the Country
5 at large. I mean, he's done statistical analysis on all
6 manner of things over a number of years. The two big themes
7 that he continuously plays: If you don't have enough
8 doctors and you don't have enough nurses you will not have a
9 safe service. It is pretty much a straight line graph.
10 There is a question as to whether you should have a service
11 there at all. I think that politically, and from a
12 population point of view, they would say, "We need
13 something. We could not have nothing". Then if you say,
14 well, we will have a high-quality triage service. We all
15 know that high-quality triage needs high quality staff; it
16 is not just a tick list.
17 You also need very high-quality transport. 46 miles on
18 a motorway, with a police escort, is 46 minutes. It is not
19 around the small country lanes. I know there is a big
20 feeder road once you get out of Barrow, but, nevertheless,
21 that is a difficult drive. I have tried it myself and it
22 does not matter what you try you will not get it in under an
23 hour. I guess you would if you have blue lights, but I
24 couldn't do it in the car.
25 I do not know the answer to your question but you are

1 from Scotland and you have many rural areas in Scotland.
2 Now I have not read about the risk assessments of the
3 isolated areas in Scotland, but I do understand from the
4 Scots that they seem to have addressed many of these
5 problems -- or maybe I am wrong? Maybe NHS England should
6 go to NHS Scotland and say, "How do you do this?" Is that a
7 reasonable answer?
8 PROF FORSYTH: Well, I think we have got some of the
9 examples and, I think, that there are is always going to be
10 an element of risk. You will never reduce risk but, I
11 think, you will not eradicate risk but you can certainly
12 reduce risk.
13 DR CHESHIRE: Yes.
14 PROF FORSYTH: Matters around looking at what is safe
15 to provide in certain locations, and more risk than that,
16 move out. That is finding the level of risk and level of
17 care that you are happy with.
18 DR CHESHIRE: I could not agree more but, I think, that the
19 interesting thing is that even when you do that in a
20 conurbation like Greater Manchester, where there is the big
21 "healthy together" thing at the moment, nobody can agree
22 about what they will do. Everybody says, yes. In Greater
23 Manchester you can have big centres, it is not that
24 difficult. You can have smaller centres, it is not that
25 difficult. They could talk on the phone, it is not that

1 difficult. I do not know who is going to have the skill to
2 bring that lot together. I think it is much more difficult
3 when you are far from the centre.
4 I mean, I am in danger of repeating myself; I do not
5 want to do that.
6 PROF FORSYTH: It is a difficult problem. We are
7 not -- it is not our remit to reconfigure the services.
8 DR CHESHIRE: I think it's vital because if all we can do is
9 say, "This is a problem", and not solve it, then it
10 continues to be a problem; we continue to put mothers and
11 babies and others at risk. We have to find a solution. I
12 would love to be able to help but I --
13 MR BROOKES: Just a couple of questions. Were you involved
14 in the board-to-board Foundation Trust for Morecambe Bay
15 Hospital? Do you recall?
16 DR CHESHIRE: Can you tell me when it was?
17 MR BROOKES: I cannot actually. Clearly even if you were,
18 you do not recall it that well.
19 DR CHESHIRE: I do not.
20 PROF MONTGOMERY: 2008.
21 DR CHESHIRE: No.
22 MR BROOKES: Okay. There was two board-to-boards.
23 I was interested in -- you must have interacted with
24 the Board; more than Medical Directors or just with the
25 Medical Director?

1 DR CHESHIRE: Mainly Medical Director.

2 MR BROOKES: You were not able to form a feeling, an

3 assessment of the quality of the Board --

4 DR CHESHIRE: Of the Board, no. I can volunteer an opinion

5 about the Chief Executive and the Chair --

6 MR BROOKES: That will be helpful, thank you.

7 DR CHESHIRE: -- should you wish. I thought they were both

8 very defensive. At the Gold Command they did not want

9 people to be involved and they thought they could handle the

10 problem.

11 DR WALTERS: Who is "they"? Chief Executive and

12 the --

13 DR CHESHIRE: The chair. Eddie Cane and -- I can't remember

14 the Chief Executive.

15 DR WALTERS: Tony Halsall.

16 DR CHESHIRE: Yes. I have seen that before in FTs that have

17 only just got on by the skin of their teeth, or the

18 fingernails. Of course, they had and they knew it and I

19 think they were in the frame for trying to fix it. I think

20 that probably they were very committed to fixing it and only

21 realised, as time went by, that this just was going to

22 escape them and they couldn't it. They were defensive. I

23 cannot go beyond that. I do remember thinking, "Gosh, this

24 is an unusual meeting, I have not had things like this

25 before".

1 PROF MONTGOMERY: Can I just test that last bit because
2 we have heard from other people that they felt that by the
3 time the Gold Command -- the Trust was looking for some
4 help. Is your observation about the Chairman and Chief
5 Executive consistent with that? That is to say the Chair
6 and Chief Executive might have thought they could handle it,
7 but below them, the team was realising it needed assistance?
8 DR CHESHIRE: My recollection of the meeting is that the
9 emotional context of it was not that they were asking for
10 help. They may have done later on but that first meeting
11 that did not feel like it to me.
12 PROF MONTGOMERY: I was asking about whether you felt
13 if the Chair and Chief Executive were like that and the rest
14 of the organisation realised they were struggling, did the
15 Medical Director, for example recognise the need for help,
16 or was the Medical Director also felt we can handle it?
17 DR CHESHIRE: I think if he said he could handle it he knew
18 he could not.
19 MR BROOKES: Any further questions? Thank you very much.
20 That has been extremely helpful.
21 DR CHESHIRE: Are you sure?
22 MR BROOKES: Yes. Thank you very much.
23 DR CHESHIRE: Thank you.
24 ———————————
25

THE MORECAMBE BAY INVESTIGATION

Tuesday, 4 November 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

JENNIFER CLAY

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1 (At 11.44 a.m.)

2 DR KIRKUP: Hello. I'm Bill Kirkup. I'm the Chairman of the Investigation. I'll ask
3 my two colleagues to introduce themselves to you.

4 PROF: FORSYTH: Good morning. I'm Stewart Forsyth. I'm a paediatrician and
5 Medical Director from Dundee.

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

9 DR KIRKUP: You'll see that we're recording proceedings.

10 MS CLAY: Yes.

11 DR KIRKUP: We'll produce an agreed record at the end. You may also know that
12 family members are invited to be present as observers. As it happens, we
13 don't have any with us this morning but they may listen to the recording
14 subsequently. You'll also know that we've asked you to leave behind any
15 mobile phones, tablets, that might act as a recording device. That's just to
16 emphasise that we don't want anything to go outside of the room until we
17 produce the report with the findings in context.

18 MS CLAY: Am I allowed to say to anybody that I've attended this inquiry or
19 anything, because –

20 DR KIRKUP: Yes, the fact that you're attending this morning is public; it's on the
21 investigation's website.

22 MS CLAY: Oh, right. Because I didn't really know whether I should be saying
23 things in general when people say 'What's happening?'.

24 DR KIRKUP: Yes, you're very welcome to tell them that you've attended. You
25 may tell them in general what the subject areas were, but nothing more than
26 that, particularly nothing about what questions or what answers you gave
27 because, as I say, we want to hold everything back until we can produce a
28 report with everything in context.

29 Any more questions from you about the process?

30 MS CLAY: Well, not really, no. I don't really know what I'd be able to elucidate to
31 the situation.

32 DR KIRKUP: That's alright. I'm going to start off with a general question and then
33 I'll ask my two colleagues to come in in turn. But my general question is:
34 you started in the Cumbria Intelligence Observatory, is that right?

1 MS CLAY: Yes.
2 DR KIRKUP: In 2008?
3 MS CLAY: Oh, I pre-date the Cumbrian Intelligence Observatory.
4 DR KIRKUP: Okay, tell me when you started then.
5 MS CLAY: Oh, gosh. I've worked in public health for over 20 years. I mean, I
6 worked with Peter Tiplady if you can remember him.
7 DR KIRKUP: Yes, I do.
8 MS CLAY: I mean, I started when it was East Cumbria Health Authority.
9 DR KIRKUP: Okay.
10 MS CLAY: And I went through all the reorganisations of the NHS in Cumbria for
11 30-odd years.
12 DR KIRKUP: So when was the Cumbria Observatory formed then? It must have
13 been before 2008, wasn't it?
14 MS CLAY: Well, that was always John Ashton's, sort of, little sphere of
15 importance. You know, sort of taking over from the public health, the
16 regional public health observatories.
17 DR KIRKUP: Yes, I see.
18 MS CLAY: And it was when he sort of came into post, we were all sort of going to
19 work in very close relationships with the county council, partner
20 organisations, which is the police and fire service and anybody else who
21 wanted to join the group. It was all sort of a very loose organisation. I
22 mean, prior to John Ashton arriving we always did have a very good
23 relationship with the county council and we did share information where we
24 could. So, I mean, it sort of became more formalised then and it was
25 badged up a bit.
26 DR KIRKUP: Okay.
27 MS CLAY: Yeah.
28 DR KIRKUP: And are you still working there?
29 MS CLAY: Now, I was made redundant last year.
30 DR KIRKUP: Oh, I'm sorry.
31 MS CLAY: Following our transfer from the NHS. I mean, I couldn't do my job in
32 the council.
33 DR KIRKUP: So 2013 you didn't go to the local authority?

1 MS CLAY: Well, I transferred 1 April 2013 to Cumbria County Council but it was
2 an impossibility to do a public health job in the county council because I
3 dealt with patient identifiable data.
4 DR KIRKUP: Right.
5 MS CLAY: And I just could not access that data.
6 DR KIRKUP: You couldn't access the data? Okay, understood. Thank you.
7 Julian.
8 MR BROOKES: Okay, thank you.
9 Could you just describe the role you had when you were working with
10 John Ashton at the PCT?
11 MS CLAY: Yes. Well, basically, I was one of a small team of public health
12 analysts. There was only a team of three really. We had a senior analyst
13 and then there was myself and we had a data assistant below us. And we
14 sort of just dealt with the general public health data requests that came in
15 and also tried to feed into all the other commissioning process that was
16 going on at the same time. It was always an area... in public health you
17 were always sort of flying by the seat of your pants almost. You didn't know
18 what you were going to be doing really on a day to day basis because it just
19 depended on what happened, if there was the news, what happened and
20 things like that; you responded to certain things.
21 And, as you know, John was quite a character. And he sort of
22 wanted a very small lean, mean fighting machine when he moved to
23 Cumbria because the intelligence team actually used to sit within public
24 health; we were part of the wider team. But when John took over we were
25 moved into the Information Department. And that's when our role got sort
26 of slightly diluted a bit because we got pulled into doing other things rather
27 than just concentrating on public health work as well. And you just seemed
28 to lose the impetus of what was going on in the department because you
29 weren't part of the bigger sphere of things.
30 MR BROOKES: Okay. So during your time there, there was a number of reports
31 that John produced –
32 MS CLAY: Oh, yes.
33 MR BROOKES: One was on maternity and –

1 MS CLAY: When John first started he always had a very keen interest in
2 maternity services and he wanted to, sort of, do a series of reports on the
3 lifecycle of Cumbria. And I was involved in writing *Born in Cumbria*. And it
4 was sort of looking at what was happening now compared to what was, in
5 theory, happening at the turn of the 20th century and what happened post
6 formation of the NHS and how maternity had changed so much, how giving
7 birth used to be such a life threatening situation and all of a sudden with the
8 impact of public health and better nursing care how standards changed.
9 And then we were trying to look at how maternity services were being run
10 throughout the districts and trying to compare things.
11 MR BROOKES: And from that report was anything highlighted through the
12 analysis that you were able to do about Morecambe Bay in particular? Did
13 that stand out as a particular set of issues around maternity services?
14 MS CLAY: It's not an easy thing to analyse, maternity data, because this is what I
15 found. Because, basically, I don't know whether you're familiar with dealing
16 with hospital data. You have what we call the admitted patient care data
17 set. And that's very good at looking at what's happening to somebody
18 who's admitted with an illness and their journey in the hospital. But when
19 you start looking at maternity services, that's when it falls over. You can
20 certainly find out how many people have been admitted into obstetrics and
21 things like that but, you know, there was also... and when I was trying to get
22 this data I was sort of hitting obstacle after obstacle. And then I suddenly
23 found out West Cumberland Hospital in Whitehaven recorded some data
24 better than they did in Carlisle. And then other data you couldn't find for
25 Morecambe Bay. And when I sort of investigated further, what they used to
26 do was complete something called the 'Maternity Tale'. And we actually
27 didn't subscribe to getting the data from the Maternity Tale. And I
28 approached our information team to say, 'Why don't we routinely look at this
29 data?' And nobody had asked them to do it.
30 MR BROOKES: So, just to be clear, there was a data called set Maternity Tale?
31 MS CLAY: Maternity Tale.
32 MR BROOKES: Which the Trusts in Cumbria were completing?
33 MS CLAY: I can't honestly say because the way the Information Department was
34 set up I couldn't actually go and retrieve data; I couldn't approach the Trust

1 and say 'I want this data'. Somebody else had to do that on my behalf. I
2 was told I'm an analyst, 'you analyse data; you don't collect data'. That's
3 what I was told by our senior manager from Information.
4 MR BROOKES: Okay. But there was this data set called the Maternity Tale?
5 MS CLAY: Yes, but I don't really think it would have answered everything you
6 wanted because I think it was more or less like a voluntary thing that was
7 completed.
8 MR BROOKES: Right. Because that's what I was trying to understand: what were
9 the requirements? Do you know what the requirements of the Trust were in
10 terms of data sets they needed to complete on maternity? And did you –
11 MS CLAY: I couldn't actually honestly say what is statutory required to be
12 completed for this purpose because one of our greatest difficulties was in
13 maternity services, particularly in light of teenage pregnancies, was trying to
14 find the age of a mother. And, you know, time and time again you tried to
15 find out 'how can I find out the age of the mother giving birth?'. And I
16 couldn't do it. I mean, John would go and meet with the clinicians and such
17 like and 'oh, yes, this information is collected' but it depended on what
18 actually gets entered onto the systems for the data retrieval. I mean,
19 because medical records, they contain so much information and there's
20 only a finite number of fields that you can enter data into. And the process
21 of how they decide what's done, I just do not know.
22 I mean, it was almost like a game of trying to find alternate routes in
23 to try and get data to analyse. As I said, I would go in and, sort of, just take
24 a download of people who had gone in under the speciality of obstetrics.
25 And I would have to eyeball the records to see what I was wanting. And
26 you must realise when you're looking at data there's about 10 or 12
27 diagnostic fields you've got to sift through as well to find out what's going
28 on. There's like a history you have to follow. And because you have your
29 primary diagnosis, which would be like a maternity event, a birth or
30 something like that, but it might not even be recorded as a live birth or a still
31 birth or something like that. I mean, it's just one of these things. It's all
32 subject to the quality of the data that's been input.
33 MR BROOKES: Well, it sounds like it's more than that as well. It sounded to me
34 like you were saying there was an inconsistency in what data was collected.

1 MS CLAY: Oh, yes there is.
2 MR BROOKES: And then secondly there's an issue about quality of data.
3 MS CLAY: I mean, I think talking as a person who dealt with data, I mean, I'm not
4 the ideal person to talk on data retrieval but I know my colleagues who used
5 to design the databases acted as the warehouses for us to pull the data off.
6 It used to be a constant battle trying to get systems to match up because, I
7 mean, there's no national system that said 'you have to put your data in
8 here'. I mean, people can just go off and buy whatever package they
9 wanted to enter the data into. And, I mean, as long as it records the
10 minimum data set that's required by the information centre that's what you
11 work with.
12 MR BROOKES: And does that minimum data set not cover the kind of information
13 that is useful for making assessments of the quality of service, for example?
14 MS CLAY: I think a lot of what the issues are... there was a certain time constraint
15 as well to try and get work done. And I could maybe sit for two or three
16 days scrolling through medical records trying to find out the cases you were
17 looking for. And you had to match NHS numbers and patient IDs and things
18 like that. And, you know, it's like a path that people have to follow, sort of
19 thing, and it's not easy to work with. And it was quite an achievement for
20 me to get out what I did because I certainly did find that it sticks in the
21 memory when I was looking at, like, caesarean sections and things like that;
22 there was a higher proportion of caesarean sections in the south of the
23 county than elsewhere. But you didn't get the full detail if you had a... You
24 know, but then it was trying to say, well, what was the outcome? You
25 couldn't just say 'has that baby lived or died?' or something like that. It's not
26 easy.
27 MR BROOKES: And you may not be aware of this but was there any discussions
28 that you were aware of between PCTs as commissioners of services about
29 specifying what they required as part of their contracts in terms of data?
30 MS CLAY: I think there was always ongoing discussions about improving the
31 quality of data.
32 MR BROOKES: Well, that's different. I'm talking about actually specifying what
33 information was required.
34 MS CLAY: I wouldn't know; I wasn't party to the commissioning process.

1 MR BROOKES: Okay.
2 MS CLAY: This is what –
3 MR BROOKES: But from what you saw there was no indication that there was a
4 comprehensive data set for maternity services that was consistent across –
5 MS CLAY: Across the county? No, there wasn't. There wasn't.
6 MR BROOKES: Okay.
7 MS CLAY: There was no overall that you could just go and say 'this is a maternity
8 data set; look at that'. It was not available.
9 MR BROOKES: So would it be fair to say that it was difficult to make informed
10 judgements about the quality of maternity services in particular areas?
11 MS CLAY: I would say so, yeah. I mean, you can compare but the thing is the
12 way I was told with my public health, I mean, you need to compare yourself
13 with somebody. And if there's nobody else to compare yourself with how do
14 you know if it's good or bad? And this is what we struggled with, is getting
15 the comparator data to say 'this is a problem', 'that's a problem'. I mean,
16 the only consistent thing we ever had to sort of work with was what was
17 provided with us from the Office for National Statistics was the annual vital
18 statistics which looked at live births and still births. But then the trouble with
19 those was that they were delayed by up to six months into the following
20 year. You were always looking retrospectively at what had happened.
21 And I know if we ever did find anything particularly in the case of
22 early infant deaths and that we always did investigate them because, I
23 mean, we used to have ongoing problems in Whitehaven; we had problems
24 in the maternity unit there and situations were investigated. And if we had
25 any issues we would raise them and say 'look, there's something going
26 wrong'. We would sort of say 'look, this is above the expected average that
27 you would want'.
28 MR BROOKES: Did you do any analysis of that type for Morecambe Bay?
29 MS CLAY: It wouldn't be done for the whole of Morecambe Bay; it would just be
30 done for Cumbria because we were just a resident-focused organisation.
31 MR BROOKES: But if you had potentially specific serious incidents at a particular
32 maternity unit was that something which you would look at?
33 MS CLAY: Well, what we used to do is we used to produce this form, this vital
34 statistics form, and send it off to all the senior officers showing if it was

1 higher rates than expected and things like that for action to be taken or
2 anything. And, I mean, once it left me I don't know what happened to it.
3 MR BROOKES: Can you recall whether Morecombe Bay was high or...?
4 MS CLAY: Personally, I can't remember it. I mean, if I was still at work I could go
5 to the file and look at it. I mean, if there was anything untoward it would be
6 highlighted and brought to people's attention because the way the county
7 was organised, there was a senior manager within public health who was
8 responsible for either South Cumbria, West Cumbria or East Cumbria and it
9 would go to them and we would say 'look, there's something going on'.
10 MR BROOKES: Okay.
11 MS CLAY: But nothing really springs to mind.
12 MR BROOKES: Do you recall whether there was any conversations or ask for
13 analysis around a cluster of serious incidents at –
14 MS CLAY: My senior manager would probably have been involved with some of
15 those discussions because, I mean, I know at the time there was a lot of
16 work done looking at what was happening with maternity services and with
17 deaths in particular. But I wasn't party to that so I don't really know what
18 the outcome of that was. That was my manager, [Martin Ewin?]
19 MR BROOKES: Okay.
20 MS CLAY: And we just used to provide the information to them and what they did
21 with it outwith us I cannot say.
22 MR BROOKES: Because one of the things we have been struggling to
23 understand is there were five cases together in maternity services at Barrow
24 and somewhere along the line a conclusion was reached that they were not
25 linked. Do you recall whether there were any discussions about this –
26 MS CLAY: I wouldn't be party to any... I wasn't part of public health so I wasn't
27 party to any discussions that went on. So, I mean, no doubt they would be
28 discussed within public health. I can remember various people coming to
29 me and saying 'can you give us the figures?'. I can only give them the
30 figures that I have. I mean, a lot of this, in my personal opinion, somebody
31 would actually probably need to go and look at the medical records to see
32 what was going on. Whether that had been done I don't know.
33 MR BROOKES: But it wasn't done to your knowledge?

1 MS CLAY: Not to my knowledge. I mean, historically when we'd had an incident
2 at Copeland this used to be done; people would go down and we'd have
3 specialist trainees in public health that would go on too and see what was
4 going on and such like.
5 There's another issue as well when you're looking at maternity
6 services and particularly when babies die: it's how they're coded. It's not
7 coded to the ICD-10 classification; it goes to the Wigglesworth codes.
8 MR BROOKES: I'll take your word on that. I've not heard of Wigglesworth codes.
9 MS CLAY: It's what is called the Wigglesworth system and it's a very loose
10 classification because so many first-week deaths it can be just due to
11 prematurity as well. But you don't really know what's happening unless
12 you've looked into details of what's gone on with that baby's death. Has
13 anybody ever mentioned to you ~~[the Kesdey?]~~ CESDI.
14 MR BROOKES: Yes.
15 DR KIRKUP: Yes, we know about ~~Kesdey~~ CESDI. We know about Wigglesworth
16 too, believe me.
17 MR BROOKES: Sorry.
18 DR KIRKUP: It's named after a guy called Ian Wigglesworth who I've certainly
19 met.
20 MS CLAY: Because this was always the anomaly within the county: the north of
21 the country fed into ~~Kesdey~~ CESDI and the south didn't. And, you know,
22 sort of local systems developed for looking at maternity services. And this
23 was in the northern and Yorkshire part but I don't think a similar situation
24 was in the north-west.
25 MR BROOKES: Yeah.
26 DR KIRKUP: That's right.
27 MR BROOKES: So just to reflect what I think I've heard, which is that there was
28 inconsistency in terms of data collected, inconsistency about quality and
29 difficulties in terms of making comparisons with like with like, difficulty in
30 identifying from that whether there were any particular trends that should be
31 investigated.
32 MS CLAY: Mm-hmm.

1 MR BROOKES: Were there any particular issues around quality of data for
2 Barrow-in-Furness as well or from Morecambe Bay? Was that an additional
3 issue or was that something they were as good as anyone else at?
4 MS CLAY: Once again, I am sort of coming in as a third party on my take on what
5 people said to me. This is not a personal experience but Morecambe Bay
6 was always referred to as a 'black hole'. There was always difficulties
7 getting data out of Morecambe Bay and I don't know why but it would be
8 somebody else –
9 MR BROOKES: Was that general and not just maternity services? It was all
10 services?
11 MS CLAY: It was not just maternity services; it was all sort of data issues as well.
12 Because, I mean, even latterly when you were trying to sort of monitor
13 breastfeeding and things like that you couldn't do that. Smoking and
14 pregnancy. I think a lot depends on which actual data recording system
15 was being used at the time. It limited what could be entered onto it.
16 Because I know when we transferred over to the county council last year, I
17 mean the worry was how you were actually going to get your hands on the
18 breastfeeding data because the work it took to get it was so involved. It
19 was just a worry.
20 DR KIRKUP: Can I ask: did the difficulty in extracting data from Morecambe Bay,
21 did that apply before the Trust merged do you think? Could you get data
22 from South Lakeland and from Barrow?
23 MS CLAY: I think, going back historically, I think we looked at data differently. I
24 think because I sort of came from the north you were always very much
25 more... because my Director of Public Health, he was a statistician, he was
26 always very involved in looking at figures and, sort of, looking at what was, I
27 would call, the bread and butter public health which is your infant deaths
28 and that sort of thing. And then that changed because somewhere in the
29 process – it's not just since 2006 or whatever – somewhere over that time
30 commissioning seemed to water down what public health did. And you sort
31 of just, on a personal basis you tried to keep doing what you always used to
32 do and you used to wonder 'is anybody actually doing anything with this?'.
33 You never knew.

1 And I think because Cumbria as well, they were at the forefront of a
2 lot of the initiatives with GP commissioning and things like that. And I think
3 sometimes that took overall preference to anything else that was going on.
4 DR KIRKUP: So from your perspective that was when the decline in the flow of
5 data began?
6 MS CLAY: I wouldn't say there was a decline in the flow of data.
7 DR KIRKUP: Okay.
8 MS CLAY: I would just say the data flowed but it was bringing two systems
9 together and things like that because you used to go to the national clearing
10 house to get your data back and things like that.
11 DR KIRKUP: Sure.
12 MS CLAY: And you would get this job lot of data back that the information centre
13 deemed that's what you wanted.
14 DR KIRKUP: Okay.
15 MS CLAY: But then you say 'I certainly[?] don't want to look at what they want to
16 look at'. We're not counting how many people have been on waiting lists or
17 done this, done that or whatever; I want to go and look at more detail at
18 something else. And that's when you used to have to go and approach the
19 Trust directly to get the data from them.
20 DR KIRKUP: What I am trying to get at is: is there difficulty in getting data from
21 Morecambe Bay? Is it something to do with the fact that they're a combined
22 Trust that looks in several different directions?
23 MS CLAY: Probably –
24 DR KIRKUP: Or did it predate that? Hang on, there's an alternative. Did it
25 predate that? Was it always actually a bit difficult to get stuff out of Barrow
26 when it was Barrow and South Lakeland or whatever it was? South
27 Cumbria Health Authority.
28 MS CLAY: South Cumbria.
29 DR KIRKUP: Yeah.
30 MS CLAY: I think the problem used to be was splitting the data for South Cumbria
31 and North Lancashire sometimes maybe.
32 DR KIRKUP: Yes.
33 MS CLAY: I don't know.
34 DR KIRKUP: That's what I'm getting at really.

1 MS CLAY: I mean, that would be done on a central... I mean, the classic one,
2 once you get the system set up in place that you have a postcode look-up
3 table and anybody with that postcode gets fired over to Cumbria; if it's not
4 that it goes to Lancashire.
5 DR KIRKUP: But you were suggesting there was a difficulty getting the data out of
6 Morecambe Bay in the first place. Or have I picked that up wrong?
7 MS CLAY: I am talking about going in to get the more specialist requests of data.
8 It's maybe staffing issues and things like that that people weren't there. I
9 mean, I used to work a lot with cancer data and things like that and you'd
10 suddenly find it was more easy to get cancer data out of one person than it
11 was out of somebody else, and if somebody was off nothing got done.
12 DR KIRKUP: Sure. Okay.
13 Sorry, Julian.
14 MR BROOKES: That's absolutely fine. Just on that bit, there was a couple of
15 other things along that line, historical line, as well because exactly the point.
16 Because we are aware, for example, that they introduced a new data
17 system. And I wondered whether or not that exacerbated the position as
18 well.
19 MS CLAY: I think it did do.
20 MR BROOKES: But it was bad before that as well?
21 MS CLAY: I think it always has been bad. I think it's not... I don't know enough
22 about the data collecting systems to be able to comment on the quality of
23 them. I mean, that was my colleague, [Phil ~~[Burchem?]~~ Bertram, who would
24 go in and get all this data and that. And, I mean, I would go down and you
25 would hear mumblings that their system was crap and, you know, crap-in,
26 crap-out sort of thing. And, you know, you're just party to those sorts of
27 conversations when you've just sort of walked down the corridor and said
28 'Phil, by the way, I've been asked to do this; do you think you can try and
29 get this data for me?', 'I'll try'. And it would come in and you've never
30 get... But sometimes it was just the different formats it would come in and
31 things like that. It's not just like going in and you can get everything just
32 coming in one nice big download; you had to sort of match things up and it
33 never came out in complete fields and things like that.

1 MR BROOKES: Okay. So if you wanted to look at something specific around
2 maternity services at a particular Trust would that most likely be a bespoke
3 request of information?
4 MS CLAY: I think it would have been... I think a lot of the issues might well have
5 been that, you know, in theory you think everything's available and it should
6 be but sometimes you can put data in but people don't actually give a lot of
7 thought about how you get data out. And, you know, I know John met with
8 all the clinicians and things like that and 'oh, you should be able to find out
9 on a weekly basis how many babies are born'. Have you ever tried doing
10 that? You cannot find out how many babies are born on a weekly basis.
11 You would have to actually ring up maternity units and say 'so-and-so, can
12 you tell me how many babies you've got on your book?'. And then if you
13 got to Barrow or Lancaster, how can you ask them how many Cumbria
14 babies have been born? They wouldn't know.
15 MR BROOKES: So poorly designed systems?
16 MS CLAY: Poorly designed systems, I would say.
17 MR BROOKES: Poorly inputted information potentially? Making it difficult, taking
18 your analogy of crap-in / crap-out.
19 MS CLAY: Uh-huh.
20 MR BROOKES: So concerns about the quality of data input, put it that way.
21 MS CLAY: Yes, I mean I suppose it's one of these things. I mean, I always
22 remember it used to be when you were analysing data and you were
23 looking at babies being born it amazed me how many men actually gave
24 birth. You know, it's just silly little things like that.
25 MR BROOKES: Yeah.
26 MS CLAY: And, I mean, how come somebody hasn't said 'you don't have
27 male...'? You know, you don't have that field on it. I mean, sometimes
28 people just punch things in incorrectly and, you know, it's easily done
29 because of the volume of what they're putting through.
30 MR BROOKES: From talking to your colleagues from across the North-West, etc.,
31 was this a specific or particular problem to yourselves or was this a general
32 issue in terms of the quality –
33 MS CLAY: I actually don't think other areas within the North-West could do what
34 we could do with data. Because I think whenever I had meetings with the

1 North-West region we were very fortunate in Cumbria that we had access to
2 the GP databases and we could actually link data and things like that. And
3 everything we did was done to the best of our abilities and I think we were
4 actually sometimes a bit of trailblazers with what we could do with data.
5 And I just don't know how this went wrong. I just do not know how this
6 happened. I mean, I can actually remember talking to Mr Titcombe on the
7 phone. He was desperate. He had spoken to them at Barrow wanting to
8 know what had happened. They wouldn't speak to him. And he came
9 through to Public Health as a last resort and I happened to pick the phone
10 up. And I said, 'Look,' I said, 'If there's any untoward incidents they should
11 be investigated.' I don't know why they weren't investigated on-site. I
12 mean, I knew they would be investigated elsewhere.
13 MR BROOKES: Okay. But that wouldn't have been something that would have
14 come to you; those investigations wouldn't have come to you specifically at
15 the –
16 MS CLAY: They wouldn't come to me, no. I think it was just desperate trying to
17 find out what else had happened at Barrow.
18 MR BROOKES: Yeah.
19 MS CLAY: And the trouble is with data, it's confidential.
20 MR BROOKES: Sure.
21 MS CLAY: And there's only a certain amount of data you can share with the
22 public. There's so much you can... I used to have this data, NHS / non-
23 NHS, and you couldn't share it outside the building. And –
24 MR BROOKES: Okay, just one final question from me. During your time there
25 were you asked or aware of any specific bespoke pieces of work which
26 were done around maternity services in Morecambe Bay from a PCT
27 perspective?
28 MS CLAY: There might well have been certain things where they've looked at
29 things. I wasn't asked to do anything. Personally I wasn't asked to do
30 anything. I think my manager might well have done something. I don't
31 know.
32 MR BROOKES: Okay.
33 MS CLAY: But, I mean, I can tell you what we used to have in terms of we did
34 keep records of what happened to any deaths in children under 17 because

1 it was fed into the ~~Kesdey~~ CESDI inquiry and we had an ongoing
2 spreadsheet of every death that occurred. And people did come and look at
3 those deaths.
4 MR BROOKES: So you would have had sufficient information to see 'oh, hang on
5 a sec, there seems to be a cluster of deaths here' or –
6 MS CLAY: Yeah, and that data was taken away and somebody else dealt with it
7 and I don't know who dealt with it but –
8 MR BROOKES: So despite the complexity of the information system and
9 challenges –
10 MS CLAY: We found other ways round of doing it. Because what we used to get
11 – we were very fortunate – we used to get birth and death certificates.
12 MR BROOKES: Okay.
13 MS CLAY: And if we found any deaths under 17 or 18 we used to record it
14 because that was basic public health.
15 MR BROOKES: Yeah. So just to make sure I'm clear on this, there would have
16 been sufficient information available within the PCT to have identified there
17 was a potential concern in a particular Trust, be it Barrow or whatever, so
18 further investigation could happen.
19 MS CLAY: There might well be an issue though because the trouble is it might not
20 be Barrow; the death might well have occurred outwith Barrow.
21 MR BROOKES: I understand, yes.
22 MS CLAY: This is where some of the issues –
23 MR BROOKES: Yeah, but if there was information about a particular Trust you
24 would have had sufficient information to be able to say 'hang on a sec, that
25 looks a bit strange; we need to do further work on that'.
26 MS CLAY: And, I mean, it was looked at. That data was looked at. I didn't
27 because it was my colleague, it was our data assistant who used to take
28 this from the routine birth and death certificates and keep it.
29 MR BROOKES: Yeah.
30 MS CLAY: And, I mean, it was always fed up the line, what was going on.
31 MR BROOKES: Okay. Thank you very much.
32 DR KIRKUP: Thank you.
33 Stewart.
34 PROF: FORSYTH: So did you provide an annual perinatal report?

1 MS CLAY: I know I didn't do... No, I didn't do perinatal reports. I mean, all I used
2 to do was produce a report of vital statistics which just showed you your
3 births, your deaths, your first week deaths, your neonatal, your still births
4 and all this. Broken down for Cumbria, the six districts, with a national
5 comparison. And that originated from the vital stats forms that we used to
6 receive from ONS. And that would be for the previous year's occurrences.
7 And if there was anything untoward, as I said previously, it would have been
8 highlighted in red on the report when it was fed up to managers.
9 PROF: FORSYTH: So there was no report available on actual death rates in
10 terms of looking at other outcomes in the perinatal period, for example, from
11 the baby's perspective, the number of days in intensive care or –
12 MS CLAY: No, we couldn't have done that type of work. You know, it's this
13 journey in... It's very difficult to find the patient journey because, I mean, at
14 the end of the day you were counting first finished consultant episodes
15 which you were counting people, not episodes. And tracing this episode
16 because you can end up in maternity the baby is born and then it's
17 transferred to SCBU or somewhere like that. And it's trying to find that
18 journey where it's been sent to SCBU and then it's been poorly and then it's
19 sent on somewhere, maybe to Newcastle or Manchester or something like
20 that. And it's actually picking up that journey; it's not easy.
21 PROF: FORSYTH: So that information is not available?
22 MS CLAY: No.
23 PROF: FORSYTH: To anyone? To the clinicians?
24 MS CLAY: It would be available to clinicians I would say.
25 PROF: FORSYTH: Do you know if there was an information system at Trust level
26 that collected that information?
27 MS CLAY: I wouldn't know. I mean, I don't know how it happens on... shall I say
28 at the coalface, on the maternity ward, what happens. You know, once that
29 baby has left the ward and it's gone on somewhere else and it goes into
30 Children's –
31 PROF: FORSYTH: And what about things like Apgar scores?
32 MS CLAY: Pardon?
33 PROF: FORSYTH: The Apgar score.
34 MS CLAY: Never heard of it.

1 PROF: FORSYTH: I'm not surprised. These are measures of the condition of the baby at birth, for example.

3 MS CLAY: I mean, I could summarise... Not summarise, that isn't the right word. I could theorise maybe at Trust level, because I'm sort of looking at PCT level, at Trust level. It was always margins were always very tight in the Trusts: staff shortages, things like that. And I don't actually think anybody actually looked at the Trust itself because they didn't have the people to look.

9 PROF: FORSYTH: What about completeness of data from Morecambe Bay Trust? Was the data reasonably complete that you did get, whatever data that was, or think it was deficient?

12 MS CLAY: To the best of my knowledge it was. But I mean, as I say, we were just working with the minimum data set so they'd have to complete that.

14 PROF: FORSYTH: Yes.

15 MS CLAY: So you can pick up so much from the minimum data set. And I mean, I suppose, it's almost like... I'm going back to... completely not relevant to what we're discussing here but we had a high incident of suicides in Cumbria. What we actually did was employ somebody to actually go and read the coroner's reports. But I think this is what one of the issues was: that nobody actually went and read the records.

21 PROF: FORSYTH: What about other data from a public health perspective? Did you look at staffing data, workforce data?

23 MS CLAY: I think there was workforce data collected by the commissioners. Because I remember, it's ringing a bell somewhere, that there were sort of meant to be minimum staffing levels within the commissioning arrangements for the units.

27 PROF: FORSYTH: But you didn't, for example, link that data to clinical outcome data?

29 MS CLAY: That wasn't part of my job to do that. And, I mean, as I say, I think at the time it was all dashboards, performance, 'what are we achieving?', 'have we hit that goal?', 'have we failed on that target?'. And I think that took priority over everything else.

33 PROF: FORSYTH: What about consumer data?

34 MS CLAY: Pardon?

1 PROF: FORSYTH: Consumer data? Patient/user data?
2 MS CLAY: I would never see that.
3 PROF: FORSYTH: You would never –
4 MS CLAY: That would never come to me. Unless –
5 PROF: FORSYTH: Was that around? Do you know whether somebody else was
6 collecting that data?
7 MS CLAY: Well, if there's been a survey done somebody must collect it and –
8 PROF: FORSYTH: So that did come into a public health document?
9 MS CLAY: That actually didn't come into the Trust, into the PCT. I mean, working
10 with other areas I got involved in – I worked with sexual health data – and I
11 think it was one of the best meetings I ever had was when we were sat
12 across the table with the specialists and he said 'well, we collect this, we
13 collect that' and there was somebody there from the lab and 'they do this'.
14 And, you know, well, if you're prepared to share that data with us we will
15 analyse it for you. And we used to have those relationships quite openly
16 when Public Health were actually part of the Trust itself. I mean, when I first
17 set off in Public Health we sat in Cumberland Infirmary and the consultants
18 would come up the stairs and say 'I think we've got a problem; can you look
19 at this?'. And, you know, once we left there I don't think anybody was in a
20 position to be able to look at data and analyse it, and I don't think they had
21 analysts within the Trusts themselves. They had data collectors. And, I
22 mean, there's a difference between collecting data and understanding it.
23 And it's –
24 PROF: FORSYTH: So if you were looking at [perinatal charts?] for all the Trusts in
25 England and you were looking at Morecambe Bay's data, would you think it
26 was worth looking at or do you think it's doubly[?] telling us the story?
27 MS CLAY: I don't quite understand.
28 PROF: FORSYTH: Well, I just wondered, comparing the data from Morecambe
29 Bay Trust in terms of perinatal mortality, seeing whether it's an outlier
30 compared to the other Trusts. I'm just wondering whether the value of that
31 –
32 MS CLAY: Well, it would have been picked up as something like that if it was, sort
33 of, a target area. I mean, because everything is focused on target areas
34 really and I think it's always because it always seems to me that children's

1 services and maternity services are a bit of the forgotten area really, aren't
2 they, because everybody is looking at 'we want to stop people dying from
3 smoking' or 'we want to stop dying from alcohol poisoning' and things like
4 that. And, you know, you have to have the national systems in place to put
5 the comparator data in. I mean, there's always a lot of talk about all these
6 national systems like Dr Foster and things like that that would do all this but
7 they never worked.
8 I think a lot of issues tend, in my opinion... Originally, even looking
9 at maternal deaths, we used to investigate maternal deaths on a local level
10 and that's stopped; it went to a national level. And I think sometimes when
11 things get centralised, areas where there are problems get lost because
12 nobody knows where Barrow-in-Furness is and that Barrow-in-Furness is
13 near Ulverston and places like that. I mean, we had a meningitis outbreak
14 that the health protection didn't even know we had because they didn't
15 realise Allerdale was next to Copeland. And, you know, I think sometimes
16 it's the local knowledge of the people that should be keeping an eye on
17 things. And, to me... I don't know. It seems to me, well, if there was a
18 problem why didn't the Trust say 'look what's happened here'?
19 PROF: FORSYTH: Okay, thank you.
20 DR KIRKUP: Just on that theme really, I'm recognising what you're saying about
21 the previous system before commissioning came along and public health
22 was integral to hospital and health services; less so in primary care but
23 more so in hospital services.
24 MS CLAY: Yeah.
25 DR KIRKUP: Since then, what has been the output of what you've done? Since
26 commissioning came along, where does your analysis go to? Who makes
27 use of it? What do they do with it?
28 MS CLAY: Well, I mean, I just ended up latterly doing local health profiles for
29 communities and supporting people with initiatives that they wanted to try
30 and get money to try and target things. Well, we need to know what the
31 health profile is stating. And, you know, you sort of get supporting these
32 sorts of things and...
33 DR KIRKUP: Have you known it being used to inform commissioning? That sort
34 of analysis?

1 MS CLAY: It should be, yes.
2 DR KIRKUP: That's not what I said, though. Have you known it be used?
3 MS CLAY: Well, I know my alcohol work did. I know some of my work did inform
4 changes in services.
5 DR KIRKUP: Was that the nature of a specific initiative that you were asked to
6 do? 'We think we want to change alcohol commissioning so give us the
7 information.' Was that how it worked?
8 MS CLAY: Yeah. And I think it's one of these things. It's actually... it's
9 sometimes being given the time as well to do work properly. And, you
10 know, a lot of this you can't turn it round in five minutes.
11 DR KIRKUP: Sure.
12 MS CLAY: And, you know, sometimes you've maybe got to wait a couple of
13 months to get the data from a Trust. And then by the time you've got that
14 it's out of date. You know, you're always sort of shutting the stable door
15 after the horse has bolted a bit. It's not instant; you don't get anything
16 instantaneously.
17 DR KIRKUP: Yeah. What I'm picking up, though, is that there hasn't been a very
18 close linkage between the public health analysis work and the
19 commissioning work.
20 MS CLAY: It might have been. I mean, as I say, I was just a very junior member
21 of the team.
22 DR KIRKUP: Yeah, sure.
23 MS CLAY: And, I mean, you know, my senior manager, he used to go to the
24 commissioning meetings and would support the commissioning process
25 and he would come back and say 'can we do various bits and pieces' and
26 that, and that's what we did. And then we sort of got dragged into, as I said,
27 this dashboard route and things like that.
28 DR KIRKUP: Okay. So he would go to the meetings, come back with requests for
29 you to do a particular bit of analysis and then that would go back to the next
30 meeting?
31 MS CLAY: Yeah.
32 DR KIRKUP: So that is a linkage between –
33 MS CLAY: Well, yes, there is that linkage, yes. Because, I mean, public health
34 and commissioners work very closely together, yes, so I would imagine.

1 DR KIRKUP: Okay. Did that apply to maternity services?
2 MS CLAY: I wouldn't know.
3 DR KIRKUP: But could you recall any instance where your manager had come
4 back from one of those meetings and said 'we need to get some more data
5 on maternity services'?
6 MS CLAY: He probably did do. I mean, I cannot honestly say I can remember it.
7 DR KIRKUP: Okay.
8 MS CLAY: I mean, I know at the time we did look at the situation and what was
9 going on and people were asked to do investigations and things like that.
10 DR KIRKUP: Can you give us an example of an investigation?
11 MS CLAY: I didn't do it.
12 DR KIRKUP: Pardon?
13 MS CLAY: I didn't do it. It's hearsay to me. I was out of the loop of a lot of what
14 was going on because –
15 DR KIRKUP: Okay. But you didn't have any knowledge about what kind of
16 investigation?
17 MS CLAY: No.
18 DR KIRKUP: Whether it was into deaths or untoward incidents or general patterns
19 of –
20 MS CLAY: Well, there must have been... As I said, I didn't sit in public health. I
21 don't know.
22 DR KIRKUP: Okay.
23 MS CLAY: I mean, that was the biggest mistake there ever was because we did
24 actually sit saying 'oh, well, we can find out about that and we can do this
25 and we can do that'.
26 DR KIRKUP: So what was the distinction between the analysis that was done in
27 the place that you did sit, which was the observatory, the intelligence
28 observatory, and the public health department? Who did what? Who
29 decided?
30 MS CLAY: Well, my role was primarily to deal with public health data. And what I
31 did, I used to produce reports, send them up to the people who had asked
32 for them and then they would be put into the observatory.
33 DR KIRKUP: So what were the public health people doing? Were they also
34 working on analysis? That's what I'm trying to get at.

1 MS CLAY: No. I don't think so. I don't know because, I mean –
2 MR BROOKES: Was there a standard set of pieces of work which were done
3 every year or every quarter?
4 MS CLAY: Oh, yes, there was rolling reports that we did.
5 MR BROOKES: What kind of things were they?
6 MS CLAY: It would sort of be like, you know, the health of Cumbria. I mean, you
7 would look at the health of Allerdale, doing health profiles, things like that
8 that you would update maybe every two years. There would be the annual
9 reports and things like that that you would feed into. And, I mean, as I said,
10 we used to look at the infant deaths and that when we used to do the vital
11 stats and things like that. So it was all fed up the chain. But once I'd fed it
12 up the chain, where it went after that I don't know.
13 MR BROOKES: Okay.
14 DR KIRKUP: Okay.
15 Any more?
16 MR BROOKES: No.
17 DR KIRKUP: Any more?
18 PROF: FORSYTH: No.
19 DR KIRKUP: Is there anything else you would like to say to us?
20 MS CLAY: I don't think so really. I mean, I don't know whether I've been able to
21 elucidate anything on this. I mean, it's not easy.
22 DR KIRKUP: No, I appreciate that but we're open to your contribution so thank
23 you for coming.
24 MS CLAY: As I say, I mean, we always used to say that the trouble is with the
25 health service was there was too much interference at government level
26 because they always seemed to be moving the goalposts a bit. And I think
27 if there was a bit more concentrating on what was actually going on in the
28 hospital rather than what the government's set the target at you'd maybe
29 know more what was going on.
30 DR KIRKUP: Okay.
31 MS CLAY: But, I mean, everybody will say that. But I hope I've been able to help
32 anyway.
33 DR KIRKUP: Yes, thank you.
34 MR BROOKES: You have, thank you.

1 DR KIRKUP: Thanks very much for coming.

2 MS CLAY: Yes, thank you.

3

4 (Meeting concluded)

THE MORECAMBE BAY INVESTIGATION

Thursday, 10 July 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
Professor James Walker – Expert Adviser on Obstetrics
Professor Jonathan Montgomery – Expert Adviser on Ethics
Dr Geraldine Walters – Expert Adviser on Nursing

BEVERLEY COLE

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1 DR KIRKUP: Hello, thank you for coming. I'm Bill Kirkup. I am the Chair of the
2 investigation. I will ask the other panel members to introduce themselves.
3 Geraldine?
4 DR WALTERS: Geraldine Walters, Non-Executive Director of Nursing and
5 Midwifery at King's College Hospital.
6 PROF FORSYTH: Stewart Forsyth. I'm a paediatrician and, latterly, a Medical
7 Director in Tayside, Scotland.
8 MR BROOKES: I'm Julian Brookes. I'm currently Deputy Chief Operating Officer at
9 Public Health England but was Head of Clinical Quality for the Department of
10 Health.
11 PROF MONTGOMERY: Jonathan Montgomery. I am currently Professor of
12 Healthcare law at University College, London, and Chair of the Health
13 Research Authority. I was previously a Chair of a PCT, NHS.
14 PROF WALKER: I'm Jimmy Walker. I am an obstetrician. I am a Professor of
15 Obstetrics in Leeds University. I was previously Chairman of [CMeds?] and
16 also was obstetric adviser for the National Patient Safety Agency.
17 DR KIRKUP: As you can see, we are wired for sound. We are making a recording
18 of proceedings and will produce an agreed record of them at the end. We
19 sometimes have families in attendance as observers at these sessions. As it
20 happens there aren't any today but they are able to listen to relevant parts of
21 the recording if they want to at a subsequent time. You will have been asked
22 to hand over any telephones, recording devices, etc. It is just to underline the
23 fact that it is important that information about this process does not go out at
24 any other time. We want it all to emerge as one set of findings with everything

1 considered in context. Do you have any questions about the process?

2 MS COLE: No.

3 DR KIRKUP: I will start off by just asking you a pretty general question and hand
4 over to Jonathan to do the majority of the questioning. We may want to chip in
5 occasionally but don't worry; it's not going to be a prolonged grilling from
6 everybody, far from it. We want a conversation, really, as much as anything.
7 So, can I ask you when you started at CQC and what jobs have you done
8 there up to the present?

9 MS COLE: Okay. I started at CQC in about September 2011. Prior to that – I have
10 a nursing background. I've also been a regulator before so I worked in previous
11 organisations, in the health authority days of regulation and in the National
12 Care ~~Service~~ Standards Commission and the Healthcare Commission. I then
13 went into general practice for six years as a practice manager and then came
14 back into CQC in September 2011 as an inspector. That didn't last very long,
15 and I became a compliance manager, managing a team of inspectors in I think
16 it was about April, September 2012. So, I had a period of time when I was an
17 inspector. I did a bit of acting up as a manager in Northumberland and then I
18 was compliance manager for Cumbria. I am now as of April 2014 the Head of
19 General Practice for the north region.

20 DR KIRKUP: Thank you. That is very helpful. Jonathan?

21 PROF MONTGOMERY: Thank you. We obviously want to focus on this area, so
22 prior to you coming in September 2011 did you have any contact with this area
23 in this other role as a practice manager [inaudible] that would help us to know
24 about.

1 MS COLE: With Morecambe Bay?

2 PROF MONTGOMERY: Yes.

3 MS COLE: No, no, I wasn't living in Cumbria then.

4 PROF MONTGOMERY: Okay, so can you tell us a bit more then about the
5 inspector and compliance manager roles and in particular how they have
6 related to the trust? We understand from documentation from other interviews
7 about the section 48 investigation but we understand that your bit of it is on the
8 more day-to-day side of things. So, it would be really helpful to understand
9 how that works.

10 MS COLE: As a compliance manager – I suppose as an inspector I had very limited
11 experience of Morecambe Bay. It was more coming in as a compliance
12 manager for Cumbria and that would have been – I have had to write the dates
13 down to remind myself – about September 2012 as the compliance manager
14 and prior to that I had a few weeks as the inspector for Morecambe Bay and I
15 think I was given Morecambe Bay because of my nursing background and
16 because I have had quite senior positions in both the NHS and in the
17 independent healthcare sector so they thought I probably have a reasonable
18 amount of experience to be able to have a look at it.

19 As the manager I had 10 inspectors within the team and two of them
20 had responsibility for the day-to-day management of Morecambe Bay.
21 Morecambe Bay being quite complex and quite complicated, I felt it was unfair
22 to give one inspector that responsibility because at that time we were getting a
23 lot of inquiries, a lot of issues that we needed to look at so they shared
24 responsibility, especially with it being such a large geographical area. So, I had

1 two inspectors who had day-to-day management and control of that. They
2 would have the initial relationship between the different three locations. So,
3 they would have a regular communication with – and it would have been Jackie
4 Holt at the time who was Director of Nursing and also she had the clinical
5 governance role. So, that would be the first person that they would go to if they
6 needed to discuss anything or had any discussions that they needed.

7 So, that was them. From my point of view it would be regular meetings
8 and discussions with the inspectors and then I had more of a regional role, so if
9 we needed to take anything up a level I would contact Jackie Daniel at that
10 time because I don't know any – I didn't have anything to do with the previous
11 board, so I would contact Jackie Daniel and we would have those particular
12 conversations. I would also be the link with NHS England and the local area
13 teams and I would attend quality surveillance group meetings on a monthly
14 basis to discuss how Morecambe Bay was doing and then I would have a
15 regional focus with Monitor. So, there would be a relationship holder for
16 Morecambe Bay at a regional level for Monitor, so I would have discussions if I
17 needed to with them. Who else would I? No, that would have been it then.
18 So, that would have been NHS England and Monitor.

19 PROF MONTGOMERY: That's really helpful, thank you. We needed probably just
20 to go over that to understand what went on.

21 MS COLE: Yes, that's fine.

22 PROF MONTGOMERY: Can I ask you first of all about the handover? So, you
23 arrived in September 2011. Plenty of activity was going on at that stage, so
24 can you tell us a little bit about how you were briefed and what you were

1 briefed about?

2 MS COLE: In September 2011 I was on induction and then I worked for Lancashire

3 so I had nothing to do with Morecambe Bay until about probably April 2012.

4 PROF MONTGOMERY: Yes.

5 MS COLE: And at the time, when they asked me to look at Morecambe Bay, the

6 manager, ~~Joe~~ Joanne Wildman at the time, briefed me on some of the issues.

7 We also had what is called a regulatory plan, which is a bit of a briefing

8 document so that, God forbid I got hit by a bus, somebody else would be able

9 to take that piece of paper and would actually be able to see the key issues, so

10 it would have any inspections that we had done and the outcomes of those –

11 not in detail but just you would be able to see the date we did that inspection

12 then, this is what came out of that. There was then a Gold Command or there

13 was a meeting, so there would be a very brief document there so you could

14 look at that. We have also got a computer system called CRM which any

15 communication that you have with a trust, whether it's an inspection or whether

16 it's a conversation about something, you document that on CRM, so I'd have

17 had to have done a bit of interrogation of CRM to actually get some of that as

18 well.

19 PROF MONTGOMERY: That's helpful. We're going to have a chance to do that

20 ourselves. You haven't said what was in it – as you went in April, what were

21 the things that were particularly brought to your attention as being live?

22 MS COLE: When I took it over ~~the things were~~ we had to do a review of what we

23 had done so far in terms of our inspections and the main focus of that would

24 have been August when we went back in to look at the A&E departments in

1 Furness General and Royal Lancaster and the maternity unit in Furness
2 General and Royal Lancaster. ~~And they had been~~ Issues had been generated
3 by previous inspections so we'd had some ~~Morley~~ warning notices from the
4 Section 48 and we'd had some compliance actions from previous visits to the
5 A&E and also previous visits to the maternity. So, that was the priority at that
6 time.
7 PROF MONTGOMERY: Okay, and how did it feel in terms of the relative priority of
8 those two, the maternity and the A&E issues?
9 MS COLE: In what sort of way?
10 PROF MONTGOMERY: Well, which you felt more concerned about, which ---
11 MS COLE: I suppose maternity would have been more concerning because of the
12 issues that had happened before and the maternal deaths etc. that were there,
13 so that was always a big focus on everybody's mind, and A&E would have
14 been second. However, the priority in that sense, that was in my head, but the
15 warning notices were against A&E and it was compliance actions for maternity.
16 So, you know, your priority in a way is skewed a little bit there as well because
17 you've got warning notices.
18 PROF MONTGOMERY: That's really helpful and helps to disentangle it because
19 one of two understandings was that Section 48 didn't look at maternity.
20 MS COLE: No.
21 PROF MONTGOMERY: So, take us through the difference between the compliance
22 notice and the warning notice and what you were following up and how you
23 were following up.
24 MS COLE: Okay. With maternity it was following up the previous inspection which

1 would have been – I think it was back in 2011, and there were issues around cleanliness and infection control. There were issues around staffing. There were issues around medical records storage. So, there were those issues for that and they had been part of a routine inspection. So, every year we have to visit every – it doesn't matter whether it's a hospital. Under the old – I will make it quite clear that this is prior to April because our inspection methodology has changed, so we would have to visit every location and that didn't matter whether it was a care home or a hospital, once a year, minimum. And so the maternity issues were generated from an inspection previously.

PROF MONTGOMERY: And they initially resulted in a warning notice?

MS COLE: The maternity wasn't a warning – not as far as I can remember.

PROF MONTGOMERY: Okay.

MS COLE: It was compliance actions, but the A&E came from the section 48. So, section 48 can't generate warning notices itself; it can only make recommendations, but if you see a breach of regulations then you have to get the team that manages it to actually deal with those.

PROF MONTGOMERY: And compliance actions, how are they visible to the public?

MS COLE: They are on the report.

PROF MONTGOMERY: On the report?

MS COLE: The published report.

PROF MONTGOMERY: Okay and do they have a duration or -

MS COLE: It varies. Compliance actions, very much the onus is on the provider of the service to tell you how they are going to meet that. We don't write in our report, 'You will do this, this, this, this and this to become compliant'. So, you

1 would expect an action plan from the trust to tell you how long they are going to
2 take to do that. You then give a bit of leeway because you want – actually, it's
3 not just a case of expecting them to comply. Somewhere like Morecambe Bay
4 and somewhere where it has got – it could be a care home anywhere – where
5 there's a troublesome history you want to see some sustainability of that
6 because if I go in and look at somewhere and yes, they've done everything you
7 wanted to do, I also want to know whether I am going to be coming back in six
8 months' time and finding the same problem there again. So, you want to give
9 them a bit of leeway to get that sustainability and see that carried on.
10 PROF MONTGOMERY: So, when you were looking at this as you came in, there'll
11 be a compliance plan, will there, to address – I am particularly interested in
12 maternity things.
13 MS COLE: There is a report, so you would have a report and you would – the
14 inspector would keep a record of when they needed to go back.
15 PROF MONTGOMERY: So, they would have a sort of 'brought forward' system?
16 There would be a flag to say -
17 MS COLE: Yes, yes.
18 PROF MONTGOMERY: If you haven't heard anything -
19 MS COLE: If you look on our published website, it has crosses, black crosses, when
20 there is a compliance action or a warning notice. So, the same system is on
21 our system that means that you keep an eye on it and make sure that you are
22 going back in to inspect.
23 PROF MONTGOMERY: Thank you. You've talked about the inspector's day-to-day
24 relationship being with Jackie Holt at that stage. Where did you come in once

1 you took over as compliance manager? Who would you relate to?

2 MS COLE: Jackie but also the Chief Exec.

3 PROF MONTGOMERY: So, can you tell us a bit about those two people and your

4 experience of relating to them, how often you saw them, what sort of -

5 MS COLE: It would vary. It would vary. I probably saw them formally because

6 occasionally with the quality surveillance groups on behalf of the NHS England

7 they would often be called to special QSGs so we'd have a single hospital

8 QSG. So, somewhere like Morecambe Bay and North Cumbria, we were

9 seeing them on a more regular basis than we would perhaps at a trust that was

10 moving along quite fine. So, we'd often see them on a formal basis with the

11 QSG.

12 PROF MONTGOMERY: How often was – just thinking for Morecambe Bay, how

13 often?

14 MS COLE: For Morecambe Bay we had a monthly QSG but we would probably see

15 the trust at least – the Chief Executive at least quarterly. To be honest, you did

16 it as you needed to do it as well, so you didn't stick to that because it depended

17 what issues came up at the time.

18 PROF MONTGOMERY: So, can you take us through some of those issues? Our

19 terms of reference go to the end of June 2013, so that is about nine months of

20 your work. It would be really good to have a flavour of how responsive, how

21 much you took the initiative, how much they came to you with things through

22 that period.

23 MS COLE: Again, I think it varied. I always had – I always got on well with Jackie

24 and with the other Jackie – yes, both Jackies, the Chief Executive and the

1 nurse. It depended what the issue was. Sometimes it took a little longer for
2 them to respond but again if they were having to go and investigate an issue
3 that had come up then I wouldn't have wanted them to have come back too
4 quick because I wanted to know that that was investigated properly. I felt they
5 had a fairly good relationship with me. They were usually picking up the phone.
6 Towards the latter part they were starting to pick up the phone on a more
7 proactive level and tell us ahead of if something was going to be a problem.
8 That wasn't there at the beginning, but I think as the relationship and we got to
9 know each other as an organisation, they certainly were picking up the phone
10 and saying, 'Look, we're ringing you just to tell you'. Now, that was after Jackie
11 left, so after Jackie left they had two nurses in.
12 PROF MONTGOMERY: That is Jackie Holt?
13 MS COLE: Holt, yes, sorry. They had two nurses acting up while we were waiting
14 for a new appointment, one at Furness General and one at RLI and they were
15 more – they were much better at picking up the phone and saying, 'Look, I
16 think there might be a problem. We're just giving you a heads up', and then we
17 could have a dialogue with them then. So, it moved as the time -
18 PROF MONTGOMERY: So, it moved from being a little bit more reactive to you to
19 being more proactive?
20 MS COLE: Yes, yes. Now, Jackie Daniel was always very approachable and never
21 really minded if I rang her up to query something if, say, Jackie Holt was off on
22 holiday or something like that but I suppose at her level the day-to-day issues
23 wouldn't have been coming to me.
24 PROF MONTGOMERY: That's really helpful. Can you say a bit more about the

1 other partners in the Quality Surveillance Group? Who else would be around
2 that table?
3 MS COLE: In the QSGs you had the local area teams and you'd usually have the
4 Medical Director and the nurse and the Chief Operating Officer. You would
5 have the CCG, people from the CCG. We also at that time some –
6 Healthwatch had just come into being so occasionally a representative of
7 Healthwatch would come along; the local authority, because some of the
8 issues we were touching on were around child safeguarding at that time, which
9 was a big problem in Cumbria in general, Morecambe Bay being part of that
10 but also everywhere else. So, we needed them to come along if they had
11 problems with safeguarding as well, and also we would have the Deanery
12 would come along as from an educational point of view and would be talking to
13 us about medical education because of course it is a big issue on being able to
14 recruit and keep trainees at Furness General in particular, so getting middle
15 grade doctors at Furness General was difficult.
16 PROF MONTGOMERY: And how was the agenda for the QSGs constructed?
17 MS COLE: It's constructed by – it's an NHS England team initiative and it's their
18 agenda but they would usually send round a week, 10 days before and we
19 would all – because we were not just focusing on Morecambe Bay all the time,
20 you had to put together some of the issues that had come up and what we tried
21 to do was be as forthcoming and get that soft intelligence that we could without
22 compromising each other's confidentiality and looking at things when really
23 they are not in the public domain. So, you have to be careful but we wanted to
24 have a relationship as most QSGs will of being able to discuss worrying things

1 before they start to take effect.

2 PROF MONTGOMERY: How did what was left of the various reports in relation to

3 Morecambe Bay especially the maternity ones – how did they get brought

4 together in that piece of work? Was there some assessment of what was still

5 outstanding -

6 MS COLE: Well, I made that assessment when I first went in so it was obvious that

7 we'd got issues from the section 48 that we needed to pick up that had become

8 warning notices and compliance actions within the terms of A&E but with

9 maternity it was from previous inspections. So, you just pick them up and you

10 go back in. We went in at the same time and did both because it was easier to

11 take the team in and we needed a specialist for maternity because I'm

12 personally very strongly in favour that you need to take in people who actually

13 know about that. I am not a midwife by background; I am a general nurse and

14 women's health but not midwifery so we took a senior midwife in with us to look

15 at maternity at that time and they had complied with the compliance actions.

16 PROF MONTGOMERY: So, that was around the CQC inspection and the

17 identification of differences.

18 MS COLE: Yes.

19 PROF MONTGOMERY: What about the other reports that the Trust was working

20 on, so the stuff that Monitor had commissioned and the like? That was still

21 very live at that stage. There is a series of things that from other people's

22 portfolios would have fed in. Were they discussed around the whole group?

23 MS COLE: At the QSGs, yes, yes. So, Monitor would come along to those as well

24 and they would feed in anything that was happening as well.

1 PROF MONTGOMERY: Okay. Was the trust a member of the QSG?

2 MS COLE: Not unless they are invited.

3 PROF MONTGOMERY: Okay.

4 MS COLE: They have to be invited.

5 PROF MONTGOMERY: So, what was the pattern of inviting them? Were they

6 mostly there for the discussions?

7 MS COLE: Usually about once a quarter there was a special QSG where the trust –

8 we had like an open meeting at the beginning and then the trust would be

9 asked to come along at the end and we would talk about some of the issues

10 that we have been talking about and they would do some presentations on

11 what they were doing about those issues.

12 PROF MONTGOMERY: Okay and who from the trust came?

13 MS COLE: Usually Jackie Daniels and a whole entourage of other people.

14 PROF MONTGOMERY: Right, so she would front it but she would be supported?

15 MS COLE: Yes. I think that's all I had about the QSG, but others may have some

16 other things. Do you want to check -

17 DR WALTERS: What sort of things were you talking about in relation to the other

18 sorts of reports, because you had had the compliance actions. Obviously they

19 were less important than the warning notice, what you were interested in, but

20 some of the issues from the Fielding Report and the Central Manchester

21 Report, did the QSG -

22 MS COLE: Well, they wouldn't have come up at any of the ones that I went to

23 because they were prior to the investigation. They didn't come up much -

24 DR WALTERS: But the findings were still active though weren't they?

1 MS COLE: Yes. They didn't talk about them in great detail.

2 DR WALTERS: Right, so in the CQC you wouldn't look at reports?

3 MS COLE: No, we did.

4 DR WALTERS: Right, but not these?

5 MS COLE: I didn't have active involvement in the Fielding Report, with the Fielding
6 Report.

7 DR WALTERS: Right, so if you're looking at a trust – this is just me trying to
8 understand the process, so, sorry to labour the point. If you are looking at a
9 trust like Morecambe Bay, you have had some compliance actions in relation to
10 the 2011 visit, but then there are a whole load of other things that have come
11 out from other inspections from their independent – or commissioned by
12 Monitor – you wouldn't go into assurance around some of those actions?

13 MS COLE: We would look at the reports.

14 DR WALTERS: Right.

15 MS COLE: And if we felt there was anything within the reports that might breach a
16 regulation, then that would be of concern to us.

17 DR WALTERS: Right, so by that then there was nothing in these reports which you
18 feel would raise the sort of CQC's concern about quality in maternity services?

19 MS COLE: Not as far as I can remember, but I can't honestly remember having a
20 major input into the Fielding Report issues.

21 PROF WALKER: So, if I can just follow up on that, really, you said at the beginning
22 when you took up the post you were given and document – I can't remember
23 what you called it but you said it was like a briefing document.

24 MS COLE: Just a regulatory plan.

1 PROF WALKER: Right, a regulatory plan. So, was that based on official visits and
2 assessments, or was there some sort of background opinion or noise within
3 that that would say, 'Your last report said this but actually there were slight
4 concerns about x and y'? Would it include a memory that should be passed on
5 to you about concerns?

6 MS COLE: No, it was very much, 'This happened on this date. We went in and did
7 an inspection. Gold Command was going on, when I first came in so it would
8 be – Gold Command was set up then. There was no opinion or memory within
9 that.

10 PROF WALKER: Okay, so was there any ability to pass memory on from your
11 predecessor about things which have not quite got the official stamping and
12 reporting but there were concerns about? Would that be lost with the person
13 before you going and you coming?

14 MS COLE: I am trying to think of an example but I can't. But no, the memory would
15 be by talking to that person. I was lucky that I had the previous manager there.

16 DR KIRKUP: I think you called it soft intelligence?

17 MS COLE: Yes, we do document soft intelligence on CRM.

18 PROF WALKER: Okay, but it's more from what was said before, we have a
19 situation where there's been various reports coming out highlighting concerns
20 about maternity care but in fact on your documentation there were things about
21 hygiene and note keeping, I think, or note storing – I can't remember what it
22 was – which you were going back in to revisit. So, all the revisits that your
23 inspectors were doing wouldn't really tackle any concerns about the previous
24 worries about care of women in the maternal beds or the neo-natal beds.

1 Would that be correct?

2 MS COLE: Well, that was prior to me coming in.

3 PROF WALKER: Sure, I know that was prior to you coming in but there wasn't such

4 a methodology of seeing how they are coping with that or changing to improve

5 that sort of care because that would not be on your radar?

6 MS COLE: It would be as part of normal inspections and we have inspected several

7 times within maternity. You have to remember that we are not the only ones

8 monitoring. We had – I think there were other external people going in as well.

9 Certainly around maternity there were external people going in and monitoring.

10 There were governance issues. Price WaterhouseCoopers was going in doing

11 governance issues, so we do certainly look – we did certainly look at those

12 types of issues that were coming up.

13 PROF WALKER: No, I appreciate there were other people coming in. There was

14 partly confusion sometimes not actually in this situation but a CQC report

15 comes out which finds no problem in a unit and where other people or other

16 problems then occur after that or during that time, and it is whether the reason

17 why CQC does find a problem, it's the matrix they are working to. So, what you

18 are saying is that going into the reviews when you went into Furness it would

19 be very much along a routine matrix that you would assess the maternity unit

20 plus anything previously flagged up. You'd want to look at how they'd changed

21 or improved. It wouldn't be – you wouldn't flag up necessarily anything from

22 someone else's report which you felt you as CQC should also focus on?

23 MS COLE: If something came up in another report that we had an issue with we

24 would usually ring and speak to the trust about that issue. It depends what the

1 issue is or what the issue was. We would certainly have a dialogue. If there's
2 something that we thought might be breaching a regulation at that time then we
3 would have wanted to talk to -
4 PROF MONTGOMERY: So, the issue would be did it relate to one of the standards
5 that you were actually -
6 MS COLE: Is it something under our regulatory remit.
7 PROF MONTGOMERY: Okay.
8 MR BROOKES: Can you just tell me what you believe was the function of the
9 Quality Surveillance Group?
10 MS COLE: The function of the Quality Surveillance Group was to get everybody
11 around the table who had a concern or was commissioning or had a regulatory
12 remit for the health economy because the QSG is not just set up for the
13 hospitals. It actually has a remit to look at all healthcare so it's looking at care
14 homes. There's also one for general practice and primary medical services so
15 it was there to get everybody around the table to try and make sure that we
16 were not overburdening providers with everybody going in to try and do the
17 same thing and try and make a decision on who's responsible and who should
18 be going in to do something and then come back and feed it back.
19 Certainly from a commissioning point of view it was there to make sure
20 that there was somebody to help and support the trust to actually make those
21 improvements because we can't do that. We can only point out the problems.
22 MR BROOKES: So, locally it is the place, the forum, which has all the information in
23 terms of quality coming in from the various regulators and commissioners. Is
24 that correct?

1 MS COLE: It would have a great deal of it. It would have the overview. It wouldn't
2 necessarily have all of the detail.
3 MR BROOKES: And it would monitor progress?
4 MS COLE: It did monitor progress, yes, or it does monitor progress.
5 PROF MONTGOMERY: And do you believe –
6 DR KIRKUP: Was that against a formal action plan or was it -
7 MS COLE: There are actions that will arise from each meeting, so they will go
8 through the meeting minutes to look at those actions and it will take off. It will
9 then – whoever is responsible for doing that piece of work will go off and do
10 that piece of work and report back to the QSG.
11 MR BROOKES: And do you believe it filled that function effectively?
12 MS COLE: I think it took a long time to get itself started. Morecambe Bay was very
13 – well, as you know, is very complex the issues there, North Cumbria the
14 same. The partnership – we have three trusts in Cumbria, all of which have
15 major concerns and I think a bit like Morecambe Bay it had an awful lot on its
16 plate to try and juggle and I think it was very slow to get started and with it
17 being a new organisation, CCGs having just come in I think it did take a long
18 time to fulfil that.
19 MR BROOKES: If through its monitoring it could see that there wasn't progress
20 being made what could it do?
21 MS COLE: It quite often did talk to the relevant – talk to us and see what we could
22 do about going in and having a look at things. It also could go in itself. A QSG
23 could say to the CCG or to the local area team, 'Go in', and we have had them
24 go in to monitor standards on wards within hospitals. So, it can actually go in

1 and do something itself, and I think it reports upwards to NHS England.

2 MR BROOKES: I am just trying to square the circle because as we said there were

3 a lot of reports identifying similar issues, concerns over a period of time and

4 this – I accept this is further on in the stream – but accepting that this is a

5 forum where these things all have the opportunity to be brought, in your view,

6 during your time there, were they effective in dealing with the whole range of

7 things which had been identified as being concerns within the trust?

8 MS COLE: I personally don't feel that QSG – from when it came into being didn't

9 look at every piece of historical documentation.

10 MR BROOKES: It took it from that point in time?

11 MS COLE: Yes.

12 MR BROOKES: Okay.

13 MS COLE: So, it went from there.

14 MR BROOKES: Thank you. that's fair enough. Thank you.

15 PROF WALKER: Can I ask just piece of clarification? You mentioned after Jackie

16 Holt left that the people who took over from her called you more often, or

17 communicated more often. Now, does that imply that Jackie Holt should have

18 called you more often and didn't or the new people coming in needed more

19 support from you and so therefore phoned you more often or there is no

20 implication there at all?

21 MS COLE: They rang on a variety of reasons. Not all of them were very serious or

22 worrying, and I think it was more the latter. They were wanting to know that

23 they hadn't missed anything. It's the same with any organisation that you

24 suddenly see a spike in reporting serious or untoward incidents. If they've

1 been told about something you will often get people putting more and more in
2 so that you're getting everything rather than nothing.
3 DR KIRKUP: Okay, we need to move on, thank you.
4 PROF MONTGOMERY: I think there are three areas I want to pick up. One was
5 you touched on Gold Command. I just want to understand, as you arrived,
6 what was your understanding of where Gold Command had got to and what
7 was your involvement and [within this aftermath?]
8 MS COLE: I attended Gold Command as part of the CQC. I was an inspector at the
9 time that it first went into being so I was going along for the education of Gold
10 Command and to input any intelligence that we had.
11 PROF MONTGOMERY: So, how did it work? I am very interested in understanding
12 who took responsibility for leading. What was the trust's response and what
13 was your sense as you joined it because it had been going a while hadn't it?
14 MS COLE: It had. It had been going a while. Everybody was – similar people that
15 were round the QSG except you did have Morecambe Bay. The trust was at
16 Gold Command. It was very much – I think it was Department of Health led.
17 I'm trying to tax my memory here but I think it was Department of Health led
18 because I don't think at that time NHS England had come into being. It was
19 still in shadow form and everybody was round the table, and it was focusing
20 very much on maternity but it also then had an issue with outpatients. It had
21 some issues where appointments hadn't gone out to a large amount of
22 outpatients, so it picked up – started to pick up other things that were going on
23 as well in Morecambe Bay.
24 PROF MONTGOMERY: And who from the trust went?

1 MS COLE: Jackie Holt, Jackie Daniel, I think, but to be perfectly honest I can't
2 actually remember. I know Jackie Holt would but there was always good
3 representation from the trust.
4 PROF MONTGOMERY: But if you had a sense of who was the key responsibility on
5 the trust side for actioning that it would be Jackie Holt would it?
6 MS COLE: Yes.
7 PROF MONTGOMERY: Who did it feel as though they were driving the agenda?
8 Was that driven by the trust coming and looking at what it did?
9 MS COLE: It was shadow NHS England, or Department of Health, whoever it was. I
10 am sure it was the shadow.
11 PROF MONTGOMERY: If you were trying to get a sense of how good the trust was
12 by this stage independently identifying and actioning things, what would have
13 been your sense in observing it? Would the trust have been able to move that
14 agenda forward without the support of Gold Command or was it Gold
15 Command that drove it?
16 MS COLE: I think that Gold Command was driving the agenda.
17 PROF MONTGOMERY: That's really helpful. And did that feel as though it
18 changed? Did it feel as though that was handed back to the trust, or to the end
19 of Gold Command it just felt like that?
20 MS COLE: For those particular issues it sort of had a natural finish, so yes.
21 PROF MONTGOMERY: Thank you. The second thing I wanted to ask a bit about
22 was public and patient and family involvement because I think you go to
23 Overview and Scrutiny to report on things that come out of the CGC work.
24 MS COLE: I do.

1 PROF MONTGOMERY: So, you clearly have a role in liaising with the community
2 and I wonder if you could explain how that operates to us, how you pull in
3 feedback from local community and what sort of engagement you have?
4 MS COLE: Various. Well, we have had a lot of engagement with the public. A lot of
5 the public through doing some of our inspections had us on their radar so we
6 would get quite a lot of calls from the public. I certainly went to the Cumbria
7 Overview and Scrutiny Committee every month and reported to them on what
8 we were seeing as an inspectorate and they would give me quite good
9 feedback and patient involvement from there. Healthwatch had come into
10 being as well, so I had regular meetings with Healthwatch and we would get
11 some information from them and on our inspections we would talk to as many
12 patients as possible.
13 PROF MONTGOMERY: And in those bits of feedback, if you want to call it that, or
14 with those connections, where did the maternity issues sit against the range of
15 concerns that those groups have had? Were they top of the pile of priorities?
16 Were they one amongst a number or were they thought to be sorted or what?
17 MS COLE: I think by the time I came in, maternity wasn't as high on the patients'
18 agenda. Certainly the issues that were coming to me were more around A&E
19 and access to A&E and going through the system, and a lot around complaints,
20 not being able to get their complaints answered particularly quickly, the attitude
21 of staff in managing those complaints and answering them fully and the length
22 of time it takes, so we got an awful lot through quite a long period of time
23 around complaints.
24 PROF MONTGOMERY: And is your perception of that aspect that it is for the whole

1 trust, that it was different for different sites? Do you have a feel about that?

2 MS COLE: It was different from maternity. Maternity, when we went in and did the

3 August inspections, maternity had turned around its complaints handling, and it

4 was handling them on a more one-to-one, face-to-face basis. If they'd got a

5 complaint that came in, a matron, a senior midwife would ring the person

6 straight away and talk to them. That hadn't filtered through to the rest of the

7 hospital, so they were still managing them by letter or not managing them at all

8 and then we were starting to see that start to change when matrons and senior

9 nurses on the ward were given the autonomy and the authority to actually deal

10 with the complaint as it happened.

11 So, again that was starting to change but it was taking an awful long

12 time.

13 PROF MONTGOMERY: Did you have a perception of why that started in maternity?

14 MS COLE: Because we'd identified it as a problem.

15 PROF MONTGOMERY: So, a spotlight was shone on it?

16 MS COLE: Yes.

17 PROF MONTGOMERY: And then you began to get somewhere?

18 MS COLE: Yes.

19 PROF MONTGOMERY: Thank you. The last thing I wanted to just go back to,

20 because I have already mentioned it, is just trying to understand this

21 relationship between warning and compliance issues. So, a warning notice

22 has a duration, is that right?

23 MS COLE: Yes. You do a warning notice when it is something that you need them

24 to action fairly quickly. You can still have – it depends what the issue is. You

1 can have a slightly longer timescale on it but normally it's something that you
2 would need them to do straightaway so you will have a slightly quicker
3 turnaround.
4 PROF MONTGOMERY: So, if you get to the end of the expiry period and there are
5 still compliance issues the normal thing would be to extend them [inaudible]
6 effect.
7 MS COLE: Not necessarily. It depends what the issue is, and you might be looking
8 at other ranges of enforcement activity which could be putting a condition on –
9 and this is in general – putting a condition on the registration; it might be a fixed
10 penalty notice; it could be a warning; a PACE interview. So, there is a range of
11 issues that you could take.
12 PROF MONTGOMERY: So if we bring that down to Morecambe Bay, I think I
13 understand that there was a warning notice.
14 MS COLE: Mm hmm.
15 PROF MONTGOMERY: And it came to the end of the time period and there were
16 still compliance issues but I couldn't quite work out what the regulatory activity
17 was.
18 MS COLE: There weren't any compliance issues. They had met their warning
19 notice.
20 PROF MONTGOMERY: By the time that you came in?
21 MS COLE: By the time that we went out and did August, they had met the August
22 one. There were no compliance actions out on the warning notices. It was just
23 the warning notices. The other thing I would say is, if you do do a warning
24 notice, you have to judge whether it's minor, moderate or major under the

1 judgment framework that we had at the time. So, if you have a warning notice
2 and it might be a major issue, yes, technically if you went back in and you
3 found that they had made significant improvement that had taken it to a minor,
4 you might give a compliance action but it doesn't happen very often.
5 PROF MONTGOMERY: Okay, and just to get the timing right on that then, at the
6 point at which you were satisfied there were no outstanding compliance actions
7 -
8 MS COLE: On the issues that were -
9 PROF MONTGOMERY: On the maternity notice.
10 MS COLE: Yes.
11 PROF MONTGOMERY: When was that?
12 MS COLE: When we went back in in August.
13 PROF MONTGOMERY: For the August inspection?
14 DR WALTERS: That was the only warning notice.
15 PROF WALKER: They only had one.
16 MS COLE: Maternity didn't have any warning notices. It had compliance actions.
17 PROF MONTGOMERY: It had had a warning notice in the past -
18 MS COLE: It had but prior to me coming in.
19 MR BROOKES: Yes.
20 [Crosstalk]
21 PROF MONTGOMERY: Yes, and that's really what I've struggled to understand
22 because I think we have been told -
23 MS COLE: Different issues, though.
24 PROF MONTGOMERY: - you got to the end of the warning notice, it wasn't

1 extended but there were still compliance issues that were being -

2 MS COLE: It would be different compliance actions. So, you've got 16 regulations
3 that you can make compliance actions or warning notices against. And also to
4 make it more complicated if you had found them non-compliant on one
5 regulation and you went in, you might actually find they were compliant on that
6 particular issue within that regulation but there might be another issue so it's
7 not as easy as just that.

8 PROF MONTGOMERY: And that will all be documented in the regulatory plans,
9 CRM is it?

10 MS COLE: It will be in CRM.

11 PROF MONTGOMERY: Thank you. I'm not sure I'm clear on that yet but I think I
12 understand what documents -

13 MS COLE: They certainly didn't have any outstanding warning notices from the time
14 that I was in. It was compliance actions for maternity. It was warning notices
15 and they weren't outstanding. They were just warning notices that we've
16 entered.

17 PROF MONTGOMERY: Yes, I think I understood that. What I don't understand is
18 the transition from the warning notice to the compliance action on maternity,
19 but which is what we are about to try and understand.

20 PROF WALKER: I think what you're suggesting was there was no transfer from a
21 warning notice to compliance; the compliance notice was on different things
22 than the warning notice was on. Is that correct?

23 MS COLE: If there was – yes, at the time I was in there were no warning notices out
24 on maternity.

1 DR KIRKUP: If you then had a compliance issue on maternity would you check
2 back to the previous history to see whether there had been previous warning
3 notices?
4 MS COLE: Yes, yes.
5 DR KIRKUP: But your understanding was there hadn't been?
6 MS COLE: It was different issues. My understanding was there weren't any warning
7 notices, yes, but it was different issues.
8 DR KIRKUP: And what's happened subsequently?
9 MS COLE: In terms of?
10 DR KIRKUP: The CQC relationship with Morecambe Bay. What's happened since
11 the events that you have been describing here?
12 MS COLE: Well, we had the August inspections. The relationship as I understand
13 is still the same. It was certainly fine when I left.
14 DR KIRKUP: No, no, I don't mean that. I mean do CQC have concerns at the
15 moment about the operation of the trust?
16 MS COLE: Well, the Wave inspection has taken place, which is a very, very
17 different process.
18 DR KIRKUP: Yes, I appreciate -
19 MS COLE: They are in special measures now.
20 DR KIRKUP: Yes, indeed. Would you expect though the Wave inspection, as you
21 described it, to take account of the same kind of issues -
22 MS COLE: It takes account of -
23 DR KIRKUP: Or are you saying that they are completely unrelated to what's
24 happened before?

1 MS COLE: Not necessarily. There are still some related things there but it's a very
2 different process. You would need to really go – if you want to talk about the
3 Wave, you need somebody who knows it backwards, and it's very, very – much
4 more complex inspections than there had been before. They go into a lot more
5 detail.
6 DR KIRKUP: Right. Let me put it another way then. Were you surprised by the
7 outcome of the Wave inspection?
8 MS COLE: No.
9 DR KIRKUP: Does that not suggest, though, that there were outstanding issues
10 because of the completion of the bit that you have just described and the
11 occurrence of the Wave inspection?
12 MS COLE: It's looking at different things, and it's looking at the whole hospital.
13 With the way we regulated before, you couldn't have looked at a whole hospital
14 on the regulations that we had. Well, one, we wouldn't have had the people to
15 go in and do it at the time because we didn't have the resources to do that,
16 which is why with our old regulatory system we would go in and do the
17 minimum of the five – a minimum of five regulations we would go in and
18 inspect, and we would choose an area to do that on. The Wave has gone into
19 eight different areas and looked at it in a lot more detail.
20 MR BROOKES: So, you had a situation where the ones that had been looked at,
21 problems had been identified and then rectified. Is that what you are saying?
22 MS COLE: No, there are still some problems there but they are looking at different
23 things.
24 MR BROOKES: No, but the process you've described, was there ever an end to it?

1 Did they reach compliance? Did they reach -

2 MS COLE: With the specific issues that we were looking at -

3 MR BROOKES: Yes, specific issues.

4 MS COLE: - they reached compliance.

5 MR BROOKES: So, that was finished, was it?

6 MS COLE: Yes.

7 MR BROOKES: So, that was finished and yet there were significant problems in the

8 organisation. Doesn't that imply that the previous inspection system was

9 flawed?

10 MS COLE: I think that probably says it in the fact that we changed our methodology

11 and we are doing a very different inspection now.

12 MR BROOKES: You were looking at particular things so you could actually tick the

13 box and move on and actually still be an organisation that is failing?

14 MS COLE: No, it depends what you are looking at at the time. If we could have

15 gone in and looked at 16 outcomes, maybe across a whole hospital -

16 MR BROOKES: But you didn't.

17 MS COLE: No, we didn't, because that was our methodology at the time.

18 MR BROOKES: Okay, and it was flawed.

19 MS COLE: You would have to ask somebody who knows more about the regulation

20 than I do but it did not match what we are doing now. It's very, very different

21 now.

22 MR BROOKES: Okay.

23 PROF FORSYTH: Just following on from that it does seem to me strange that really

24 over the last three years at least there has been intensive monitoring of this

1 trust by CQC, by Monitor, and Gold Command and yet here we are in a
2 situation that the trust it has now been determined was not operating
3 adequately. Where is the failure here? Is this a failure of the inspection
4 process and support? Is it a failure of actually the people running the trust or is
5 it a failure of the trust in the way it is configured and it's unworkable?

6 MS COLE: I can only give you my opinion. I would say it's a combination of a lot of
7 that. I think that the geography of that trust, the make-up of that trust is not
8 workable. I think the health economy isn't there to support that trust in the way
9 that it is at the moment and I think that we often haven't given – the trust itself
10 has taken a long time to get its act together, but I think that's because we are
11 expecting them to change a whole culture and that culture is going to take
12 years to change. I don't think we can expect to see that culture of that. A trust
13 like that where it's very – RLI and Furness General are two totally different – I
14 might as well be sitting in two totally different hospitals because when we first
15 went in it certainly didn't function as one trust, and I've worked in large
16 hospitals that are geographically challenging but it never felt at the start when I
17 started that there was one trust. When I finished it was starting to feel better
18 and certainly across maternity they were working together a lot more and they
19 were doing things together a lot more but if I'm completely honest that wasn't
20 happening across every department. So, I would think that a lot of it is health
21 economy, and that's got to be sorted out. That trust cannot survive in the way
22 it is currently and that is what they are working on at the moment. And I don't
23 think anybody realised what an immense challenge changing that trust around
24 is going to be.

1 So, I wouldn't say the Trust Board is entirely to blame, but it's never
2 really been a Trust Board that's had the same people on it, and at senior level
3 those people haven't been there for a sustained amount of time to be able to
4 get things looking like they are changing. We were still 18 months into ~~me~~ us
5 being in and they were still waiting for senior positions to be filled within the
6 trust and without those senior positions they are floundering.
7 DR KIRKUP: If I can refer to the public reaction to things that have happened there,
8 it's a bit of a caricature but it's as if when you got to the end of the process that
9 you were involved with, everybody said, 'Oh, good, the trust's now got a clean
10 bill of health'. Therefore, it's a doubly difficult blow for them that the Wave
11 inspection comes along and says, 'No, no, far from it. They're actually in
12 special measures' and of course it's led to some pretty drastic fallout in
13 amongst the trust management and the board. When you look back on that
14 process do you feel comfortable with the notion that it was portrayed as if CQC
15 have now signed the trust off as having a clean bill of health?
16 MS COLE: I'd never got that impression because I didn't feel that we had signed the
17 trust off with a clean bill of health because I had only looked at A&E and
18 maternity so I don't think you could ever say -
19 DR KIRKUP: But can you understand what that was the way ---
20 MS COLE: Oh yes, I can see that, yes, but no, certainly we only really looked at a
21 small portion of that trust and I think that the A&E investigation, review, showed
22 that that hadn't got a clean bill of health, certainly in A&E.
23 DR KIRKUP: Yes, okay.
24 DR WALTERS: The CQC investigation in July 2012 -

1 MS COLE: Are we on the A&E one now?

2 DR WALTERS: Yes, I just wonder why was that limited to – because the QSGs
3 have met, haven't they, and everybody was inputting and just from your
4 perspective going to the meetings, what was the sort of – what was the high
5 priority of the meeting? What did people spend most of their time talking about
6 and worrying about?

7 MS COLE: I think maternity but also the health economy, so how were they going to
8 make changes, what could they do and they were starting to think about the
9 Better Care Together issues that were coming out and whether there was
10 going to be one hospital, whether it was going to stay as three hospitals,
11 whether they needed to split it up, whether they needed to relook at how they
12 were working in the community, so all of that took up quite a high proportion,
13 how we were going to get that trust working better.

14 DR WALTERS: I know we're looking at it through a maternity lens but given all
15 these independent reports and QSG meeting with people who were
16 contributing from their point of view, the July inspection just seems so swayed
17 towards A&E, it's almost as if maternity was sort of being ignored, you know,
18 that it was so important, and it was all infection control and this sort of stuff and
19 a lot of the maternity issues don't really feature. Would you agree?

20 MS COLE: No, I wouldn't agree with that because certainly I feel like I have never
21 been out of maternity. So, certainly maternity was still being monitored. It was
22 still certainly being monitored externally as well, and we were monitoring it.
23 A&E – I couldn't honestly answer any questions as to why they chose to go into
24 A&E and do a section 48 investigation because I don't – I wasn't there at that

1 time.

2 DR KIRKUP: Who should we ask about that?

3 MS COLE: Well, I think you saw Mandy Musgrave, so I would have thought that she

4 might have answered whey they decided to focus on A&E.

5 MR BROOKES: I think it's been described as being a service which was shown to

6 be symptomatic of the overall organisation, a way into looking at the whole

7 organisation. It didn't have the Wave investigations at the time.

8 MS COLE: No, no, and this was the only way they could do it.

9 MR BROOKES: So, by going to [inaudible] as a proxy to say if this isn't working

10 right, there's probably issues spreading out from that through the front door

11 into other parts of the organisation.

12 MS COLE: Yes, my understanding was it was a lot around how patients came into

13 the hospital and came out, that sort of throughput of patients and how better to

14 manage that and certainly the emergency care pathway rather than just A&E.

15 DR WALTERS: Right, okay.

16 MS COLE: So, certainly maternity wasn't ever off the agenda.

17 DR WALTERS: Right, so when you say you were in monitoring a lot, what was the

18 nature of the monitoring you were doing?

19 MS COLE: It was the regular dialogue and it was making sure that we were having

20 sight of untoward incidents and that we were watching how the trust was

21 managing untoward incidents and then of course you've got the CCGs and the

22 local area teams who were also going in.

23 DR WALTERS: Yes, and were you happy with the SUI management?

24 MS COLE: I was happier with the SUI management, yes.

1 DR WALTERS: How did it change from the beginning to -

2 MS COLE: Well, I don't know, because I wasn't there at the beginning of SUI. They

3 certainly seemed to be more responsive and picking them up more. There

4 weren't a great many of them when I came into as there were. They weren't in

5 the same severity as they were previously but they were certainly feeding into

6 the NHS system of serious untoward incidents in a better way.

7 DR WALTERS: Right. And did you look at things like midwife to birth ratios or

8 anything like that?

9 MS COLE: We did have a long conversation and some meetings about midwife to

10 birth rates because they had put their statistics in incorrectly because a report

11 that went to NHS England had actually had them on a quite low midwife to birth

12 ratio and we needed to go in and inspect that. We wanted to know what was

13 going on because that didn't seem right and in fact the trust disputed those

14 findings and actually put – they had put the statistics in wrong. They hadn't

15 added something into that mix. So, we had alerted them as had NHS England

16 and they started to relook at the figures that they had got.

17 MR BROOKES: Just a couple of things. I just want to understand a little bit the

18 relationship between Gold Command and the Quality Surveillance Group.

19 MS COLE: I don't think there was one at the time because I think the Quality

20 Surveillance Groups came in after.

21 MR BROOKES: They came in afterwards, so they didn't overlap at all?

22 MS COLE: No.

23 MR BROOKES: Okay, that's really helpful. In terms of SUIs, would you routinely

24 see the SUI report or would you just know there were SUIs being reported?

1 MS COLE: We wouldn't always see them because they go through – we get them second- hand so we get that report through our intelligence system second-hand. However, certainly with maternity the trust would ring us and tell us if they've got a problem and they would send us a copy because we would always say to them, 'Right, we need to see how you are managing that; we need to see what you are doing about that. Send us your investigation and your reports' so we would see them often and certainly -

8 MR BROOKES: So you would see some of them but not all of them?

9 MS COLE: The maternity ones definitely and we would see the reports of the ones that were entered on to the NHS system when they came into us second-hand through our intelligence.

12 MR BROOKES: What was your view of the quality of those reviews?

13 MS COLE: They were getting better.

14 MR BROOKES: But against a scale of one to two, or seven to eight?

15 MS COLE: I think from my point of view it was more on the fact that we were being told about them. Certainly, NHS England and the CCGs would be getting copies of those and they were certainly investigating them as per the NHS standard for investigating SUIs so they were certainly a lot better, I understand, than when we first started to get very little information and the robustness of the investigations were certainly a lot better.

21 MR BROOKES: Did you have any involvement in the closing of the loop? In other words, there would have been a set of recommendations. Was there any confirmation to you as an organisation that those actions had been taken and things were now resolved or was it, 'This is a SUI. It's been investigated, these

1 are the recommendations', and that's as far as your involvement was?

2 MS COLE: No, we would see some of the closures of the loop if we were there, if
3 they came in at the time, certainly. I can't off my head think of an example but
4 certainly I can remember we had a dialogue with the trust on at least two
5 occasions to see what the actual end result was.

6 MR BROOKES: Okay, thank you.

7 DR KIRKUP: Okay, is there anything you would like to say to us?

8 MS COLE: No.

9 DR WALTERS: At NHS England or DH, who do you think was responsible for
10 maternity services?

11 MS COLE: I couldn't honestly tell you at the time because I didn't have that dialogue
12 at that level.

13 DR WALTERS: Right, thank you.

14 DR KIRKUP: Thank you. Thanks very much for your help.

15 [Interview Concluded]