THE MORECAMBE BAY INVESTIGATION

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)
Maternity and Neonatal Services Investigation

Thursday, 13 February 2014

Held at:
Park Hotel (Council Building)
East Cliff, Preston, PR1 3EA

Before:

Mr Julian Brookes – Expert Adviser, Governance
Professor Stewart Forsyth – Expert Adviser, Paediatrics
Ms Jacqui Featherstone – Expert Adviser, Midwifery
Dr Catherine Calderwood – Expert Adviser, Obstetrics
Professor Jonathan Montgomery – Expert Adviser, Ethics

Ms Oonagh McIntosh – Secretary to the Investigation
Mr Paul Roberts – Documents and Evidence Manager
Mr Tom Bacon – Deputy Secretary to the Investigation

PANEL MEETING

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(11.00am)

MR BROOKES: Welcome. We are hoping that a couple of other colleagues are on their way but, given the weather and given the stories we have just been swapping, in terms of the trouble we have had to get here, even Oonagh, who had enough trouble last night getting home, we will start and see if they arrive.

Just a couple of housekeeping things as we start: it's just to say that we're not anticipating any fire alarms today so, if the alarms go, we will follow behind Oonagh and the team to take us to wherever we need to be.

Again, just to emphasise, we have apologies from Bill who has unable to come to this session and has asked me to chair this in his absence. We'll aim to break around 12.30, but we'll see how things go in terms of the discussions we want and how we get on. I'm hoping we'll close around 3.30 at the latest. If we can get through what we need to appropriately before then, we will take into consideration that people have got to travel a long way to get home and we'll see what we can do on that. As a way of thanks and as a way of opening, those are the remarks.

I'd just like to say also we have had apologies from Geraldine, who is in India, I believe, so I think that's a valid reason for not being here today, and also from Hannah Knight. Stewart, I believe, is going to present the work that she's been doing, in her absence.

Actions from the last panel meeting and matters arising.

MS McINTOSH: The main action that we need to feed back on, and I'm really going to be turning to poor Stewart, who's doing most of the work at the moment, or just maybe in case of any questions, is the meeting that Bill, Stewart and I had in Leicester with the confidential inquiry team there. We did say that we would give feedback when we'd

reflected on the questions that they posed to the team. There was a will or an initial desire by the Investigation to do some sort of investigation to know what the position was right now at the Trust, whilst we were investigating things that had happened in the past.

The team in Leicester was very clear in their view that it would be difficult for us to do any investigation that wasn't entirely confidential. It was the shared view of the sub-group that looked at that that it was actually beyond our remit. Not only that, we are not resourced to undertake that work. It may be that, in the findings that the Investigation comes up with, it determines that the Secretary of State might want to look at doing that type of work on a more frequent basis and a more random basis, but it was not for the work of the Morecambe Bay Investigation.

What Bill and Stewart have discussed, and Catherine has seen this paper, is how to actually learn from the team in Leicester, but actually make that fit for purpose for the cases the Investigation is looking at. Stewart in particular has put work into developing a process of how the Investigation will undertake the case reviews that it is going to do, so that they are done in a consistent matter and so that they are not done in any way that is a completely different approach from the methodology of the team in Leicester.

[Professor Jonathan Montgomery enters the room.]

MS McINTOSH: Jonathan, we are just talking about the Leicester visit. The first paper is matters outstanding. It was so that the Investigation won't use a completely different methodology, but adapting a tried and tested, and extremely credible and respected, methodology but making it fit for purpose. The paper at 4.1 is the proposal from the sub-group on how that work will be undertaken. I think I need to turn to Stewart, if

there is anything he wants to add.

PROFESSOR FORSYTH: I think you have covered it fairly well. Obviously we need to get feedback. This is very much a draft suggestion at this stage, and we need the panel to give us some feedback. Just to build on Oonagh's comments, we are doing something slightly different from what Leicester does, in terms of doing a confidential inquiry very much building on anonymity, etc. The key cases in our inquiry are not anonymous and it would be impossible for us not to identify them. You then have to have an external group, etc., we didn't feel that this was absolutely necessary for what we were hoping to achieve. Clearly there were some good things that Leicester did and we have incorporated this within our methodology.

Again, we need to have good benchmarks and reference documents that underpin this work. A key one, certainly from a neonatal perspective, is the Department of Health neonatal services toolkit. I think what we're trying to do is really focus on what we really need to do: to study these in-depth cases in great depth, but also refer to standard documents that are out there, which we can benchmark against, so the Department of Health, the Leicester methodology and their assessment at the end of the day is a certain standard of care. Hopefully this brings the best of what's out there. Particularly those who have been involved in reviewing the cases in that sub-group need to look at this and probably get back to Oonagh as quickly as possible about any of the changes or additions necessary.

MR BROOKES: That would be really helpful. Are there any immediate comments that anyone from the Panel wishes to make?

PROFESSOR MONTGOMERY: Can I just raise one thing, Julian? It relates to a question that was raised to us by one of the families around what was said at the inquest about

the training midwifery staff had received before they got to the Trust around signs of infection. This will pick up training that's been given once they're employed by the Trust. You're going to review their records.

PROFESSOR FORSYTH: Yes, exactly.

PROFESSOR MONTGOMERY: Is there anything we could do to open up that question and see whether we could shed any light on it? I can't immediately see how you could do that in a manageable way, but we shouldn't lose sight of that question.

PROFESSOR FORSYTH: I think a point that came out is that, if there are key members of staff who you would feel there are issues around, you would not only be looking at their status in terms of training and clinical competency at the time, but was there something else in the past? We should be able to maybe pick up on their, for example, application to the post and any interview comments, etc., that were getting picked up at that time. I think maybe there are one or two members of staff who fall into that category, I suspect.

MR BROOKES: Shall we give that to the sub-group as a specific question for them to look at and consider?

PROFESSOR MONTGOMERY: I'm not really too sure what the answer is. As it's been raised with us, I think I should keep an eye out for how we might test it.

MR BROOKES: I suppose mine's more of a general question, which is, given what you've learned from Leicester, given the proposals here and given they'll be fine-tuned, this will give us the information we believe will allow us to fill our terms of reference.

PROFESSOR FORSYTH: Yes. There are really two parts to this that I've included, which breaks into the Trust management group as well. In the discussion I had with Bill, I said it would be really important, particularly from the families' perspective. Obviously we heard this quite clearly from them: it's not just the clinical care that they're really

concerned about, but what happens after that. How does the Trust respond to their complaints or did they not respond to their complaints adequately? We therefore felt it would be good to see this from the start to the current, today, what has actually happened to these families. I think that would be, for me, with all the other reports that are out there, reviews and investigations, this is not something that has really been addressed properly. It's not taken the whole story from beginning to the end, from the families' perspective. I think that we are in a position to do that.

The first part of the work was very much reviewing the case notes and all the clinical bits around that. The second part was: how does the Trust then respond to this? It really is two separate parts, this review.

PROFESSOR MONTGOMERY: What relates to that is how we get something benchmarked. For the clinical case review bit, you've got various tools you've identified that you can measure as good practice. I think we're also going to have to develop – either ourselves or through the evidence we collect – a benchmark of expectations, both in terms of professional ethics and what the various professional codes were saying at the correct relevant times about openness and obligations to families when things may have gone wrong, and complaints procedures, which have changed throughout the period that we're talking about.

We're going to need to try to develop a timeline of what the expected standards would be at each point, so that we can put them alongside each other and understand the difference between what we might want to say is unacceptable if it was happening now with hindsight, and what was unacceptable by the prevailing standards at the time. That's going to be quite tricky to get right and we'll need the timelines to draw it out for us quite carefully to measure that.

MR BROOKES: Thank you. Is there anything else on that paper?

PROFESSOR FORSYTH: There are standards in terms of the organisation, the Trust responding or standards responding to complaints, the time you need to respond, and being open and honest, and all that stuff. There are obviously documents around.

MR BROOKES: There are a plethora of documents around this. I think distilling that down into something is going to be the challenge, rather than the fact that there aren't any. Yes, you're absolutely right; there will be a number of pieces of guidance in the time we're looking at around complaints, around good governance practice against good patient safety, which we need to make sure we consider properly, against what was available at the time. It's a similar kind of process, I think.

I think there will probably be more judgment in those than there will be in some of the more clinical side of things. Particularly if you go further back, some of the processes, procedures and expectations on organisations, in terms of governance, were less well defined than they are now. There is evidence and there is good practice from the National Patient Safety Agency, the Care Quality Commission and a number of other organisations and review bodies as well. We can draw on those.

PROFESSOR MONTGOMERY: We may need to draw attention to the fact that it is quite difficult for organisations to get it right if that guidance is unclear or conflicts. That could be a recommendation we want to consider.

MR BROOKES: Yes, indeed. Is there anything else we want to discuss in terms of the visits that we undertook after the last meeting? Is there anything that comes out from yours that would be worth reflecting?

PROFESSOR FORSYTH: I was trying to remember what I actually said. I certainly think the visit, first of all, was worthwhile. I thought, actually, the prior impressions that

were given of Barrow-in-Furness General Hospital were probably worse. It was actually quite a nice hospital.

MS FEATHERSTONE: I agree. That was definitely my opinion. Walking through the door, I definitely got a different feeling, yes.

PROFESSOR FORSYTH: That was quite a pleasant surprise. The other very encouraging thing was the staff we met – obviously they had been appointed since the incidents we're investigating – were actually very good. I thought actually we could learn from them. I thought they should be on our list of people to meet, because clearly they had gone in and found things that they were very unhappy about and made really important changes since then. I think that is a way of getting an insight into what was going on previously. I presume it would be acceptable for us to interview them and get to the bottom of 'What were your first impressions? What do you think were the key issues? What have you changed that you think has improved?' That to me I think is a very important aspect of the work we're doing. Also, when it gets down to the Terms of References 4, 5 and 6, do we feel comfortable with the services currently now being provided?

I thought that was really helpful. One or two of the structural changes I thought were not great. The new neonatal unit was not terribly well designed.

MS McINTOSH: It was terrible.

MS FEATHERSTONE: It really was dreadful. You got the opinion from the staff it was bad as well. I mean, it was very good, but it just was not conducive to giving adequate care.

PROFESSOR FORSYTH: There was a high-intensive care area – it was a tiny, little room. In fact you couldn't... If you had an intensive care incubator and ventilators and all that stuff... But actually the main thing they have to do is to transfer the baby out and there

wasn't enough room to get the transport incubator in there. There were one or two issues around that. In fact, they'd given up a very large area where the previous neonatal was. In fact, it might have been better to have –

MS FEATHERSTONE: They could have utilised that a bit better.

PROFESSOR FORSYTH: They could have also had more care rooms, etc. Some of the structural changes have not been a success. They had another problem, which came out among the comments, about the theatre being in an appropriate place. They've almost got a sort of traffic-light system across a public corridor to get to the theatre, which is not ideal, so there are one or two things.

I thought, generally, the staffing and the leadership was clearly much better than it has been in the past. A question that had been raised was 'are we sitting here talking about something that is continuing to be a problem?' I felt coming away with some confidence that staff now in charge know what they're doing and are going in the right direction. Therefore, I feel reasonably comfortable about the current service.

MR BROOKES: Just to conclude on that, there was nothing immediately that you felt was of sufficient concern that there needed to be attention brought to it.

PROFESSOR FORSYTH: No.

MR BROOKES: That's very important. You joined the –

PROFESSOR MONTGOMERY: I joined by telephone. There were three things that struck me from the telephone conversation.

MR BROOKES: This is with the Board Members, Chair and Chief Executive.

PROFESSOR MONTGOMERY: Yes. The first echoes what we've just heard, which is that there is clearly a fresh perspective in the teams there at the moment. By and large, I thought they were addressing things I would have expected them to be addressing, from

what we've heard already. I still think there are some questions we need to work out whether they're in our terms of reference to probe or not about quite how grounded the various policies are and how well the monitoring is. I think I would expect to find this in most places. They've got a set of systems, but whether they quite communicate with each other effectively for you to pick up early warning signs of something that is a little bit under a different place will connect together, I'm not sure they've quite pulled that off yet, but I don't think they thought they pulled it off either. They've got some robust-looking and –sounding approaches, but whether they're quite getting from them yet feedback – I haven't myself offered any whistleblowing things, for example. I think there are a few things where I'm not sure at this stage whether they'll filter through to the terms of reference.

The second thing I picked up that they're willing to work out how to get right is they were clearly very focused, as you'd expect, on their CQC visit. We need to work out how we get appropriate feedback from that, which does relate to our terms of reference, and how we avoid getting sucked into things that are already other people's responsibility.

The third thing was around the supervision of midwives. We've read the Health Service Commissioner's report, which was very critical of the local supervised midwives' response, and drew inferences about the fact that the whole system was not suitable. We heard there, and I picked up from the press, that the new supervised midwives team has won a national award for the work that it's done. We'll need to think quite carefully about how we make sense and the sort of structural problems with that supervision system, and what was the problem with that in the way it was operating locally.

MR BROOKES: I think that's right. Just to add to that, for me, it crystallised the challenge for us, which is particularly investigating what has happened a number of years ago. We had a new Chair, a new Board, a new Chief Executive and new senior director posts. Clearly they're talking about what they have done to improve what they found. We need to test whether or not that goes below the executive level of the organisation. We weren't able to do that on the day, but that's something we'll need to do. Also, getting to an understanding of what happened previously requires us very much to talk to people who were previously at the organisation. That was very positive, very welcoming and an open discussion, I thought, but very much about now, where a lot of what we need to do is talk about what has happened previously. I like the idea of 'what did you find when you come in?' as being a series of questions, and I'd like to do that with the people we met, but we also need to try very hard to have good and constructive conversations with the people who were previously in post, because that is going to be critical in terms of finding out more.

PROFESSOR MONTGOMERY: I've begun to formulate in my mind a way of asking the question, which we might be along the lines of 'Do we think and do they think that, if the system they have in place now had been in place at key points, would that or would that not have maybe enabled them to handle things better?' We need to make a judgment about whether what we want to say is, 'We've identified these problems and we want to say that the thing we're recommending is that people carry on doing what they're doing and make sure it sticks,' or whether we think that what they're doing isn't going to address that.

I wonder if we have to ask ourselves similar questions around regulatory changes. For example, the recommendations in the Francis inquiry are now being put

into place. We might need to ask ourselves, once they're in place, would we believe that they would pick up the sorts of problems that we're talking about or do the problems we've identified suggest that. We might formulate a way of asking it, which is, once we've satisfied ourselves as regards the systems that have been put in place in response to what they've perceived, and we'll try to imagine what they would have generated in terms of identification problems, at the stages that they want.

MR BROOKES: I agree with that. Alongside that, we just need to bottom out the evidence base about what did actually happen. At the moment, we haven't got that triangulation. What did happen? What are the systems now? First of all, have they got it right if there were issues, and are we comfortable with the systems that are now in place? These seem to me to be the three stages to the questions we need to ask. No, I was encouraged by the openness of the discussions. We probably do need to test the evidence, so I reserve judgment until we know the evidence.

PROFESSOR FORSYTH: Just in relation to that, I think the case reviews will hopefully give us the links to where to really start looking and who to start meeting. The idea is speaking to staff who were there at the time – I'm not talking now, for example – that might help us to identify who the key people would be. I think this is really sort of where it begins and sort of our desire to communicate with different people…

PROFESSOR MONTGOMERY: Presumably those case reviews will also identify gaps where you were expecting there to be some evidence, but you cannot find it. One of the things we've heard is that it might not be there, and actually it would be important for us to be alert to the fact that no evidence of something there might be important in our findings.

MR BROOKES: Anything else?

MS FEATHERSTONE: I agree with what Stewart was saying. The impression that I got of Barrow was definitely very different than what I was expecting. Certainly in discussion with the staff, they were very much on board and saying what they were doing. It is just the evidence to show that they are actually doing what they're doing, and it's sustainable as well. It wasn't apparent how many staff were there working who had been around at that time. It was to get a bit finer detail, but what we got on the surface certainly was really worthwhile.

MR BROOKES: Okay, that second visit was really helpful. It's useful to frame some of what we're doing and actually have an idea about the facilities and getting pictures in your minds when we're talking to other people. I'm sure we'll be following those visits up. Unless there's anything else on that item, I'll move on.

MS McINTOSH: Just two small things, if you don't mind. One is just to give a quick update. Bill and I went to see Cumbria Constabulary and we were going to raise with them what the sort of peer review process was going to be, because James Titcombe had asked if the Investigation is going to include or could include the police investigation. At the last Panel meeting, there was obviously an agreement that that was not appropriate. We went to see the police and shared that concern that had been expressed with them.

They were explaining that the process for the IPCC is not exactly the same as in the NHS. When someone wants to refer something to the Parliamentary and Health Service Ombudsman, they can, but actually the police refer cases to the IPCC. The IPCC then decides if they're going to investigate. It would be Cumbria Constabulary's position that it would be their choice to refer the case to the IPCC or for peer review, via the IPCC for peer review. There are mechanisms in place, and Cumbria

Constabulary reiterated their commitment that whatever they had done should be transparent. They've obviously recognised that we couldn't help with what they'd done and didn't think that was appropriate, but it was just to sort of round that off, because we did say we were having those discussions.

MR BROOKES: That's very helpful. Is that something that we can make the families aware of?

MS McINTOSH: I talked to Bill about that as we came out and then afterwards. The Chairman's view was that the response that he had given and then discussed with you, which everyone supported and ratified, he decided not to revisit that, not to return to the families unless they came back with a question to him. They haven't come back. He said to them, 'Come back to me if you want to think about that and talk a bit more about it, and also if you want me to come and meet you.' He extended that and there hasn't been any response to that. When he does go and talk to them that would be part of the discussions. He's said, 'When we have things to tell you, I will communicate.' That doesn't mean that the families have not been in touch, because a couple of families have been in touch, but they've been in touch with different issues or have just copied the Investigation to correspondence they've been having with other organisations and regulators.

MR BROOKES: I just want to make sure that the families are appropriately aware of what routes they should go through if they have particular – it's not about us doing anything, other than what we've already said. It's just making sure that they're aware of the processes, so that if they have concerns about the way in which the police have operated there is a process they go down and they know what route they can do.

MS McINTOSH: The response that the Chairman sent has gone on to the Investigation

website and, as far as I'm aware, we haven't had any queries about that. We've had queries from them about other things, but not about that, so it seems that the message has been received and understood, which is the key thing.

MR BROOKES: That's really helpful, thank you. Anything else on that item?

MS McINTOSH: No.

MR BROOKES: If we move on to item 4, which is an update on the notice that the Investigation placed in local papers, as members will recall, while we have spoken to a number of families, we were conscious that it was important to give the opportunity to as many people as possible to come forward if they felt that they had information that was relevant to the Investigation. We placed a notice in local papers asking people to consider whether they had this information to come forward. Tom, I believe you were going to give us an update on where we've got to.

MR BACON: Panel members saw the open letter that went out at the end of January. It ran for two weeks in local newspapers and on their associated websites. We've to date had 42 members of the public contact us wanting to share information. Those calls are still coming in. One of those calls was this morning, even though the advert stopped running in the first couple of days in February. It's just worth noting that it's still being picked up now.

The paper that you've got in your pack explains how the Secretariat has been dealing with these contacts as they're received. The panel has already considered how to deal with members of the public that contacted it and we've been following that process. As we got in touch with them, we have either been sending them a pro forma for them to complete themselves or making ourselves available to go through the pro forma with them over the phone. We've then taken that information –

[Dr Catherine Calderwood enters the room.]

MR BROOKES: Can I just stop to say where we are? We've just basically been through matters arising. We've all had interesting journeys getting here, so welcome. We've just been talking about the visits we did and some work that Stewart's done in terms of the assessments, which you're aware of, and we've just moved on to talking about the notice we put into the newspapers for the families. Tom is talking to that.

MR BACON: We've taken the responses we've received to date and summarised them. That's the table that you've got in the pack there. We put them into four categories. The first category are where members of the public have got in touch and the information they've had to give is clearly in the scope of the Investigation's Terms of Reference. The second category is where it's clearly out of scope, and thus far there are only two that are clearly out of scope and those are both for time reasons. I think one case was too late, in 2013, and one was before the Investigation's Terms of Reference. The third category is the sort of middle category, which could be in scope of the Investigation's work, but it's not clear from the information that we've received. The fourth category is where somebody has been in contact with us, but we've yet to receive the full details from their pro forma.

The Panel's asked to consider two main things. The first is, where it is clear that the information is in the scope of the Investigation's work, do you want to open an invitation to those people to attend a future meeting and share their experiences, as has been the case with families so far? The second is, where it is not clear from the information that's been received whether it is in scope, perhaps because the member of the public is not sure whether it was registered as a SUI or not, do you want to include those pieces in the sampling exercise where we're looking at SUIs? Those are the two

main questions that the panel is asked to consider today.

MR BROOKES: Let's take the first question first. Can you just repeat the question for us, please?

MR BACON: For those cases where it's clear that the member of the public's information is in scope of the Investigation's work, do you want to extend an invitation for them to attend a future Panel meeting, as was the case with families so far?

DR CALDERWOOD: Tom, what was the wording in the newspaper advertisement?

MR BACON: It asked for anyone who had concerns about care received in any neonatal or maternity units of the Trust, during the time of the period, to get in touch with the Investigation.

DR CALDERWOOD: I suppose the families that have come forward so far have had a maternal death, a stillbirth, neonatal death or quite significant harm. I think not all of these are in that same category, but we asked for concern of care.

MR BACON: Yes.

PROFESSOR MONTGOMERY: I had another question about where we pull the guillotine down, but it relates to the manageability of how we do this. I think we need to meet the families at the beginning, because we need to understand what generates it and the concern, and to scope the sort of question we need to have a look at. I don't think we saw them because we needed to see them in order to understand the individual's care – and that's what the review's basis is. I think my instinct would be to say that we don't need to see these people on a routine basis. It could be that, later on, something thematic comes and we might want to extend to all those who have expressed concerns an invitation to come and discuss a particular thematic issue and attend a session. You could get back to them and ask them if they might come as part of that. But I think we

should separate the question of us understanding the nature of concerns from the case reviews. What this invitation prompts is the need for us to look at the cases if they have flagged them up in enough detail to us to understand the details. I don't think I would encourage us to seeing anybody who's expressed an interest. A further set of reasons I think is necessary.

DR CALDERWOOD: I suppose several of them – and I think we have also heard that from some of the families – they have discussed poor communication. It's then very difficult to have a standard against which to… There's a different way – potentially a way to deal with that sort of case, which isn't what we're proposing, if that makes sense. I agree with you, Jonathan: it's difficult to know really because we haven't got much detail.

MR BACON: It's worth just saying that this is a very high-level summary. Some pro formas went on for two, three or four pages, so this is just to try to get an overview.

DR CALDERWOOD: So you have some other information as well.

MR BACON: But sitting beneath this document, for each of those, is more information in a pro forma that's been received, which goes into all the detail and uses the right words, whereas this is the Secretariat's attempt to summarise that for the ease of the Panel.

MR BROOKES: Can I frame it slightly differently, in terms of the questions for us? We've asked people to raise their concerns and we need to make sure that we handle those concerns appropriately. That's the principle behind this. Irrespective of the cases that are in category one here, is the principle that, if we feel that they're in scope, we should have further contact with those families? I'm not saying they come and present to us; I'm saying further contact. Effectively they've met the criteria by being in category one. They've answered the response and we have some responsibility to do

something with the information that they've provided for us. I'm not saying we've got the right cases in the categories – I don't know – but what I'm saying is that, if they fall into the top category and are within scope, we have, in my view, some responsibility in terms of proceeding with them to be included within the review. That doesn't mean, as I say, they have to come and give us evidence.

PROFESSOR MONTGOMERY: I'd absolutely agree with that. I think we need to make sure that we can say, as members of the Panel, that we have looked at the information that they have sent in. If so, no one should be able to go back to you and say, 'What did you do with it?' and your answer is, 'I looked at it and involved it.' It has to come to us in some way—

MR BROOKES: Exactly. I think we need to consider the thing. If we feel that they fall within the scope, we include them in the overall review. Category two, similarly, we are saying those are out of scope and therefore we can explain why we're not logically including this, and we need further information on the other ones. There seem to be two tasks. One is just to check, as Panel members, we're comfortable with these. We probably can't do this from the high-level information, so we need to think about how we do that. If we've got cases that we leave in there, the families need to be aware that we're doing it. The last thing I want is for them to come back and say, 'We raised these concerns and nobody would listen,' because that is obviously a criticism of previous approaches.

PROFESSOR MONTGOMERY: Legally, presumably they'll want to come back and say we can start working through all this in detail, and we just wanted to know how many things that was and we've got to get that balance right. There's another thing that can go wrong. One think that could go wrong is that people think that they weren't listened

to at all. The other is that we could do much more than they were expecting. We could refer back to them and open up wounds that actually they didn't want to think about again. You're right that the principle is that we have to show respect to the people who come to us and respond to them responsibly. The first question is whether we want routinely to say that everybody who comes in should come and meet us. I don't think we should do that.

MR BROOKES: I think that's absolutely a fair point, but we do need to make sure that we get the categorisation right. If they are a category one, definitely in scope, they are included in the Investigation. We need to let the families know that and we need to make sure that they're clear what that means to them.

PROFESSOR FORSYTH: There is a sensitivity around all of this. As you say, it could go badly wrong. I do think that we need to have documented what our process is for dealing with these extra cases. We have developed a pro forma, sent it out, returned it; now what are our further elections in relation to how we're handling that information? How do we then go back to the families to tell them what is our reaction and our response to it, what are we going to do with it and what have we done with it? We do need to follow this through, so they are quite clear about this.

The Panel needs to see the pro formas that have been returned. I think it would be insufficient for us to go on the summaries, so I am afraid that's something else that we need to be reading to go through these.

PROFESSOR MONTGOMERY: Is a key decision whether they should into the case review?

PROFESSOR FORSYTH: Maybe. What we could say as part of the process is that the Panel has received the completed pro formas; they have reviewed them and, under their judgment, questions have arisen from that. Maybe it would be the case that we actually

feel that we would like to interview the families.

PROFESSOR MONTGOMERY: We wouldn't exclude it.

PROFESSOR FORSYTH: No, I wouldn't exclude that. If we go through the process of reviewing them, our various options in terms of further election would arise from that.

MR BROOKES: So we've got a high-level summary here and we've got some initial categorisations. We need to probably just check that we are comfortable as a Panel with those, and then we need to determine how we then approach and proceed with those individual cases. Is that correct? I'm jumping ahead slightly, but is that something that we might expect one of the sub-groups to lead on? We'll talk about that later, okay. I just think we should be clear, and then we should write to the families and explain to them precisely what we're doing. Yes? Okay, thank you.

PROFESSOR FORSYTH: Can I ask...? In scope, I was particularly concerned about the first one that's out of scope.

MR BROOKES: That's timing is it?

PROFESSOR FORSYTH: It's timing in terms of the incident occurring, but the care results were probably started within scope. The pregnancy obviously started within the time. Particularly if we are also going to, as part of our terms of reference, say 'everything is fine now', this is a bit of a worry.

DR CALDERWOOD: I thought exactly the same, Stewart. There's been a time limit for a reason and I would need to have very good reasons to change that. What encouraged me about it is that there is a root cause analysis ongoing.

PROFESSOR FORSYTH: This was 1 October. We're now into February.

DR CALDERWOOD: I think that's completely reasonable. That's three or four months ago. You don't know when she complained, etc. I think what encouraged me is that that is

not being ignored by the Trust. I suppose there is also nothing to stop us making an enquiry about what the outcome of that was in our later communication with the Trust. I think there have been very good reasons for the dates and it would be very difficult.

PROFESSOR MONTGOMERY: We could ask the Trust what the progress is on doing it when they come to talk to us. We do not operate with a guillotine on dates.

MR BROOKES: We will find, potentially, newer ones and newer ones coming along. I think we agree we need to stick with the guillotine date, but that doesn't mean that we lose sight of those that have been timed out.

PROFESSOR MONTGOMERY: We could say to the families that 'We can't look at your particular case because it is out of scope, but we will be asking the Trust to explain how they're handling complaints, including yours,' or something of that sort, so we can show that we're responding to it.

MR BROOKES: That underlines a principle here, which is that all families that have contacted us need to be very clear of what action we are not doing, so we need to set a high standard in terms of our communications back to them.

MS McINTOSH: Can I just ask? You've talked about the options for actions. Do you want us to come up with some options for you to discuss or are you looking? Is it the Panel's view that, when you look at the individual cases, you would develop the options for further actions? It's just that, if everyone looks at them differently, and there are 30 cases, you might come up with a whole range of proposals.

MR BROOKES: I think some standardised options would be really helpful.

MS McINTOSH: They might not be the right ones, but then at least we have something to work on anyway.

MR BROOKES: I think we need to be seen to have a standard approach and a set approach,

which is fair and reasonable to all cases.

MS McINTOSH: Thank you.

PROFESSOR MONTGOMERY: Linked with that, Julian, we have to try to work out what we're going to do with people who come quite late on in this process, who could have responded to this advert, but didn't in the timeframe we were expecting and how we deal with those. I think it's quite reasonable for us to take a view that, in order to move the Investigation forward, we have for management purposes to take a cut-off and say that we're going to take everything that's come in by this period and move forward. We'll need to still respond to people who come in after that, but it might be an acceptable response to say, 'We've reviewed what you've sent in. It raises similar things to cases we're already investigating and it's beyond the time at which we were able to move to a specific investigation, so we won't be able to do a case review at that stage, on your case.' We need to decide where that cut-off lies.

MR BROOKES: We do. I think, realistically, over the next few weeks, we'll get to a stage where we will probably come to a natural end. If there is something that comes in that is so serious, well then it will be in the Investigation and we will need to reflect that. You're right; we've given a commitment by the end of the summer to have completed this work. I wince when we say that, but we have and it's important therefore that we have to set some sensible parameters around it, but don't discount any case. We need to make sure that anyone who comes through is clear on why or why we are not including it in the Investigation.

I just had one other question. We've extended this now to all hospitals within the Trust, where obviously our initial concerns were around Barrow. Is everybody comfortable with that and was that what everyone's expectation was?

MS McINTOSH: I don't know if everyone's comfortable with it, but our Terms of Reference talk about 'the Trust', so it would have been very unfair on Barrow to have just gone to Barrow-in-Furness.

Can I just go back to the point that we've just discussed about the cut-off? Probably what might be quite useful is if we take out a test case from this and we see how long it takes to look at the test case, because then when people say, 'It was arbitrary,' no, it wasn't arbitrary. It's taken us two months to look at a case, and we have to be writing the report by, so therefore we stopped on... We put that on our website, so that it's fair and it's fair to the Panel, I think, then.

MR BROOKES: I think that's a really good idea. I think also we will get to a point of drafting when it becomes very difficult to start adding new cases in.

PROFESSOR MONTGOMERY: Do we need then to decide about what our criteria are for moving these into a case review? We might have criteria that are around it doesn't seem to raise a new issue. If we know how long it takes us to do the case reviews, we might say some of these seem to raise the same type of problem as we had. I think that's the distinction between the very serious outcomes and the poor care issues. If you have a death, you clearly would need to do a full case review, because the family's entitled about that, but if you had a complaint about poor communication and we already have cases that are going to involve communication issues, we might not think it needs the same detailed scrutiny. Again, we need a rationale, don't we, for explaining that?

MR BROOKES: There are just on the summaries here some similarities between previous cases, so we need to consider whether or not doing an additional case brings additional information, because actually it might. It might be quite useful.

PROFESSOR MONTGOMERY: It always might, but it is about balancing our resources to get through it in a timely manner.

MR BROOKES: Okay, thank you. Any further points on that item or shall we move on?

DR CALDERWOOD: I just wanted to ask, Tom, about the one that's in 'may be in scope'. It seemed to be about someone with an [redacted] Were they pregnant?

MR BACON: No. It's only 'maybe' because it might be considered in scope if it was registered as a serious untoward incident, and just because the Terms of Reference asked us to look at SUIs and the response to SUIs. It may be, which is why the suggestion was it's included. We will check whether it is and, if it is, we will include it as part of the random sampling piece of work looking at the responses to SUIs.

DR CALDERWOOD: We weren't restricting ourselves to the maternity unit and neonatal services.

MS McINTOSH: No, we're not, because whilst we're established as a maternity and neonatal services investigation, the Terms of Reference actually leave it open for someone to say, 'Well, actually, a coronary care case…' Because actually, if you look at all SUIs, the Terms of Reference don't just refer to maternity and neonatal SUIs, and they don't just refer to just maternity and neonatal services incidents. It's hard for us because we can't close it down to a narrower field for review.

PROFESSOR MONTGOMERY: But what we're looking at then is the response to SUIs, as opposed to the cases that generated them.

MS McINTOSH: Exactly, yes. It's how they were handled.

PROFESSOR MONTGOMERY: We're forward from the SUI was recognised and what happened next.

PROFESSOR FORSYTH: Because we don't give a clinical opinion—

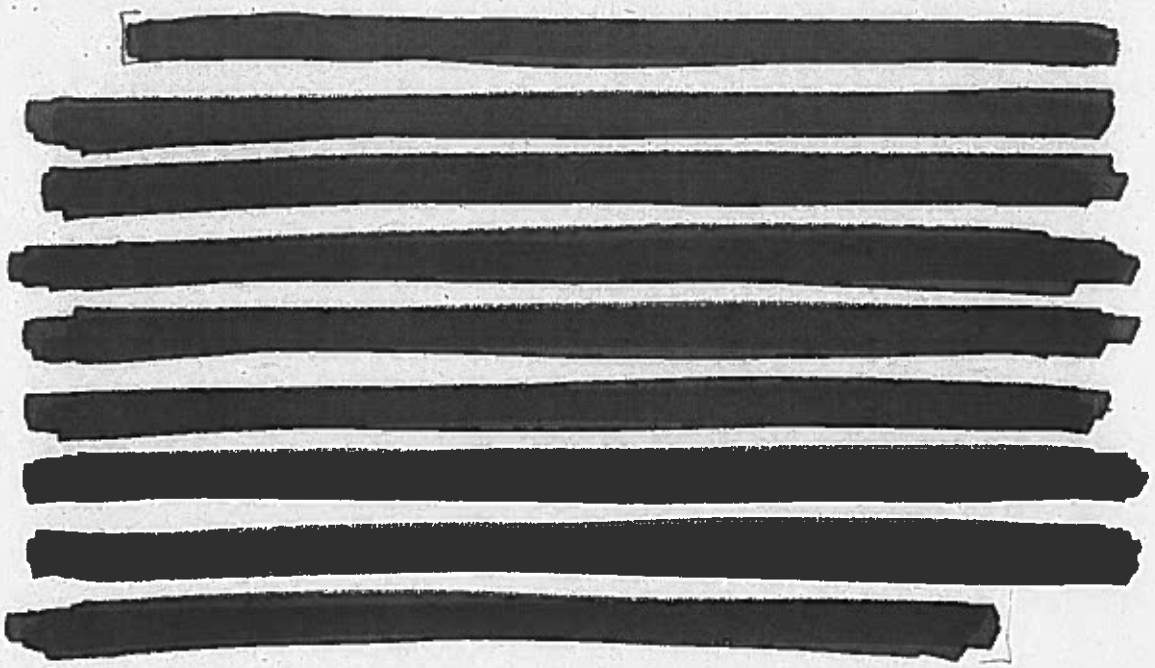
MS McINTOSH: No, absolutely not. It's about the management and the handling really. I suppose there's... Implicit in that is: were incidents that arose in the maternity and neonatal department treated the same as they would be anywhere else in the hospital, or is it actually not an area of concern? And actually looking at other cases gives you, not a proper benchmark, but at least a feel for how that Trust looked at things.

MR BROOKES: Okay, thank you. I'm going to turn to Stewart now on item 5, Neonatal Outcomes. Stewart, you get the task of being Hannah today.

PROFESSOR FORSYTH: This is Hannah's. I think this is another challenge we have. Obviously one of the questions that we'll be asked, I'm sure, and we'll want to have an answer for is whether the maternity and neonatal services in Barrow-in-Furness were an outlier compared to the rest of England. It's really difficult to answer that question for two reasons. One is that we need to have really good data on all of England to compare with. Certainly Barrow-in-Furness is a very unusual unit and there are not many similar around the United Kingdom for comparison, and so how we handle comparative analysis is really quite tricky. What we don't want to do is to hang our judgment on fairly poor quality data. I think what Hannah's doing is trying to find out if there is actually some good data in there that we actually feel comfortable with, which we would be happy to put in our report, for example. I'm glad Catherine's here because –

DR CALDERWOOD: [redacted]

PROFESSOR FORSYTH: [redacted]



DR CALDERWOOD: I would even say that is true in 24 to 28 weeks. We would have expected those babies, some of them anyway, to have been transferred elsewhere. Why were they being...?

PROFESSOR FORSYTH: There is only one that's actually born.

DR CALDERWOOD: The numbers may be very small.

PROFESSOR FORSYTH: I think there was only one born in –

DR CALDERWOOD: That lowers the count.

PROFESSOR FORSYTH: Likewise, when we were looking in relation to resuscitation, the number of babies requiring resuscitation was again surprisingly high, compared to the all-England data. There is a hint there that – it all might be down to how they interpreted the findings and went to the diagnosis – but I don't think that should be ignored. What we're going to try to do is the outcome score, which historically would have been something we would have done for many, many years – some discredit it slightly, but it's an actual score of the condition of the baby at one minute and five minutes. Hannah was going to get an update from the all-England data, but she's going

to try to get that data for Barrow and compare it to the West Midlands data they have. This is again to get a feel for the condition of the baby. The suggestion is, from the resuscitation data and the diagnosis of birth asphyxia that more mature babies are being born in poorer conditions in Barrow, compared to all-England.

DR CALDERWOOD: This is the whole Trust though, I think, Stewart.

PROFESSOR FORSYTH: Yes, this is the whole Trust.

DR CALDERWOOD: I suppose what it does is raises questions I would like just to investigate. There may be a straightforward explanation as it's coding or it may be statistically an outcome with such low numbers, but you can bash those off very quickly. It's the next question then, if what remains is a higher incident. Is this evidence of practice that is different than other places, because of something they're doing or something they're not doing that's inappropriate?

PROFESSOR MONTGOMERY: Can I ask a question about governance? Would we have expected this information to have been spotted? There's a set of questions about how valuable the information is and there's a set of questions about, even if it isn't reliable, should, for example, people have picked it up and therefore thought about it so we would expect to see some discussion, in the way that you would now for standardised mortality rates, irrespective of whether they turn out to be reflecting the volality[?] about the Trust configuration. You would be very concerned if the Trust hadn't asked that question. That's analysis data that you would have expected them to be monitoring through their clinical guidance.

PROFESSOR FORSYTH: Yes, the Trust should be producing a perinatal mortality report every year, on which that data should be present. That should go to at least a governance committee, if not to the Trust executive team.

DR CALDERWOOD: That's mortality; this is not mortality data though, most of it. At that level of data, not all mortality data would necessarily get to Board level. That depends. I would expect a unit to have a regular perinatal morbidity and mortality meeting, at which there was an investigation or discussion about mortality and morbidity. That doesn't go anywhere above maternity unit governance. It wouldn't necessarily go higher than that anywhere. I don't think that this data, if that's what you're asking, Jonathan, the stuff that's presented here – firstly, it's quite difficult to get the all-England data and interpret it, unless you know all of the caveats around it, as Hannah does, but it wouldn't be generally known. I wouldn't expect units to flag their own data in very small numbers against national data.

PROFESSOR MONTGOMERY: We had the earlier discussion; we somehow have to get the timeline of what might be reasonable to expect when. We shouldn't expect the Trust to have access to all the analytical support that we've got, but we should have an understanding of what would be expected.

DR CALDERWOOD: I think that the difficulty is that the numbers are overall small, and so if you ever produced a graph of it, I'm not sure that everybody would say that the numbers are too low to interpret that. That's always been one of the issues with this question.

PROFESSOR MONTGOMERY: Although I think even a very small number, if you have more than one, you should be asking the question. I don't know whether you would say that about these sorts of figures as well.

DR CALDERWOOD: Again, sometimes it is down to individuals and what the mode of all of this is. In some units, there is somebody who would be very driven who would do comparisons and compare with the unit along the road, etc., but that is not –

PROFESSOR MONTGOMERY: Would those meetings be documented meetings?

DR CALDERWOOD: They should be.

MR BROOKES: I think it's that way around actually. We need to understand what they were doing and then to determine whether, under the circumstances, that was reasonable practice.

PROFESSOR MONTGOMERY: Actually, we might say it was reasonable practice, but it isn't the best practice. We might draw attention to what we think should have happened, not as a criticism but as a suggestion for the future.

MR BROOKES: What we are looking at is somewhere along that spectrum of 'You absolutely should have been doing this, and the information's in front of you and you did nothing with it,' to the other end, where it's actually 'With the kinds of expertise and the benefits of hindsight we have now, that might be the pattern, but you couldn't have told it at the time.' Somewhere along there we need to make some judgments. It's really about what they were doing and whether that was reasonable at the time. I think that's pretty much a rule across a lot of the things we will actually be doing. There may be some different judgments about what is reasonable, but that's part of the discussions the Panel will bring to it.

DR CALDERWOOD: What I think might be interesting as well, is that in the NHS Cumbria review, which covered this Trust and another one, there were significant differences flagged between the two Trusts in the pattern of baby stillbirths. That was produced nearly a year ago now. What was their response to that? That was something that must have gone to them; who did it go to and what did they then do to try to understand their own data?

MR BROOKES: One of the biggest questions in my mind is exactly along those lines. There

is a variety of investigations and reports, which highlight concerns and poor practice. What was the response to that is really important, because if there was no meaningful response that tells you something. If there was a response, why didn't it work? There are a number of questions, but it isn't as if this comes as a complete surprise. It's about the fact that there have been a number of opportunities along the way to actually pick this up and what happened about that. That's really, from the governance point of view as much as anything else, my major concern, and obviously from a clinical point of view as well.

DR CALDERWOOD: Some of our work has been done for us, because that has been predating this Panel. It's also been an enormous case-note review process, which is what we are proposing for a different reason. In fact, that is where I would say, in the practice, you could definitely say there should have been a response and what you would have expected that response to be.

PROFESSOR MONTGOMERY: It also relates to the reflections we're having after – I think I joined by teleconference – with the Board. They gave pretty good accounts separately of things they were doing. They weren't very convincing about their ability to see things that kept coming across. They were significant in one side only but, if they saw them coming up in more than one, it would be a bit of a flag.

PROFESSOR FORSYTH: The final point is this is a problem of small numbers. It's something we've got to think about, particularly in terms of our recommendations. A lot of the poor practices that have come to light eventually are in units with small numbers. If you're in a busy unit with a lot of numbers, it stands out when you compare with larger. You know there were only about three deaths in the last year. Actually, three deaths for a small unit would be enormous. I think this is a classic

situation where something's been going on for years, not in the particular case, pre-judging it, but there are lots of examples of smaller units carrying on and then, suddenly, something just comes to light when you actually amalgamate data and see what's happening.

PROFESSOR MONTGOMERY: Somehow we've got to get some advice on how you'd work in the absence of the quantitative data. In a big unit, your quantitative unit could tell you quite a lot but, in a small unit, it's not going to pick it up quickly for you.

DR CALDERWOOD: Almost, I think, that's where the detailed case reviews are more. I initially looked at the numbers and thought, 'All of these stories I've heard, I know this is an outlier; this can't be right.' We will never convince the statisticians. Similarly, the Trust will – it's not to give them data that then is not statistically viable because of the lower numbers. Going down that track is not going to be productive. We need to find another way of learning the lessons, because I suspect Hannah will eventually come to the conclusion that we cannot make very strong questions because of the statistics. That may be, or otherwise, the way that everybody will then look at it. That's what happens with all of these. There's somebody way up there and you say that they only did three cases. One was a bad outcome; that's 33%. No matter how much you may feel that they're an outlier, that's not acceptable.

PROFESSOR MONTGOMERY: It's not really because it's 33% though, is it?

DR CALDERWOOD: Exactly.

MR BROOKES: There are a number of things here, aren't there? There's the fact that we absolutely need to do the analysis. What we may conclude from the analysis is unclear and we don't want to prejudge that, but it may be that there is not sufficient data or size of sample or whatever to actually make concrete conclusions. However, we therefore

need to make sure that we've done other things to get to the bottom of whether or not there are risks in what we can actually—

PROFESSOR MONTGOMERY: We might actually need to say, if you're running a unit smaller than this number of deliveries, you should not use the statistical analysis as your measure. You need something different. Actually, that would be quite a useful recommendation to make, if that's what falls out of the Panel.

DR CALDERWOOD: The other thing that happens then is that the cleverer people do other types of analysis on it, three-year rolling averages, etc., etc., so, in fact, just taking the absolute number is maybe not –

MR BROOKES: We don't want to get into a debate on publication about the quality of the stats.

DR CALDERWOOD: That'll be exactly what happens.

MR BROOKES: If we believe that the data does not provide sufficient evidence, we just say that; we move on and we look at other aspects of it. That may be actually quite powerful, because it can be open to interpretation, especially when we're talking about the sizes of caseloads we're talking about at the moment, so that might be a way we can go. We need to then be able to say, 'We got that far. We were unable to draw any firm conclusions. Therefore, we did X, Y and Z. We did a case study review, notes review and the range of other things we can do.' We can build on all the information that has previously been collected through the different investigations or internal investigations that have happened. Okay, that's really helpful, in some ways. Unless there's anything else, we'll move on, which is probably going to be our most substantial discussion today. Who knows?

This is following on from item 6, assessing the evidence. You will all have

seen and contributed to the paper that is here at 4.5, which is a slightly revised version of the paper that Bill sent round relatively recently, and it's taking into account the different comments that came back on this particular paper. The fundamentals of it are that we all recognise now, and anyone who's been on a panel recently, that despite or because of the amount of evidence that is now coming in, there is a tremendous amount of evidence. It's probably got to, or it has got to, the stage of physical impossibility really for all of us to plough through every single thing individually. We need to think about how we collectively look at the evidence to ensure that we are covering the ground, but also balancing what we need and providing support and advice to the team, in terms of how we categorise the evidence and place the evidence into certain particular places to enable ease of access, but also a cataloguing process for the Investigation team to adhere to as well.

I'm not going to go through the document in detail, but noting here over 1,100 documents and it's probably increased significantly since then. We are looking potentially at the creation of four groups, and there is some suggested membership of those groups on the second page of the paper and then there are some brief descriptions of the kind of work that those groups would do.

First of all, if we could, look at have we got the groups right. These are slightly different from the ones we originally had. Let's ask that question first and then we'll move on to membership and how we organise and do that. No, I'll step back from that. First of all, is the approach that is being taken in the paper one that members feel is the correct approach and the way in which we should move forward? I think that's a yes. That's good, then we have created four groups: a clinical group, a Trust management group, an external response group and a report group. Is there anything

you want to say about those, particularly the report group?

MS McINTOSH: When Bill and I discussed this, when we find out who's leading each of the groups, then they will be the automatic go-to people. It doesn't mean it's another group you've got to sit on and something else to be bogged down, but actually it will feed in. If you are the sub-group lead and you have delegated something to A.N. Other, then it may be A.N. Other we go to. Actually, rather than just trawling around and asking the whole group first, it's about using your time and not interrupting as much as you could do.

MR BROOKES: Then in terms of membership of the groups, recognising that this is not a closed shop and that anybody can join any group that they wish to or any session that they're able to do, but recognising that we all have other things to do in our lives as well, it's about trying to manage and coordinate effectively. Does anyone feel that they are not in the right group to start off with, would want to be in an additional group or are they comfortable with their membership?

DR CALDERWOOD: I thought it was good that, first of all, all of us are on more than one and that Bill then is on them all. Each group is going to end up approaching things in a similar way, so that there isn't one group that's decided to do it one way and it doesn't match the others. I felt comfortable that that would keep us at least approaching things in a similar way.

MR BROOKES: I have to say, I did question whether Bill would have the capacity to be involved in each group in my response to him, but I believe he quite rightly wants to keep oversight. That doesn't mean he'll be at each of the group's meetings. Your point of consistency is really good, in having all of the people in more than one group. That keeps that continuity across. Stewart, any comments?

PROFESSOR FORSYTH: I think I'm happy with the composition of the groups.

MS FEATHERSTONE: Obviously I'm in the clinical. Just with regard to the Trust management, from what I've done on my own, I would just like to follow through because of the complaints. That was very pertinent when we went to the visits. It was alright what they were doing, but it was just to make sure, so I would just like to see some of the responses in that as well.

MR BROOKES: You'll be very welcome in any of those sessions as well.

PROFESSOR MONTGOMERY: The only thing I was going to say is I wonder whether we've got the name right for the report group, because it could be that the consistency point as we go through comes from using that group. It's not just about the report; it's about checking that nothing falls through the net. It might be that Bill could do that as part of dealing with that, but it might be that it's good to use it a little bit more like a steering group.

MR BROOKES: Coordination internally, yes.

PROFESSOR MONTGOMERY: That was the bit I didn't understand from the paper. If this was to be done in a couple of months' time, would that kick off? Actually, if it is about making sure that everything goes somewhere and, if things are going in more than one place, that's kind of duplication as opposed to –

MR BROOKES: Having said that as well, the report group needs to kick off immediately anyway, because it needs to start fleshing out what the report's going to be like – the sections, the elements – so that we can be clear in terms of the other groups what inputs they need to be looking to design, in terms of the output, if you see what I mean.

MS McINTOSH: Obviously as this work starts, then Panel meetings are going to change and what's discussed at the panel meeting is going to have a very different feel about it.

Bill's view was very much that the Panel meeting is an opportunity for the fourth group that's listed there – to be renamed – to be feeding into Panel meeting discussions, rather than just having a discussion with X sub-group or Y sub-group. That's how it will be hopefully managed.

MR BROOKES: Okay, and I would quite like to do this today, but if we can't, we can't. I'd quite like to just have a discussion about who could lead these groups.

DR CALDERWOOD: Bill; he's not here!

MR BROOKES: Geraldine is not here either, so that's quite helpful. Have you had any conversations with Bill about what that means, in terms of each group?

MS McINTOSH: It's about two things. One is about kick-starting the discussion about delegating areas of work to colleagues, so that you won't have duplication within. It's just a steering and management oversight role. The second bit was very much what I referred to a moment ago about feeding back in and not having to put an onus on the whole group to feed back in. I suppose there's something in there under the oversight, going back to the first point, about making sure that Panel members are keeping up with things and, if they can't, how do we shift the resources around within the team to do that? It is a classic manager role, in a way, but ensuring that all the balls stay in the air, I suppose – not easy.

MR BROOKES: Okay, shall we take them one at a time? If we can't come up with it and people feel they want to have conversations about it, I absolutely understand that. If there is anyone who would like to take on the role, I think it's important that we do have someone leading it. That gives an additional focus to what we're talking about, but I don't think it matters too much about who it is. That's why I wanted to explore the roles, because it's about having the time to do that, as much as anything.

PROFESSOR MONTGOMERY: That is in liaison with Oonagh and the teams.

MS McINTOSH: Absolutely, yes.

MR BROOKES: Yes, I'm envisioning that the teams support each of these streams and it's not done in isolation. Does anyone want to say anything?

PROFESSOR MONTGOMERY: I won't volunteer for the clinical, but I'm happy to pick up the external response, as long as it can wait about three weeks before we come back to it because, in about three weeks' time, I get a little bit of space. In about six weeks' time I'll have time to do it properly, if that's helpful.

MS McINTOSH: I think that feels perfectly reasonable, because there's such a lot of material to be worked through. Nothing's going to happen.

PROFESSOR FORSYTH: It seems to me that the first paper was an attempt to try in my own mind to get an idea of how we are going to do this. It's all very well to get a team together and decide who the leader is, but actually how are we going to do this? It seems to me that each of the four groups on the piece of work is going to have to set up an action plan, on which they've got agreement on. We then can actually see how this is all going to knit together.

There were a number of comments that came back when we saw the first paper about interfaces and making sure that we're not duplicating or actually making great big holes in the investigation. I think that there's a bit of work; whoever takes on leadership roles has a bit of work to do, I think, in terms of being the driver to try to get that action plan or whatever you want to call it. I'm happy to do that for the clinical group to be seen as – if you call it the leader – to get that and to liaise with the members. I know, Catherine, you have enough jobs and everyone else is busy, but I'm happy to do that if people are in agreement.

MR BROOKES: I don't think anyone's going to disagree with that and a good rationale as well. Trust management? That one I just would like to take stock on, because Jonathan has already volunteered; Stewart's already volunteered. That really only leaves Geraldine and myself. Geraldine, I'd just like to talk to here about that, because it is the area I know I would feel least comfortable about. I'd be quite happy, for example, to do the externals, because I've done a lot of that. I'll speak to Geraldine. When's she back?

MS McINTOSH: I think she's got another week away.

MR BROOKES: We'll leave that one between the two of us. It will be one of us. I will do it if Geraldine doesn't feel that she's got the time.

PROFESSOR MONTGOMERY: If you would really rather do the external one, I'm happy to have a conversation about the management one, but I'm a little bit away from that now.

MR BROOKES: It's the same; that's how I feel as well. Let me have that conversation first and, if we need to, that's great.

MS McINTOSH: The advantage we've got, and it's really naughty when people aren't here to talk about them, is that Geraldine is the one member of the Panel who is currently sitting on an acute Trust management board and a high profile one. Having had a clinical governance background, she really adds value to that group. I know that's what Bill was thinking of when he –

MR BROOKES: That's why I want to have the conversation. I don't want to volunteer her in her absence. We just need to see what we can do. Geraldine and I have worked together in the past, so we'll work something out between us; that's absolutely fine. Jacqui, are you happy with that?

MS FEATHERSTONE: Yes, because I haven't done anything like this before. I'm very happy to give as much as I can, but I don't have the expertise in that, so I would be very happy to be led, absolutely not a problem.

MS McINTOSH: Can I just confirm, Jacqui, we're adding your name not in square brackets, but I'm adding your name to Trust management.

MS FEATHERSTONE: It just follows through, otherwise there was no outcome.

PROFESSOR MONTGOMERY: I think once we know the plans, there'll be some evidence sessions where I might say, 'Actually, I really need to hear…' as a dimension. We just have to be realistic about it.

MS McINTOSH: Do you mind if I just come in now about something I was going to raise under any other business? I'm quite conscious that, for those of you who've got PAs, they're despairing at the fact that the Investigation is holding so many dates in your diaries at the moment. Actually now we've got the groups together, we will go back to the huge list of dates that we've worked through and look at what availability we've got for the groups. I will share those dates with the groups and if they look good, brilliant; we'll firm up some days. If they look bad, then this is where the 'ad hoc jobs' that you always put in the job description, the leader's got to be talking to their colleagues to say, 'We will have to free up some dates.' That will enable us to look at the Venn diagram of where the overlaps are. If you're going to get, I don't know, former Trust Chief Executives in, that's not just about Trust management; that's actually about what you did in clinical reports and what you did with statistics, etc., so it feeds into both. We can actually look at that, if your PAs could just bear with us a few days longer.

PROFESSOR MONTGOMERY: There will be some people, whether or not we're in the relevant group, we will want to see the white of their eyes.

MS McINTOSH: Absolutely.

MR BROOKES: Therefore, as part of the process, we all need to know when all the groups are meeting.

MS McINTOSH: Absolutely.

DR CALDERWOOD: Oonagh, did you get anywhere with the senior Board teleconferencing facility?

MS McINTOSH: Tom, can you give us some feedback on that?

MR BACON: Yes. It is possible. I was hoping that we could have done some testing this week, so I could have something a bit more substantive. It's a web-based system, so it might not be appropriate if there were interviews, for example, but it might be appropriate for meetings. It would involve us bringing in a camera.

MR BROOKES: What system is it?

MR BACON: I don't know the name of it. It's essentially a secure version of Skype, basically. It goes through the internet. You're given a website to log into in front of a camera. We've got a similar system at this end.

DR CALDERWOOD: Cisco or somebody, WebEx.

MR BACON: It's something like that. It's a secure version of it.

MR BROOKES: For my sins, completely differently, I'm doing something on video conferencing across Public Health England, because getting everybody to meetings is challenging. It's quite interesting.

MR BACON: The system that Public Health England uses will be something that's available internally through a link with the Department of Health computers as well. I don't know how compatible it is with external computers.

DR CALDERWOOD: You don't always have a camera is my experience of it, so some

people you can see but not everybody.

MR BACON: Most laptops these days have got them built in. It will vary. One of the advantages of the system we're looking at is, if necessary, we could at the other end have a camera sent. If one of your computers didn't have a camera, we could have something sent for the purposes of that meeting.

MR BROOKES: That's excellent, thank you. Okay, that was actually easier than I thought it was going to be. Is there anything in terms of next steps that we haven't covered? I don't think so. The big challenge then is Huddle as well, in terms of trying to arrange the information, which is seen as appropriate to each of the groups as well.

MS McINTOSH: Before we leave this, if we could go on to the other two papers there, which are supporting it, at the bottom of the paper that Bill amended, it talks about the role of the Secretariat and how the Secretariat is then going to support each of the sub-groups. Actually, the process behind that needs to be understood by everybody and kind of signed up to by everybody really. What we've circulated to you is a draft set of search terms because, for each of the sub-groups, to help the Secretariat, Paul and his team to actually identify which documents need to be flagged up for you, we need to know what the search terms are that each of the sub-groups will want to use.

Now, there's a huge list of terms in front of you. Paul, you need to say when you want people to come back to you to actually help with this. Maybe it's better if we hand over and look at your next paper and the slides that are shared there, and talk about the process we want to use and how the search term process feeds into that.

MR ROBERTS: Certainly on the list of search terms, I wasn't sure how relevant the list of names were, because they were the names that we got from the police evidence, so it doesn't include all of the names we have got. Similarly, we've got a couple of

additional names from some forgotten corner, which are included in there as well. That list of search terms there are just things that we've put down on the paper to get your feel and your feedback on them, as to whether they're appropriate search terms or not relevant, other than those other things that we should include.

In terms of the next paper you've got here, which is the presentation, if I just run you through that. The words are probably a bit small, but I'll talk you through it. I can email it to you. What we're proposing to do is that, as we get the evidence in, we are obviously going to give every document a unique reference number, so that we can easily identify it. All the organisations will be prefixed with a four-digit number, which they'll be allocated on a separate slide. As soon as possible after we've received the evidence, we're going to create the index. The proposal is that we open up the index to Huddle as the starting point.

Up to now, what we've done is, when we've got evidence in, we've banged all the evidence straight on to Huddle, by organisation or by case, which creates this mountain of evidence. It's a needle in a haystack almost. Hopefully, by creating the index of all the documents that we've got, and we've put on Huddle yesterday a new folder under the organisation – everything's by organisation – called a master index list. That's simpler, because it brings it right to the very front, to the top of everything. We're going to put all the indexes, as we create them, into that folder. That will be done today for a number of indexes that we've already created. That will enable you then to look at those indexes by organisation and look at all the documents, and then tell us which documents you would like us to upload for you to look at, so that you're prioritising the stuff, rather than us putting on everything. I'll tell you in a minute just how many documents we've got from each organisation. Hopefully this will be a much

better way.

The other thing is that, if we do it that way, we can maintain a record of what we've given you to look at. Therefore, we can identify what you haven't looked at. The worry is that, if we put everything up there, the only way around it is for you to actually create a list yourselves of what you've looked at. Now, ultimately we can put everything on, so that's not an issue. The way we've set it up at the moment is a different workspace for every different organisation. That's probably the way we'll carry on unless you think that we should do it differently, but what we'll only do is upload stuff that you want.

In addition, we've recently recruited some additional staff, so it's not just Jo and myself now; we've got two other staff. Once you've finalised all the names for the sub-groups, a member of the team will be allocated to your sub-group and they'll be your go-to person. You can always come to me if you've got an issue, but they will be your go-to person for your sub-group, for any evidence that you want or any queries that you've got, so you've got a focal point as well. Are you happy with that thus far?

MR BROOKES: I think so.

MR ROBERTS: The next line is just a list of the four-digit numbers that we've allocated to the various organisations and, if more organisations come to light, we'll just keep adding to the list. The next slide is an extract really from every letter that we've sent to the organisations requesting evidence. There's been a standard letter and an annex, and the annex has been a list of all the evidence that we've asked them to provide. We've got one document that's got about 29 pages in.

MS McINTOSH: I'm not going to show it to you because it's depressing.

MR ROBERTS: That's all the annexes, so that's got all the evidence that we've requested

from all the organisations. We've split it up, so that there's a separate page now for every organisation and we can just upload that. That is an example. That's the Litigation Authority, so that's what we've asked the Litigation Authority to provide. There's a separate one of these for all of the 19 organisations that we've contacted, which just makes it easier for you to cross-reference what the Investigation has asked for and what's been provided.

The next three slides are examples of the indexes. I've done three because they're all different. The first one relates to the NHSLA, so you can see it's got a unique reference number. The content, you'll have to ignore any spelling mistakes because that's as they have given it to us. We've just cut and pasted it. What you'll see is you will see the index with the unique reference number, the content of what's in it and the format that it's in, whether it's pdf, whether it's Word, it's Excel or whether it's an email. Okay? The end column is that we would record what we've done. The first one there is, as I say, the NHSLA.

The next one is for the Trust and this is slightly different, because the Trust one is an overarching index. The Trust so far, the annex for the Trust requested, has 17 different pieces of information that we wanted from them, pieces of evidence sent in questions. They've answered one to eight, and then summed up at the end. Thankfully, the Trust has been very helpful by allocating their own unique reference numbers to each of the sets of questions. What we've got there is this overarching index of what they provided so far and the contents. The first one is information on maternal and neonatal deaths. The second one is about neonatal transfers, and so on and so forth. If you wanted to look at any of that evidence, we've got it.

We're currently working on creating the full index list, but there are 242

documents. Now, those documents are already uploaded to Huddle, because as soon as we've got them to Huddle, as soon as we've given them the unique reference numbers, we put them on Huddle, because I felt that it was important that you had information from the Trust as soon as possible. Now, if you want to look through this overarching list that will tell us what you specifically want; we can move it to a different location so it makes it easier for you to look at it. We can do whatever you want with them. Again, it tells you what format it is.

The third one is just another example and this one's from Lancashire North CCG. Again, they've provided their own unique reference numbers, so we've just added an additional unique reference number to enable us to add it. In terms of the evidence, that's it for that set of slides. As we say, we've produced that and you can have hard copy of those slides, if you want it, or we'll send it electronically.

In terms of all the evidence itself, excluding anything that comes from the families, we've written to 19 organisations. There are six of them so far where we've not received any evidence as yet. Two of them are from the Department of Health, the legacy team and the policy team. The legacy team, I can tell you, emailed me yesterday. They are currently gathering evidence from the North West Strategic Health Authority. They have got between 900 and 1,000 boxes of evidence to look through to try to find stuff relating to Morecambe Bay. What's in the boxes I have no idea. Nationally, they've got –

MS McINTOSH: 480,000.

PROFESSOR MONTGOMERY: And this is a one-person team, is it?

MS McINTOSH: This is just one man and a dog.

MR ROBERTS: It's a mammoth task for them and it's going to be a couple of weeks

before –

MS McINTOSH: Before they've opened all the boxes. I think the problem they're encountering is that every PCT and every SHA archive their material differently. It's safe to say that some of them took care over their archiving and some of them didn't have the time and opportunity to.

MR ROBERTS: The other organisation that we're waiting information from, the two legacy and policy, and the CQC, we've had a meeting with them. We expect them to start sending their evidence to us in the next couple of weeks. HealthWatch we haven't received anything from yet. NICE we haven't received anything from, and Public Health England we haven't received anything from yet. The documents from the Ombudsman, there was an issue there with the Ombudsman, and Oonagh and Bill have got a meeting.

MS McINTOSH: Yes, we've got a meeting next Wednesday with both the Ombudsman and also the General Medical Council, both of which want to have further discussions about documents, how they release documents and whether they can release documents. The Ombudsman in particular has real difficulty in the legislation. Sorry, Paul.

MR ROBERTS: That's okay. We've currently got indexes for the CMACE reports that Hannah got. We've got an index for Cumbria Constabulary. We've got one from the coroner. We've got one for the Health and Safety Executive. We've got Cumbria CCG, NHS England, Lancashire North CCG and the Litigation Authority, and this overarching. We've got all those indexes and they'll be uploaded, as I said, today for you to start looking through.

MR BROOKES: Can I just ask a question about those? Quite a few of these are obviously successor organisations and some aren't. For example, Public Health England only

came into existence last April, so there are some like those, then you've got NHS North of England, which would have been an SHA for some of the time. How are we handling those? Are we going to just keep the most recent organisational structure? Do you see what I mean? There are sub-groups below some of these names as well.

MR ROBERTS: Where it's an organisation that has been abolished that will be run from the Department of Health. Hopefully they will split it up for us into the different organisations, sub-divided there by those organisations. What you've got there is a list of the current organisations, so Public Health England is as it is today.

MS McINTOSH: What that folder will contain will be everything from 1 April 2013 to 30 June 2013, within our terms.

MR BROOKES: For example, the Strategic Health Authority would be under the NHS North of England, even though it didn't exist for part of the time.

MR ROBERTS: In total, there are currently 2,655 documents available for you to look at. That's as it stands today. If we set Cumbria Constabulary aside, which was 1,097, the majority of them, 650, are from Monitor. I think we created the index for that. If we didn't do it yesterday, we're in the process of creating that. The next largest was going to be the NMC, which supplied us with 178 documents. As I say, they're not uploaded yet.

PROFESSOR MONTGOMERY: Would the police fit in our groups?

MS McINTOSH: Well, there are issues around the police evidence, because we've been given full cooperation by Cumbria Constabulary and the Trust has raised with us something, which is actually an issue for them to resolve with Cumbria Constabulary. That information was given to Cumbria Constabulary for the police purposes and not for the Investigation purposes. What we have done in this tome, or the annex that Paul

referred to that went to the Trust, which is a very lengthy document, is we actually asked for the same material. That actually gets around the data protection materials, but actually we've asked for more, because our Terms of Reference are much wider than the police investigation. The Trust was right to raise their concerns with us, and Bill considered the response that went to them. This is so that, if any questions are raised of the Trust, it is not about the Investigation.

One of the things, one of the advantages we had in getting the police evidence, was that we automatically have some names to start our work around, but also we were able to put stuff on to Huddle that you were able to navigate and look at. In particular, when we get from the Trust the case notes, they're already on the system and I know that Bill has already been looking at some of the case notes. Actually it's not that we're... We're being very careful about the evidence that we've got from the police and we had a memorandum of understanding in place well before they shared evidence with us, because we were aware of the sensitivities. We will be getting duplicates from the Trust and there is also something around our role of checking that we have actually received everything from the Trust that we asked for and making sure that there are no gaps. We've said previously that gaps may just be omissions. We have to just be mindful of that.

MR ROBERTS: Certainly in terms of evidence from the Trust, for example, as I said, they've provided evidence in relation to questions one to eight. Nine, ten, eleven and twelve were far more complex and they wanted some feedback from us about what was required. For example, on that index from the Trust, it talks about all SUIs and clinical incidents between 2004 and 2013. They provided that as an Excel spreadsheet. There are 1,100 lines on the spreadsheet, but it covers 73,500 incidents. Clearly you're not

going to look at 73,500 incidents. I think 51 of them were serious.

MR BROOKES: Sorry, how many?

MR ROBERTS: 51. There are probably more than that, but what it does do is it breaks it down with a list of identifiers. For example, failure of antenatal screening to detect a condition, failure to follow CTG guidelines, incomplete notes, communication failure within the team, communication failure outside the team. I just plucked these up at random. Looking at that, those were some of the things that I found were some big numbers really. I suppose what we're going to need from the Panel is to say, 'This is a random sample of what we need to look at.' That might be a useful one to look at, in terms of the serious incidents.

MR BROOKES: Just to see if this is how we could do it, for example – I'm not suggesting this is how everyone would want to do it – we've got all these indexes now. If the sub-groups were to look at what information they particularly felt was needed that could be then uploaded into a sub-group folder, and then those could be allocated to individuals within those, by that mechanism.

MR ROBERTS: Yes. The plan is not to exclude any of the evidence from you. What we can do is we can continue to upload all the documents into the evidence by organisation, so that it will all be there. What we can do is create another set of workplaces specifically for the groups, and then you tell us what you want and we'll make sure a copy of whatever you want goes into that.

MR BROOKES: That does two things, as you said. You've got workspace in which you're working to and playing through everything. The second thing is, if there is suddenly a large chunk of organisations that has fallen between the different groups, we can make a judgment on whether or not that needs to be looked at and, if so, where it goes. Wow.

PROFESSOR FORSYTH: It does lead into thinking how are the sub-groups going to really operate. It's going to be really important that we remain focused. We've talked about duplication. The idea of, say, the clinical group looking through a whole range of documents into our sub-group, and actually you may be having the same documents in your sub-group and you're poring through these, reading all these documents and so are we. Again, it's going to be difficult. Time's limited. We therefore need to have a system whereby we're all 'Oh, that's really important; we all have to read it.' That's where I think the integration between the groups again is going to be fairly critical in all of this. I'm just thinking, if we were all sitting down at our first sub-group meeting separately and thinking the same problems and whatever, actually it would be quite nice if – I don't know whether the Panel is going to have a discussion about how we see –

MR BROOKES: That is a working framework. One of the things it might be worth looking at is the leaders of each of the groups sitting down and agreeing some common ground, on which each of the groups can work. That might help; it might not.

DR CALDERWOOD: Didn't you say that we could flag it once we've read it and we would then know who has read it?

MR ROBERTS: No, it's not very easy.

MS McINTOSH: We could look at whether or not within the Secretariat we could see whether or not a document is being asked for by more than one sub-group and easily say, 'Just to let you know, Stewart, Jonathan's already taken that away three days ago.'

MR BROOKES: There's an incentive to be slow.

MS McINTOSH: Exactly. I think we could definitely do some communication around that.

MR BROOKES: For example, if one of the groups sat down and said, 'This is the core information we require,' I think it's really important the other groups know that, so then

there can be some judgment about whether or not there is a need for more than one group to read it or whether not.

PROFESSOR MONTGOMERY: There are things like, if you read the Health Services Commissioner's report and raise a comment on local practice, how do we flag that up and say, 'You don't need to read the whole report, but you know in this paragraph it deals with these things'? There is a whole series of things we have to work through about how we avoid people reading unnecessarily, because there's plenty of reading.

PROFESSOR FORSYTH: I think another aspect that the sub-groups have to keep focused on is the Terms of Reference. Again, if we are drawing up a sort of work plan of what we want to do, we need to actually see how we're keeping it to different Terms of Reference for the overarching group.

MR BROOKES: We need to do a sense check.

PROFESSOR MONTGOMERY: Also, the earlier we have a sense of the structure that the report is going to have, the easier it would be to match the Terms of Reference with the work programme.

MS McINTOSH: Can I just move to a paper that's right at the back of your pack, which I think might help you with some of this? It's something that Bill has been talking about and is content with. This is actually pulling together a lot of the discussions that we've had over the previous months, starting with the terms of reference and then going into the key questions and looking at the 19 organisations that Paul has referred to. What's the Term of Reference? What are the key questions that you and the Panel identified you need to answer in order to address that Term of Reference? What information will you require to do that? Where will we actually get that from? What's Hannah's input in that? What's the analysis and the data that you need to support it? What are the

organisations?

We've left a line, a gap, here of potential interviewees, although I also have here – and I've intentionally not shared it, because I know that [redacted] is still working on it, that we are pulling together a list of key players from every organisation. Now, that will grow because obviously, as each of the sub-groups starts to look at material, and you see that Oonagh McIntosh's name keeps appearing in something. 'What was Oonagh McIntosh's role? Oh, she was X, Y or Z.' That list will be added to, but that will actually help us in the Secretariat to track whether or not, in the clinical group you've got witnesses who are overlapping with management – Trust management and external parties. Then we're going to feed into that the sub-group.

Now this will become one of those documents that will evolve as we go along. Actually, what we need to do is it will be added to, should I say. We have to agree that this is a good template to work from. It does pull together a lot of the discussions that you might feel you've had in isolation, but actually were part of a bigger jigsaw really. I hope that might help, Jonathan, answer some of the other discussion we've been having in the margins this week. It was around, and you've referred to it, how we actually drill into that. How does each of the sub-groups work? What's the actual plan and who takes responsibility feeds into that. I don't know if it necessarily needs to be incorporated into this document, but each of the sub-groups can work from it.

This looks at terms of reference 1 and 2 at the moment. We're working on the rest of it and, as soon as we can circulate to you – we're actually working on it as a matter of Priority. I don't want you to think it's going to come to you at the next Panel meeting. It will come to you before. It is just a way of checking that, when Paul identities and nominates individuals to support the sub-groups, actually we're on the

right track too. You will get together and talk, but actually we need to be supporting that as well. Sorry, I kind of jumped in, but it actually links.

MR BROOKES: No, that's really helpful and I think it's a really helpful tool. I look forward to seeing the full one.

MS McINTOSH: One final thing is this will shape the report. It doesn't give a definite structure – chapter one, chapter two, chapter three – at this stage, but it kicks it off.

PROFESSOR MONTGOMERY: It also answers Stewart's point and it helps us track those Terms of Reference, because we've got Terms of Reference and key questions, and I can see that being really helpful.

PROFESSOR FORSYTH: It also helps to track back to the key questions as well.

MR BROOKES: Just one point: we obviously need to just update the groups.

MS McINTOSH: Yes, we'll change this.

MR BROOKES: Then it's quite useful then to cut it by group as well to see what kinds of questions we've got.

PROFESSOR MONTGOMERY: This filterable spreadsheet can quite easily do that.

MS McINTOSH: One of the points that is another piece of work that we're undertaking upstairs is doing a trawl of a variety of things: the transcripts of these meetings; any email exchanges that happened, even before the Panel was established that Bill had and you had with members of the family group; any correspondence the Investigation has had, with Joe Public or with members of the families; what commitments or promises or queries have been raised, questions that have been raised that aren't in the key questions, but will sit in addition to this. If we've said, 'We'll look at that,' when the families came that was a prime example of something. 'We'll take that away and we'll no doubt be looking at that.' Actually, we need to refer to that in the report and we

need to actually look at it. Those things are also not in key questions, but that's a piece of work that we're also doing and that will help, hopefully.

MR BROOKES: That's extremely useful. Any questions from the panel?

MS FEATHERSTONE: It may be a bit of a pedantic question, but CMACE is MBRRACE now. A lot of information I don't think CMACE did get, because I'm being asked from MBRRACE for things that happened in 2009. I think there's still quite a bit of information that needs to be gathered from them. We might need to just make sure. It just doesn't seem that there's been a lot of communication between what they did and what they're doing now.

MR ROBERTS: Certainly what's on Huddle at the moment is all the reports specifically on neonatal.

MS McINTOSH: You got this from MBRRACE.

DR CALDERWOOD: You're right that, overall across England, there was a lot of legacy data that is very, very incomplete. But I got them to go and dig through the boxes and they did get the specific report.

MR BROOKES: I was just thinking exactly what Oonagh has just whispered to me, which is we've reached a natural break. We've got NHS England coming. What time are they coming?

MS McINTOSH: They're coming at 1.30pm.

MR BROOKES: Okay, so we've got a good half an hour.

MS McINTOSH: I just remind colleagues to take their papers away with them, so that nothing is left in the room unattended.

MR BROOKES: Thank you very much.

[There was an adjournment from 12.58 p.m. until 1.50 p.m.]

Joining the Meeting:

John Lawlor – Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England
Martin Clayton – Commissioning Director, Lancashire Area Team, NHS England

MR BROOKES: I'm Julian Brookes. I'm chairing the session today for Bill, who is unfortunately unable to come. We will introduce ourselves, but if you could introduce yourselves first that would be really helpful.

MR LAWLOR: John Lawlor. Area Director of Cumbria, Northumberland, Tyne and Wear bits of NHS England.

MR CLAYTON: I'm Martin Clayton. Director from the Lancashire bit.

MR BROOKES: Thank you.

[Introductions]

MR BROOKES: Welcome. Thank you for making it here, first of all. We have all heard interesting stories about getting here. Some have taken longer than others. So thank you for that. We want to make sure that we have a good understanding of the commissioning environment in which the organisation we're looking into was working in. And so we feel it's very useful to have someone to come and talk us through that, and hopefully give us an opportunity to ask any questions so that we can establish a common understanding of the environment then and the environment now. That would be really helpful. So I don't know who's going first, but if you can that would be really helpful.

MR LAWLOR: I've brought some slides. We both felt the last thing we wanted was 'Death by PowerPoint', so you've got 'Death by Printout from PowerPoint'. As you say, I'm very happy either to talk and then ask questions after – or as we go along, people can

stop and say, 'Can you describe that?'

MR BROOKES: Can we have another one here?

MR LAWLOR: Yes, sorry. So what I was going to do, very briefly, was – as it says on the first slide – a little bit about 'what is commissioning?' or what did we and what do we mean by commissioning in the health service, some of the main developments in the commissioning policy, and then a little bit about the new commissioning system. But not too much about that because obviously in terms of reference of your remit, it is just a three-month period, if you like, from when the new system went live on 1st April 2013. So that's what we'll cover and hopefully that will generate some questions.

The next slide is really just saying the way the NHS – it's a massive oversimplification of the first sort of like 30-odd years of the NHS, but effectively there weren't too many seismic shifts in the way that the NHS was structured, or the roles and responsibilities, until the introduction of what we call the 'internal market' at the time, in 1991. So that's just a very high level summary. It was a largely nationalised system of healthcare. The NHS owns and runs all the hospitals. So effectively they were all owned by the Secretary of State. It wasn't until the introduction of NHS Trusts that that changed.

Just a little bit about some of the things that have moved back. Community nursing, public health and ambulance services were run by Local Authorities until 1974. And then, as you see there, GPs, Dentists, Pharmacists and Optometrists were independent contractors, as many of them still are. And then the big change really was with the publication of 'Working for Patients' in 1989, which proposed this idea of what we called at the time the 'purchaser-provider split', that we will all remember only two well. And we worked with the more controversial bits once upon a time with GP

Fundholding.

The next slide really briefly talks about just that: the idea of purchaser-provider split. What do I mean by that? Having different organisations that are responsible for the delivery of care, the hands-on care to patients, particularly talking about physical health services but also mental health services, learning disabilities, etc. And so during the next four or five years, from 1991 to 1995, virtually every – what we called at that point 'directly managed unit' became a stand-alone separate NHS Trust. And the logic of that was about having… it provides freedom a little bit from the bureaucracy, as was perceived at the time, to be able to sort of develop more locally responsive services. And then the other organisations that were created out of all that were health authorities, who had the responsibility for what we now call 'commissioning'.

I've mentioned a couple of others there. There was a significant expansion in the role of doctors in management and leadership, particularly doctors, during that period. And then something that… you could say some of the similarities between the new clinical commission group idea – some of it was borne out of the idea of Total Purchasing Pilots.

And then it was probably in that period that the NHS first started talking about commissioning. And it was quite a heated debate between particularly GPs who wanted to be GP Fundholders – who saw themselves as purchasers – and GP practices who wanted to be primarily interested in assessing the health needs of their practice populations, and trying to work out how to help the health authorities earn the money as wisely as possible. So it was at that point really when we got into this terminology of commissioning.

The next big change was after the change in administration in 1997. It was a period of quite significant expansion in the health service. Very significant in real terms of increasing resources; lots and lots more staff employed and trained. And following the publication of 'The New NHS – Modern, Dependable', the idea of Primary Care Groups and Primary Care Trusts was born. So I suppose back to what you were saying really about the panel wanting to understand the environment, that was the point really at which the forerunner to, for example, the Morecambe Bay PCT, that existed... you know, the start of your terms of reference. They grew out of things called Primary Care Groups. What's the difference? Effectively we had health authorities that developed Primary Care Groups – or supported Primary Care Groups – which were made up of local GP practices, etc. They didn't have any statutory authorities in their own right; they acted as subcommittees of the health authorities. It wasn't until they became a Primary Care Trust they became a speciality body in their own right.

There are quite a few similarities there in regards to that with what happened with Clinical Commission Groups. They only went live and were sort of freestanding statutory bodies on the 1st April of last year. Prior to that, I worked in a PCT and we were establishing – well, two PCTs – and we were establishing six Clinical Commission Groups in the previous two years prior to that. But they only became stand-alone statutory bodies in their own right on 1st April last year.

And so the same sort of thing happened with Primary Care Trusts. And then a bit like the changes in 2010, announced by the then Secretary of State, we had an announcement of abolition of health authorities. So those bodies that, if you like, were the scaffolding on which PCGs sat got abolished; a bit like what happened with PCTs

just a year or so ago.

The NHS Plan – I don't need to talk about. That was the bit that drove the big expansion in capacity, particularly to respond to a commitment to try to eradicate the big problem that was perceived to be one of the NHS's failings, which was the length of time people waited for treatment.

And then the final bit there – that was probably the first time we started to talk about things like payment by results, foundation trusts – the concept of it – choice, the use of the independent sector. So quite a few of the things that were hotly debated during the Health and Social Care Act 2012 going through Parliament were actually things that were first mooted and indeed tried during the previous government's administration.

You'll notice so far I haven't actually defined commissioning. I was going to return to that, if you'll bear with me. And then the final bit of sort of history – after initially having 300 and something PCTs, some of which were very, very small – for example, I worked in a hospital in the late '90s, early 2000's, in Huddersfield, and we had three PCTs there, one of which only had a 60,000 population. It was a statutory body in its own right. And the big problem – lots of positives about locally responsive, but a big problem was that they couldn't actually tool themselves up with the expertise and capacity. So there was a programme of bringing PCTs together. Initially driven bottom-up, but then eventually sort of saying 'We want to have a further top-down restructuring.' So we introduced 152 PCTs from 1st October 2006 – not that I can remember it with any particular… Let's not go there. Introduction of changes about the way we would commission the more highly specialised services. So I suppose not massively relevant, but I suppose it is relevant to the extent that, for example, neonatal

services are deemed to be a specialised service, so that would be the point at which we first started to say to PCTs, 'You've got to work together – when you're commissioning some of these more specialised services.'

Development of Practice-Based Commissioning – which was almost a forerunner to the idea of Clinical Commissioning Groups under the previous administration. And had varying success really – the extent to which the GP practices embraced it. In some parts of the country it was very successful, and practices were given devolved budgets by the local PCTs. In other parts of the country they felt that they were pretty much stifled by the pre-existing PCTs. Is that fair, Martin?

MR CLAYTON: I'd say that's fair, yes.

MR LAWLOR: And then the final bit around the history. You may or may not have come across the idea of World Class Commissioning. We had a period for a few years in the mid to late 2000s, where the Department of Health particularly decided to develop 'What should World Class Commissioning look like?' What are the skills and competencies, the capabilities that PCTs need to have to be able to deliver World Class Commissioning? So quite a lot of development work and putting PCTs through quite a robust process to assess their fitness to commission. And that process was still happening literally as the new administration came into power in 2010. There was meant to be the second round of assessing PCTs. But we didn't get assessed; we got abolished.

MR CLAYTON: The other thing, just to say about… I would say that was the first time we had ever really defined, as an NHS, commissioning. Everyone had a different view of what it meant, but the first time we had a single view of commissioning was in 2009, 2010.

MR LAWLOR: I would agree with that. And then the final two bullet points are just about the Darzi report. Lord Darzi, who had obviously been a Health Minister, embarked on, I suppose, a conversation about 'What should the health service look like in the future?' That work still has some resonance in terms of deciding what the future shape of services should be. But obviously 'Liberating the NHS', the new white paper that led to the Health and Social Care Act, and then the changes took over from that.

The next slide was really just for background information. You may or may not find it useful. It tries to sort of summarise some of the background – who were the purchasers/commissioners? How many of them were there? What happened with secondary care providers? So, for example, you will know that Morecambe Bay, in the latter part of the period of your investigation, was a Foundation Trust. But for much of the period it was what we'd call an NHS Trust. So that just tries to give you a bit of a chronology of when organisations became NHS Trusts, when some of them became Foundation Trusts, etc.

And this one was more really for light relief. Some of you might have seen it, but this was the rather cheeky presentation by the Kings Fund of what the reforms meant. This was their view of how simplified it looked. So it's really just an example of how we have actually put quite a lot of extra players on the pitch. We've certainly devolved quite a lot of our decision-making to a more local level, but there are quite a lot more regulators, quasi-regulators, in the health system, if you like. So that was just the Kings Fund's way of trying to describe that.

And then the final slide – when I say 'the future', I really mean what's happening from 2013 onwards, but particularly what is happening since the 'Call to Action', which is what NHS England has called it – having a big debate about 'What

should the health service look like in 10 years' time?' Some of the headline messages there about 'fundamentally different from today's'. A much, much more empowered, engaged and in control population of patients; lots of focus on having much greater information in the public domain, much greater transparency.

And I suppose the other bit is: significantly changed roles for hospitals. So the Morecambe Bay patch – obviously which is part of my area of interest – currently has three hospitals, serving a population that you would typically expect to have one hospital for. And the reason it has three hospitals is because of the particular geographical challenges. Barrow in Furness is a really good example of that. There are two hospitals in Cumbria – one in the south, that obviously is of direct relevance to yourselves, Barrow in Furness hospital – and the similar- sized hospital in the north, which is also in the far west, at Whitehaven. Both of them have been struggling for quite a long time to sustain the full range of hospital services – partly because of their size – they're a bit smaller than you would typically expect a district general hospital to be – and when I say 'size', the number of people they serve – they serve 100 and odd thousand people. You would normally expect serving at least a quarter of a million population, preferably more. But also because of their geographical isolation. Barrow in Furness Hospital has made significant improvements in terms of its staffing and is less dependent upon local and agency staff than it used to be. It was quite heavily dependent, during the parts of the period of your inquiry.

The hospital to the north of there – which also, for my sins, is part of my patch – we have huge problems with recruitment retention. We have probably more local doctors at middle-grade consultant than we have substantive. So this gives you another sense of the context within which the events, if you like, that unfolded occurred.

And the final bit that I will show – and later ask questions – there was a slide that I was intending to put in the pack, and I just couldn't track it down in time, and if it would be useful to you – I'll send it to you later – but it just sort of like talks about the commissioning cycle. It maybe helps to define what we at least now mean by 'commissioning'. So it starts with assessing needs – so working on what we now call a 'joint strategic needs assessment' with local authorities to say 'What are the needs of the population? What are the health and care needs of the population?' Using that review of current provision to say, 'Well, do the current services meet those needs adequately or not?' and if not, what needs to change. So decide and agree the priorities for change. Specify and agree quality outcomes. So what is the specification of the services that the commissioners wish to buy?

It's fair to say that the focus historically, until probably the last three or four years, was less on the quality outcomes and more on the activity and the performance standards and the money. It's probably only in the last three or four years – I'm not saying that that wasn't there – it wasn't as big a focus for commissioners as it has been over the last few years.

And then obviously having specified and agreed what the outcomes are you are trying to achieve, design services and pathways to help achieve those. And then – and only then – enter into contracts with providers to actually be able to secure the delivery of services in line with those specifications.

Then manage demand and ensure appropriate access to care. What we mean by 'manage demand' is ensure that the right people are seeing the right specialists in the right place at the right time. And therefore that also means ensuring that GPs, as providers, and other community staff are supporting people to stay well and in the

community for as long as possible.

And then obviously finally around that loop – manage quality, performance and outcomes. I suppose that was the final thing I was going to say was that, having worked in both providers for 10 years – from 1999 to the late 2000s – I joined the PCT in January 2010, my first foray into commissioning. It then was announced to be abolished in June 2010, so it was not the best career move. Having worked in both bits, it would be fair to say that I think probably until at least 2008 – and in some parts even later – the discussions between commissioners and providers were largely around performance standards – 'Are you meeting the A&E standard?' 'Are you meeting the waiting time standard?' It started to move into things like 'Are you meeting cancer standards, etc?' But it wasn't really a focus on 'Are you delivering high quality care and are you giving good patient experience?' Those things were really only starting to feature as being an expectation of commissioners in the last couple of years of – sort of like the noughties, if you like – from about 2008 and onwards. I'm not saying that as being right or wrong; I'm just saying that was generally the situation. And that's it really.

MR BROOKES: Thank you. Just contextually, just to say to Panel members – this is like the visits we do. This is about us understanding – it's not under formal evidence – it's about us understanding commissioning. It's just important that we understand that. Who'd like to go first?

PROFESSOR FORSYTH: Picking up just the content at the end, about how it is really moving towards the quality of care, the patient experience. And that's really what we're investigating. The challenge, of course, as you've pointed out, is that it's small units. How do you do that? Particularly isolated units. I begin to break out in a sweat

when I hear about, you know, Whitehaven with all these local doctors. I mean, that is a high risk saturation. So with one hand we talk about we're going to have World Class Commissioning, but actually at the end of the day we're still stuck with these problems. Really, how do you manage them? I mean from a general point. We don't want to get down to specifics, as Julian said, but just as… What is the approach? I mean, clearly you can't also be cost effective at the same time you're doing that.

MR LAWLOR: That's right. I mean, obviously this is, as you say, sort of contextual, so I'm being very open with you. In the Cumbria system, we have a hospital in Whitehaven, a hospital in Carlisle, and a hospital that doesn't deliver what we might call very much proper acute services, but still a hospital in Penrith. A hospital in Kendal and a hospital in Barrow. So that's five hospitals, four that are acute-ish, for a 550,000 population. So straight away your point is right: it's really hard to see how you actually sort of like deliver both economically, if you like, sustainable organisations, but, more importantly, you will have safe, high quality.

I would say that during the period of the review – certainly some of my colleagues may well be called to give evidence because they work in our area too, but used to work for the Cumbria PCT – and the workforce challenges were probably even worse in parts of Morecambe Bay than they were in the north at that time. They are now worse in the north of Cumbria than they are in Morecambe Bay.

To answer your question: a few things. First of all, the National Quality Board, obviously, published some really useful guides about 'How do we manage and ensure a safe transition from the old system to the new?' And so we have – our area teams have – a particular responsibility to act as a convener of what they call a Quality Surveillance Group. And the idea of that is to probably do two of the things that were

lessons out of the Mid-Staffs enquiry. First of all, that the commissioners and the regulators and the SHA all have bits of intelligence about Mid-Staffs that if they'd have had a forum to talk about it in quite a formal way they might have not – sorry, not 'they' – it might not have taken the system quite so long to realise it wasn't a data problem. So that's the first thing that we have – is a way of ensuring that stuff is… I chair a group and Martin's colleague, Richard, chairs a group in Lancashire that consists of the Care Quality Commission, the Trust Development Authority if you've got a non-Foundation Trust, a Monitor where you've got Foundation Trusts, Health Education England for the workforce issues, CCGs, etc. And the task is very much to ask the question 'What hard and soft intelligence have we got to give us on the one hand assurance, on the other hand particularly concern about quality, safety, patient experience, etc?'

So that doesn't solve the problem really, but it at least means you've got the collective effort sitting around the table. So I've just had what we call a 'Risk Summit' on Monday about North Cumbria because of concerns about quality and safety in Obstetric services, largely to do with anaesthetic staffing. It's all public stuff, so I'm not… But that's part of the process.

So I think to answer your question 'What do you do?' – it's a bit rock and a hard place with both Barrow and Whitehaven, and there are other places, like Scarborough, that are similarly challenged but not quite as isolated. And the first question you've got to ask is: what level of safe service can you sustain in these units? And so one of the difficulties I think that the NHS has had historically is not really believing that they would be backed to take really, really difficult decisions where it may not be possible to sustain everything in the local unit. So I think that's changed

quite a bit in the last year or two.

But I think the other thing is maybe that we've not, until recently, really started to say, in a really, really comprehensive way or an evidence way, 'What are the clinical adjacencies between particular specialties and sub specialties?' I'm not saying we haven't done it, but we haven't done it as well as we could have done.

So I've just come from a meeting this morning in Lancaster where we were talking about the future of the Barrow Hospital and actually how we were going to actually sustain virtually everything that's there. And there is actually potential scope to do that – because of the particular shape of things in the south. It will have implications for the hospital services at Kendal, but there is an actual potential way forward for Barrow. I haven't got the way forward at the moment, if I'm being honest with you.

MR CLAYTON: But I don't think we should sort of underestimate what John said about the concentration of commissioners in the sort of early days of PCTs. The concentration was on delivering targets, which broadly meant hitting waiting times, throughputs and financial values. That was where the concentration and the top-down view was put, if we're honest. Less so than nowadays on the quality.

MR LAWLOR: I was a Chief Executive in a hospital, a Foundation Trust, for four years, somewhere in Yorkshire – not the Huddersfield patch – and I can honestly say we had one conversation in four years with our commissioners about the quality of our services.

MR BROOKES: I find that quite depressing.

MR LAWLOR: Yes. I mean, the positive – to just balance it – is that it was deemed to be a very high performing, in terms of quality, but nevertheless I agree with you.

MR BROOKES: It's often the problem. I've been Director of Commissioning, so... But there are times when you will receive information about the quality or worries about the quality of service which takes you out of that activity driven discussion. Can you just describe the kind of things which you would expect a good commissioner to give their service providers?

MR LAWLOR: We can probably both have a go at that. I would say now – my definition of 'now' is probably since about 2010 – I would say there was an expectation that there would be regular, challenging discussions between clinical and managerial staff in the PCT with provider colleagues – whether it was a mental health provider, a hospital provider... For example, when I was – PCG was up in Leeds – we would have meetings every month with the Chief Nurse, the Medical Director, often the Chief Executive as well, and a range of Clinical Directors in Leeds Teaching Hospitals. And some of those would be, as Martin says, largely about 'Why can't we meet the 62 day cancer standard?' for example. But other occasions they would be about what would be more directly relevant to your debate – there were clearly aspects of the service that were not being delivered (a) in line with what the expectations were that were set out in the service standards; but (b) in a way that you could be confident meant that patients were getting a good service and getting a good outcome.

In those circumstances – it wasn't actually Leeds Teaching Hospitals, but another one of the Trusts that I became responsible for when we clustered PCTs – we actually forced an independent review on the Trust that refused to accept the criticisms, and said 'everything's fine'. We had had four examples of nursing and junior doctor staff giving penicillin to patients who were known to have a risk of a reaction to it. We were quite clear in our opinion that this was happening in such close order, something

systemic had changed inside the organisation. And the Trust's Medical Director and others just would not accept that. So in this extreme, you say, 'Right, we're going to bring in other people to have a look at this.' And thank goodness we did because it was very, very evident that the training of the junior doctors and the training of the nurses had changed, and nobody had recognised that something had fallen through the cracks.

MR CLAYTON: I think the other thing that did change in terms of PCTs was, from PCG days – that was effectively a GP-led leadership, if you like – went to PCTs and much greater Professional Executive Groups – PEGs – which were usually about seven or eight GPs interested in being involved in the commissioning cycle. And what you would tend to give the response was for looking at the issue with regard to quality to that group – and usually you actually identify an individual within that group who would be the quarter[?] lead.

So taking your challenge about some data appears or somebody appears, (1) you ask that lead to have a look at that detail and investigate that further with his clinical colleagues in the secondary care or committee or wherever it might come up. And I think then you would, depending on the severity of that, it may well be that one of the routine items that will come up on the monthly quality discussion because we always – what's quite helpful about the new contract coming in for secondary care is the separation of the nuts and bolts of activity versus the quality. It was a prescribed separation of those conversations, so you made sure you had both every month with your main providers, which made you make sure you actually talked through those issues. And if it's more routine, you'd probably send it there – if it's more acute, you'd ask the Clinical Lead within the PEG to pick that up and go and have a conversation with the secondary care colleagues about what these issues were, and report back

through to the Board.

MR LAWLOR: And I think, just one other bits to add to that, which is particularly relevant to what happened in Cumbria – and as I talk about Cumbria, I recognise that, for yourselves, it is both Cumbria and North Lancs, as it is now called – but there was a period in the sort of – maybe, what, 2003 to about 2008 – where there was – probably it's not too strong a word to say it's almost an 'obsession' with the Cumbria Foundation Trust – both a political obsession but also a managerial obsession. And that did create some pretty unhealthy behaviours. Because once that happened and once you became a Foundation Trust, for a few years – and I was a Foundation Trust Chief Exec for a few years – many of my colleagues thought that they were free to do what they liked, and actually didn't really have to account to commissioners. So there was quite a tension for a number of years, in sort of the mid 2000s, around that. I wasn't in Cumbria then, so I can't say whether that was a particular feature of the Cumbria system. But that did lead to provider boards believing that they – and only they – other than the CQC, as now is – had any legitimacy in looking at and discussing quality and safety. And so it's not just that there wasn't necessarily the expectation of commissioners to be doing that; it was also a bit of 'What's it got to do with you?'

MR BROOKES: But you held the money?

MR LAWLOR: Sorry?

MR BROOKES: You held the money.

MR LAWLOR: Correct.

MR BROOKES: Because I know what you mean, but in a situation where you've got a contract, you're the person contracting the service from the provider, whether it's a Foundation Trust or not; you can specify in that contract what you expect them to

provide and the quality of level of service. Is that not what was happening?

MR LAWLOR: Oh yes, I think that was happening. I think there's a difference between that happening and it being an open and honest dialogue between two parties that see that it's in the best interests of patients to have an open and honest discussion, and a dialogue that is more of a contractual dialogue between an organisation that is trying to give you only the information that they have to. That's the way I would describe it. Again, I'm not saying that was necessarily the case. I did have experience of that on both sides of the table.

PROFESSOR FORSYTH: Just in relation to that, and one of the things that I've been struggling with – if you do have a unit within a hospital that clearly has been underperforming and there's good evidence of this, it's difficult, as far as I can see, to find out who is accountable for that. This clearly you can pin on the clinicians – whether it's by doctors or the Trust management team – and then it becomes a bit woolly after that. Do the commissioners take responsibility for—?

MR LAWLOR: Inside the organisation, you're right, it's very clear. It's the Chief Executive ultimately and the Board. You might have – if you have a clinical model, you might have Clinical Directors and all the rest of it that would take... I worked in two Trusts where it was very, very clear that they were clinically-led teams. They had the budgets and all the responsibilities and all the rest of it, and they were held to account. But ultimately, if something went wrong, it would have been the Chief Executive.

And obviously, from a professional point of view, if professional standards were compromised then the Medical Director and the Nurse Director. Outside of the NHS Trusts and Foundations – because I think it is a very fair question – I think we're much, much clearer that it is a joint accountability if something goes wrong. Again,

Martin might want to comment. My personal view would be that starts to become much, much less ambiguous around about 2008 to 2010. But prior to that, it wouldn't have been unusual for a PCT to see it as being their job to find out who was to blame in the Trust, as opposed to, say, [where we were when this was happening?]. Is that fair?

MR CLAYTON: I think that links back to almost the definition of commissioning as never really being prescribed, if you like. So it's actually 'What is the responsibility of a commissioner?' Is the responsibility of the commissioner just a customer – a consumer who goes and buys a number of widgets and walks away, and then goes back and has a look at how those widgets are being delivered every now and again? Or is it something more than that? I think sometimes, when you look at today's relationships between commissioners and providers, it's radically different from how it was then. Whereas today I think there's a feeling that actually if one fails all fails, in reality; I'm not sure it's quite the case in the early days of commissioning. It was a system that was effectively split in half and given completely different jobs. We knew the jobs. One half would provide half. That's what we'd been doing. The commissioner was a new job that wasn't really very well-defined, and people were sort of feeling their way through it. And I think that's where you'll probably find, if we ever did a survey, completely different environments all the way up and down the country of how it's being carried out. But it was an 'us and them', I think, if I'm honest.

MR LAWLOR: In the early 1990s the government's view was that they wanted them to be purchasers, not commissioners. That was one of the political hot potatoes. So, for example, Brian Mawhinney, when he was Health Minister, ran a whole series of events and papers around fanning the flames of purchasing. And at that stage it was very much 'let the market decide'. And the job of the payers was to pay for the activity that

happened, and to gain assurance that whatever the performance standards were of the day, that they were delivered, and to performance manage to deliver those standards.

I'm not saying that it was quite as stark as that, but it certainly started from that place in 1991. It probably took maybe a good 10 years before it matured into commissioners being seen as being the champions of the local population that they serve.

And the only other bit that I didn't mention earlier, that is probably worth just saying: for much of that period, including for much of the period that the Investigation is looking at, PCTs had three jobs. Only one of the three jobs was commissioning. They had all the public health responsibilities and were supposed to be driving public health programmes, tackling health inequalities, etc., and engaging with the local population around lifestyles, etc. And so some PCTs saw that as being a big part of their job. Instead of it being a third, it was like a half or three-quarters.

The other bit that many of them saw as being a very big part of their job was that they were responsible for the delivery – they were a provider as well as the commissioner – of community NHS services – district nursing and health visiting, school nursing, intermediate care type services. And picking up Martin's point – and again, I'm not being critical – but some of the people who became the leaders of PCTs had grown out of provider roles. So that was naturally a comfort zone. And then, and only then, in some places did you do the commissioning bit. Obviously in other cases there were some very, very powerful and very, very robust commissioners that saw that as being their primary job. So it's probably important just to make that point I didn't mention earlier: there were three jobs. All the way up until 2011, PCTs had three jobs. Only on the 1st April 2011 did that go down to two jobs, because then they ceased to be

a provider of community services because under the changes that were introduced then, called 'Transforming Community Services', you had to divest yourself of your provider role. So you then became a commissioner and a public health advocate.

And then, from 2013, obviously, CCGs are now primarily commissioners because they don't have any provider role; and much, not all, of the public health responsibility is transferred to local authorities.

PROFESSOR MONTGOMERY: I think it would be very tempting for us to get into the general picture, and I suspect there's almost as much variety about how CCGs operate locally as there was about how PCTs operate. You may well not be able to answer all these questions, but it's about how some of the things were worked out in this area, so I wonder if we could start with the provider arm a bit and how that was locally. And if you don't know, that's fine. But I've got a series of things which I know work in different ways in different parts of the country.

So was this PCT one of those ones that was focused on mainly being a community services provider and reluctantly a commissioner or was it—?

MR LAWLOR: I certainly wouldn't want to say whether it was reluctant—

PROFESSOR MONTGOMERY: It's not intended as a criticism at all; it's just understanding the picture.

MR LAWLOR: No, that's fine. I wasn't on the patch, so I personally wouldn't take it as a criticism. I think I would say that they had a very clear vision for how community services should integrate with GP and primary care services. And so as a consequence of which they had very good engagement of GP practices across most, if not nearly all of Cumbria. And again, I can't say quite as definitively about the North Lancs patch, which is obviously part of the Morecambe Bay area. So GPs generally bought into

being involved in commissioning in Cumbria. But particularly because they wanted to see how they could join up their own provider services with community services that they didn't run, so that was a particular focus.

PROFESSOR MONTGOMERY: And they were being trumpeted nationally for doing that.

MR LAWLOR: Yes. And again, this is not a sort of formal evidence hearing session – you'll be able to ask colleagues much more, who'll be able to evidence it. They were very, very, very disappointed, the GPs, when the changes required the community services to move into another organisation and no longer be part of the PCT. So there was a period where the GP's, the GP body, disengaged for a while from commissioning, probably towards the latter end of 2010 and into 2011, when it was quite clear that they weren't going to be able to continue to almost run them, but with the PCT. So that would be one observation. I think, to be fair – Martin, I don't know whether you – no, you weren't in the organisation—

MR CLAYTON: No I wasn't, no.

MR LAWLOR: But we have got colleagues that I'm sure you would be able to ask to come and talk about that. I think they were trying to be a robust commissioner with their providers. But partly linked to what you were saying earlier, two of the providers have been financially challenged for a long time.

PROFESSOR MONTGOMERY: That was going to be my second question, really. In some health economies, you could see that making the books balance is the only thing that keeps people in their jobs and therefore it gets all the focus. And others, you know, things are a bit less tight. I'm down the south. My PCTs used to think things were lovely up here. I'm sure everyone thinks that it's the other way round. So there's a running theme that money is tight, is there?

MR LAWLOR: I think probably, to unpack it a little bit, the Morecambe Bay Trust, as still is, were not particularly financially challenged until some of the system failures started to come to light. Well, they were certainly required by the CQC, but they'd already started to invest in sort of strengthening their clinical and managerial – particularly clinical – capacity, and that switched them into being in a deficit position. I can't tell you precisely, but I can certainly find them – and other witnesses would be able to give you chapter and verse – but my recollection is that the first year that Morecambe Bay went into a big financial difficulty was 10/11. So for much of the period, they were reasonably financially sound.

PROFESSOR MONTGOMERY: And when did they become an FT?

MR LAWLOR: They became an FT around about then. The year before or the year after.

MR CLAYTON: I think it was the year before.

MR LAWLOR: Just around about there. And why did they go into financial difficulty? Because of an express need to strengthen staffing. And the current Chief Executive—

MR BROOKES: Is that clinical staffing as well?

MR LAWLOR: Particularly clinical staffing, yes. And again, they've got three hospitals, so actually trying to staff safely, 24/7, an Obstetric unit, a neonatal unit, paediatrics, anaesthetic support. By definition, if you've got three relatively small hospitals rather than one big hospital somewhere, then it's much harder to sustain a proper, safe, 24/7 rota times three, than it is times one.

PROFESSOR MONTGOMERY: And linked with that, some PCTs and systems have had maternity commissioning strategies, and lots didn't; some had configuration exercises going on, debating what the configurations should be. Was that going on in Cumbria?

MR LAWLOR: Yes. There's been a number of service strategies and service reviews across

Cumbria. The one that I am most familiar with, because I've spent most of my time since taking the post a year ago with the North Cumbria patch. As I was saying earlier, it's probably even more challenged at the moment than the Morecambe Bay patch. They had something called 'Close to Home', their Close to Home vision. That is currently being dusted down. In all of those discussions, things like the sustainability of an obstetrics service always featured.

MR CLAYTON: I think we shouldn't underestimate your previous question about the financial environment. Although Morecambe Bay, as a provider, might not have raised lots of concerns before 10/11, 11/12, the other parts of Cumbria – which was the same area – had substantial challenge, and to be honest, I suspect it still does.

MR LAWLOR: It still has.

MR CLAYTON: If we were going to take a pie chart and show how much time we've spent worrying about the former Morecambe Bay versus the rest of Cumbria, you'd probably have a small slice for Morecambe Bay and a very large slice for Cumbria.

PROFESSOR MONTGOMERY: I guess what I'm trying to get my head around is when we expect to see more management efforts being put in, because different systems have different challenges and you would expect managers to be alert to this.

MR LAWLOR: I think I would probably say to that – and if the former PCT Chief Executive was here, she would probably say that as well – they were pretty clear, as commissioners, that the financial challenges were primarily the providers' problem. And that they understood – the commissioners understood that part of the reason why they were struggling to live within their resources was because of reliance on local and agency staff, and would certainly have wanted to help with that. But fundamentally, if they couldn't recruit substantive people and it cost them more, the commissioner in that

part of the world saw it as being the provider's problem.

In other parts of the country – and again, I'm not saying which is right and which is wrong – I've worked in parts of the country where the commissioner would say, 'We realise you can't recruit X, Y and Z, and it is costing you double to run that rota so we will give you double.' So it's more of a 'The tariff is the tariff. You'll get paid for the activity you do. If that's not enough then you'll have to look for how you can deliver efficiencies.'

I think part of the issue around the Morecambe Bay scenario was that we had only really started to get into quite significant cash-releasing efficiency requirements on providers. Towards 2005, 2006, 2007, that's when it started to be genuine money out, as opposed to 'there's enough money in the system'. Providers therefore sought to treat more patients and bring more people – more business – in, and therefore had to deliver less of what you might call hard—

PROFESSOR MONTGOMERY: One thing that is often said about systems in the NHS is that Chief Executives turn over every 18 months. In all the systems I know they stay for far too long. But I just wondered what the turnover was—

MR LAWLOR: A very, very high turnover in Cumbria. Not in the commissioning system. The Morecambe Bay, as was – there was a Morecambe Bay PCT prior to October 2006. So in other words, Cumbria wasn't a county-wide commissioner. There was a bit of Cumbria in the south, roughly half of it, and a bit of Lancashire below it, that were the commissioners of services for a population that straddled both South Cumbria and North Lancashire, that more or less coincided with the catchment population of Morecambe Bay Trust. So they had their own dedicated commissioner for that organisation and for the community.

On 1st October 2006, that changed and became a Cumbria-wide PCT, which then made it a bit messier. I'm not saying it's right or wrong. Because obviously the Cumbria PCT was very interested in what was happening in the Kendal Hospital and in the Barrow Hospital, and then North Lancs was very interested in what was happening at Lancaster Hospital, and that just added another dimension.

PROFESSOR MONTGOMERY: And the provider-side Chief Executives?

MR LAWLOR: Sorry. So the Chief Executive in the PCT – both in Morecambe Bay and in Cumbria – there was very little change in about a 10-year period. From October 2006 right through to the abolition of the PCT last March, it was the same PCT Chief Exec. The PCT was quite stable. Providers were very much revolving door.

MR BROOKES: Can I just take that to the next tier as well? The way we worked in the south is with Carruthers more than Strategic Health Authority management. Direct management units, which was not, to my understanding, up here. What was the dynamic? Can you describe that?

MR CLAYTON: I worked at the SHA during that period of time. I had nothing to do with Morecambe Bay. That's why I'm here. Mike Farrar was leading the organisation from 2007. That's when it became the North West. I think Mike had an inclusive style of leadership, would be my way of describing it. He encouraged people. He set a vision, he set a focus, and encouraged people through personal relationships, persuasion and common sense to follow that leadership. There was very little command and control. In fact, I remember on one of the reviews, one of the answers was: 'You only command and control when you're right at the cliff edge', which was possibly true. It was about bringing people with him with the strength of his argument, and the strength of his personality in some cases, rather than a control environment.

MR LAWLOR: And just to add to that, that was in significant contrast to the North East. I'm not making a judgment, but the North East SHA was much clearer, including with providers, about… not quite as far down the spectrum as Sir Ian because nobody could quite be… they broke the mould when they made Sir Ian. You may be interested to know that he is working in Cumbria at the moment. He is a Cumbria lad.

MR BROOKES: It gives him somewhere to retire to.

MR LAWLOR: The North East was much, much more grippy with providers as well as with commissioners. The reason I say that is because some of the senior staff that were in the PCT had spent much of their career in the North East. So there was a bit of a culture clash there between the North West and more of an inclusive style, and the expectation, or what people had become used to, when they used to work in the North East. Again, I'm not saying which was right and which was wrong, just facts.

PROFESSOR MONTGOMERY: It's just really helpful to understand that.

MR CLAYTON: One thing that led on from the question you asked before, which is unique in Cumbria – if you remember when we switched over to the new NHS contractors – it's about contracting. So we had North Lakes and Cumbria. We moved on to the contract and you used to have one Lead Contractor, if you remember, and Associates. That was a national model. Morecambe Bay was the only Trust in the country that had two Leads. They were both Lead Contractors. I don't know why I told you, but you can ask further questions later.

MR LAWLOR: I do. It meant that for a period there was quite a tension between both the vision for the future that the Trust had, and the vision for the future that the two PCTs had. Again, that's not peculiar, that aspect. There was a particular desire by the Lancastrians, if I put it that way – between the commissioners at Lancaster – to see

Barrow as something that was just an irritation and perhaps we can do without. Clearly, understandably – and I'm not saying that's a fair way to describe it, but there was a much greater focus on building up the size and scope of the Lancaster side, which again is not unusual following mergers. As a consequence, particularly the GPs in particularly the south-west of Cumbria became the product champions for Barrow, and that created some tensions.

PROFESSOR MONTGOMERY: A couple of questions from me. One is on basically the architecture of, not quite commissioning, but it would help understand it – one is about whether or not there was anything that emerged that became a health and wellbeing… or was local government involved in any of this sort of system planning? In some places, people have services bought and things like that. Does that happen in Cumbria?

MR LAWLOR: Certainly in Cumbria there was a pretty good relationship both at the top of the office and generally between the Council and the PCT. I wouldn't say they were as joined at the hip as some, in terms of we didn't have huge numbers of pooled budgets and all the rest of it, but they were generally on the same page, got on well, saw the future. Particularly because I think both the PCT and Council were very much in the care Close to Home, do as much as we possibly can outside of hospitals.

PROFESSOR MONTGOMERY: I'm not sure we've got county council in our list of—

MS McINTOSH: No.

MR BROOKES: There was no move to joint posts between—

MR LAWLOR: No. But the Director of Social Services at the Council in Cumbria is very good and always turns up at all of the events that we have about quality and safety around any Cumbrian provider, and is involved… They've created something in Cumbria now, the Cumbria Leaders Forum, which has all the Chief Executives of all

the organisations, including the CCG, and has the Director of Social Services and Chief Exec from the Council. So they are all pretty together. And not in a sort of cosy way. But to answer your point: relatively few proper joint posts. Quite a lot of joint working, but not a lot of joint posts, which again is not unusual.

PROFESSOR MONTGOMERY: The other area I have is about public patient involvement mechanisms. I've heard some quite confusing things from some of the families about what was going on when. I think we heard that they were just establishing a Maternity Services Liaison Committee recently, which is a couple of decades after one would have expected. I just wonder what the flavour has been. In some places, Community Health Councils have been going very strongly and everyone rather regretted the changes to other things. In other places, they were completely dysfunctional, and were building probably from scratch... What is the sort of flavour and mechanisms for involvement?

MR LAWLOR: I could say what they are now, but I couldn't say before. I understand the picture you've presented, and certainly in the two places I worked I was bitterly disappointed when the CHCs got abolished because they were really, really challenging and they kept us on our toes. And anything since hasn't been quite as good, if I'm honest. So I couldn't answer that bit, but what I could say is that, going back to what I was saying about the GPs and their interest and involvement in commissioning, particularly around community services, there were lots of debates and lots of engagement with people about 'what more can we do as locally as possible?' I know that for a fact.

The other thing we haven't said is: did you know there are six district councils in Cumbria? They are sort of like six little fiefdoms. They've become slightly less

fiefdom-y over the last few years, but they are still pretty fiefdom-y, both from a political point of view and from a GP point of view. Some of the six, still to this day, don't work as well together on a Cumbria-wide basis. But what the CCG now has is: of the six councils, two and two and two are twinned, so there are effectively three localities.

I would say 'pretty good' compared to what was *de rigour* at the time; pretty good engagement around that side. Just generally less clear about the level of engagement both by the PCT and by the providers around more specialised services.

PROFESSOR MONTGOMERY: That is something we would need to find out about.

DR CALDERWOOD: This is back to a bit more detail. You talked about the workforce and the recruitment and the retention. Was that in Barrow or is that within all three hospitals in the Trust?

MR LAWLOR: It's still a challenge, even in parts of Lancashire, where you would expect Lancashire to be relatively attractive in terms of its relatively… it's not too far away from the likes of Greater Manchester and Merseyside. I would say it gets worse the further north and the further west you go. The further north and the further west you go, the more difficult the recruitment and retention, particularly of doctors. I would say it is difficult in certain aspects of nursing and midwifery, and it still is in parts of Cumbria, but the particular challenge was and remains – particularly in the north – doctors. In the south, particularly with Barrow, it was probably both doctors and particularly midwives and neonatal nurses.

DR CALDERWOOD: So that was worse in Barrow than with other—?

MR LAWLOR: Yes. During the period it was, yes.

DR CALDERWOOD: And why did you say that you would expect Lancashire to be better?

Why wasn't it then?

MR LAWLOR: Just to be clear, I didn't work in this part of the system, so a lot of what I have said to you I can evidence because of all the various different Risk Summits and everything else over the last year. I would only say that – Martin and Richard are in the Lancashire patch. Would it be fair to say that some of the providers in Lancashire are still challenged with regards to staffing?

MR CLAYTON: I would say Lancashire is challenging, but I don't think it's Lancashire only. It's a country-wide issue. But I think it is true what you say, that the further you get away effectively from Manchester… and Barrow is on a corridor, it's at the end of the corridor.

MR LAWLOR: If you took Barrow and you took Whitehaven, because we've got lakes and we've got mountains, they might only look like they're 30 miles apart. For example, I'm going to Workington tomorrow, which is quite near Whitehaven, but you keep going. I can get to Carlisle from where I live in 50 minutes. It's another hour and three-quarters from Carlisle to Whitehaven. Similarly, Barrow is a considerable distance, even for an ambulance, from either Kendal or Lancaster. If you think about when people are making career choices…

DR CALDERWOOD: Before I knew anything, and I looked at the map as to how I was ever going to get there, I immediately thought 'it's no wonder there's a recruitment problem for doctors'.

MR LAWLOR: Correct. I think that's a big part of it, the access to it.

DR CALDERWOOD: You've alluded slightly with Jonathan's question to talking about the reconfiguration and looking at ways of providing services, if we'd stick with maternity services in particular. We've heard a little bit, but no evidence of discussion around

whether there has been talk about removing the obstetrician-led service and looking at a midwife-led service. Has that been considered? Secondly, would you feel that, at the time of the investigation, discussion around that made things worse because of destabilising the existing workforce?

MR LAWLOR: Firstly, there's been discussions going on about obstetric services in virtually every DGH that's got less than 200,000 population in England for at least a decade. I still have the scars on my back from a public consultation we started in 1999 to only have one obstetric service between two hospitals that are 4.8 miles apart. It took me 10 minutes to get between them. It took us five years to get that change made. It is not peculiar to Cumbria and North Lancs.

Yes, definitely as far as the Morecambe Bay Trust was concerned, and I think to a degree as far as the folk from the North Lancashire patch were concerned, they were certainly concerned that they were having to put a disproportionate amount of effort into trying to sustain things in Barrow. Obviously the GPs in particular, the population, and the PCT therefore, were keen to say, 'Well, you need to persuade us why that is the only solution.' It wasn't that people weren't having the same discussions or were coming in from the opposite ends of the telescope. That was certainly the case for a number of years.

More recently, a new service strategy discussion began, particularly around Morecambe Bay. It was kicked off, initially, primarily just between the clinicians inside the Morecambe Bay Trust, and then engaging the two PCTs/CCGs, as it's turned out, and then broadening it up to the providers and the Council and the rest of it. So that started again in earnest in October 2012. And then it got formally made into a programme board around about April 2013. We are on it, as an area team, as is

Martin's area team, as are the two CCGs, as is the Mental Health Community Provider, as is the Council, etc. Within that, we have the acute surgery, particularly out of hours; they're looking at obstetrics, paediatrics, etc. All of the things you would expect.

Because the other thing is that Lancaster's catchment population isn't exactly massive. People might be surprised. Carlisle, for example, the Carlisle Hospital – I know it's not directly relevant to your inquiry – but people would probably assume that Carlisle would have more deliveries than Whitehaven, but it doesn't. Whitehaven delivers 1,400 babies a year; Carlisle 1,200. If there's anywhere you probably think might be big, you would think Carlisle, but actually its catchment population to the women that choose to go there, it is smaller than the population that delivers in Whitehaven.

MR BROOKES: It would be useful to understand the political environment. You mentioned about the Councils and there is obviously a local political environment. There is also a national political environment.

MR LAWLOR: There certainly is.

MR BROOKES: As we all know, it can have varying degrees of influence on what is going on. What was the environment during the time we are looking at with the inquiry?

MR LAWLOR: I wouldn't want to say with any sort of certainty – again, it is something that would be better to ask other witnesses – but I would say, in headline terms, Cumbria is unusual not just because of the lakes and the mountains. It is a very sparsely populated area, apart from where it isn't. It has some quite large towns, but they tend to be in the middle of nowhere, so particularly Barrow in Furness and Whitehaven and Workington. And the reason I say that is because it is relevant to your question. So therefore you had some – let's call it 'Red Ken' type politics – and some proper Blue Tory, sort of

like well-heeled rural areas. There is quite a dichotomy with regard to the political make-up that reflects the difference between the very deprived and isolated communities, and the relatively well-heeled, particularly farming, but also retired-into, the Lakes. More detailed than that, I think it would be best ask the others.

MR BROOKES: Any more questions? **(None)** That's been really helpful, thank you. You have given us some food for thought. You bring your assumptions from what you know, and it's really, really helpful to understand some of the dynamics that were going on.

MR LAWLOR: Just one final thing. From a Barrow in Furness point of view, we started as area teams in April 2013 with quite a lot of significant concerns about quality and safety still at Barrow in Furness, particularly around the neonatal nursing. The real positive, I would say, is that not only have further staff been recruited, but it has stabilised now to the point where, certainly on the nursing and midwifery side, it is in a pretty sound place at the moment, is Barrow, in regard to that.

One of the things that we are busy doing is trying to work out quite how they succeeded so well after years and years of not succeeding to recruit people – because we haven't quite cracked that in North Cumbria yet. It is just another bit of context really.

MR BROOKES: Do you know why? Do you have your suspicions?

MR LAWLOR: I think a number of things. They have certainly had to go international, and they have managed to recruit quite a few staff of medical and nursing and therapy staff from abroad. But I do think there has been quite a good job in, for example, going out to all the various different sort of fairs, etc, both for doctors, for nurses. And the Trust has really put huge amounts of effort into that, sending a whole swathe of staff to

various different events to sort of market what would be good about working here.

MR BROOKES: Unless there are any final questions, thank you very much.

MR LAWLOR: Thank you. I will send you that last slide.

MS McINTOSH: That would be helpful, thank you.

[Mr Lawlor and Mr Clayton left the meeting.]

MR BROOKES: I am just checking I haven't missed anything. Any other business?

PROFESSOR MONTGOMERY: On the back of that, are we going to pick up the configuration strategy documents?

MS McINTOSH: Yes.

MR BROOKES: Any views about what you've heard? Is it as you were expecting?

PROFESSOR MONTGOMERY: I think the devil is all in the detail. It's trying to understand what actually was going on in the period we're talking about with a particular group of people. I'm intrigued that the financial stuff seems to hit the Trust slightly later, if it's the explanation for the stuff that—

MR BROOKES: It sounds to me like there was a qualified Foundation Trust acceptance, which was on the basis of improving staffing in particular areas, creating a financial problem. I'm also interested in – there doesn't seem to be much sharing in the financial problems as well, which was seen somewhere else, which was quite interesting. A complex political position, potentially. Lots of different district councils playing, potentially.

PROFESSOR MONTGOMERY: It would be really good to try to track whether what they created was a system in which nobody shared information.

MS McINTOSH: Exactly.

PROFESSOR MONTGOMERY: As opposed to a system where things were open. Most systems around that time were pretty secretive.

MR BROOKES: They were.

PROFESSOR MONTGOMERY: So it wouldn't be surprising if that was happening here.

MR BROOKES: But there was the opportunity to do that, especially when there was poor quality in terms of service and it was known. Where we were, there was a lot of pressure from above to actually ensure that your contracts reflected the kind of information you required to be able to assess the service. I didn't get that feeling for this—

PROFESSOR MONTGOMERY: No, and I was intrigued by the implication that there was money that was sent in to solve some of the problems – 'that's the tariff' – which sort of makes the idea that the quality issues were the product of the FT application.

MS McINTOSH: It was a subtle way of saying it.

DR CALDERWOOD: I suppose what I thought was: although that was the context, in fact the frontline staff are miles from any of that. The fact that there are Councils that are fighting amongst themselves, that doesn't make you produce a midwife that high-fives somebody stepping out of the—

MR BROOKES: No, it doesn't.

PROFESSOR MONTGOMERY: But if we found that the closing of obstetric services in Barrow, the hot political issue between the Councils, but we flush out that it isn't that—

DR CALDERWOOD: I think he was very upfront about the difficulty in recruiting staff.

MR BROOKES: I think that's the crux of it. It sounds to me like we have an organisation sitting there which, if not completely forgotten, was not really a big player. It was to

one side. That isolation generates the kind of lack of impetus. Now you've got a focus on it for all the wrong reasons, but a focus on it, which then means that they have to do something about it, so you get the focus. One of the things he was saying, about going abroad, etc – the things which, where improvement has been made, people have been doing it for years and years and years.

PROFESSOR MONTGOMERY: There's also a flip side, isn't there? If the perception was that they wouldn't be able to recruit, that's a reason for not tackling the cultural problem – because you are frightened that if you drive people out and you haven't got new people in, it would be even more difficult, and you might lose—

PROFESSOR FORSYTH: What is interesting from the commissioner's point of view, they seem to be able to commission a service which they would know is not going to be sustainable. That is the problem. Talking about Whitehaven, with most of the doctors being locums, how can that be a good quality commissioned service?

MR BROOKES: Well that's what I was trying to get to. There are things you can do.

PROFESSOR MONTGOMERY: Well that is also this thing about what is seen as a commissioner's responsibility and what isn't.

PROFESSOR FORSYTH: Exactly. That is why I was asking about accountability. I think the accountability in fact does very much rest with commissioners, to a certain extent. If you're commissioning a service and there's no way in which you're going to be able to sustain it at proper standards—

PROFESSOR MONTGOMERY: Part of the challenge then is: what is your alternative? In Hampshire, when we were having that debate, you had more hospitals and you could think about moving your obstetric care and perhaps at one of them making it midwifery-led. It doesn't sound as though that is a realistic option for this geography.

It is part of the dynamic of the commission pressures, isn't it? If they think that they can't move it, how else do they exercise their levers? We didn't get any clear picture of what levers they thought they had, and that's probably because they're not very easy. It would be really interesting to see whether there is anything like maternity commissioning strategy though that pulls this together. Lots of places didn't have them, so it would be surprising if there is one, but it would be interesting to see.

PROFESSOR FORSYTH: In Paediatrics they are looking to have 10 consultants in Barrow to try and sustain the service. Again, they've lost their training. So they only have newly qualified and then consultants. That gets the numbers up and will probably help recruit for a bit, but then of course comes the sustainable issue as well, in terms of maintaining—

DR CALDERWOOD: And what they are going to do all day.

PROFESSOR FORSYTH: And what they are going to do. That is probably why they are attracting staff.

MR BROOKES: They'll be fighting over—

DR CALDERWOOD: Suddenly you have interventions and admissions to the neonatal group go through the roof. That's what's happened in some parts of Scotland: double the admissions to the neonatal unit when they have extra staff, because they have nothing to do.

PROFESSOR FORSYTH: As I say, the recruitment thing sounds good, but actually it might be, again, for all the wrong reasons. You're getting people thinking, well, they need to work two days a week and I go fishing and mountaineering and whatever, and then their clinical skills go.

MR BROOKES: Okay. Any other business? **(No)** Well then, in that case, thank you very

much.

[The meeting concluded at 3.02 p.m.]

Term of Reference	Key Question Ref No.	Key Question/Commitment to be Addressed in Final Report	Information Required to Address this Question	Is the Required Information Available to the Investigation?	Relevant Organisation/s	Potential Interviewees	Panel Subgroup to Address this Question	Lead Panel Member	Status
1	1.1	Was the Trust a national outlier at any point during the review period for: - maternal mortality - intrapartum stillbirth - early neonatal deaths (within 7 days) - neonatal deaths (up to 28 days) from sepsis	HES linked to ONS CMACE reports Review of Perinatal Mortality in Cumbria Report	HES - analysis in progress CMACE - Yes (on Huddle) Cumbria report - Yes (on Huddle)	UHMB		Clinical		In Progress
	1.2	Was mortality at the Trust higher than expected for particular causes of maternal/neonatal death e.g. birth asphyxia; infection	HES linked to ONS CMACE reports Review of Perinatal Mortality in Cumbria Report	HES - analysis in progress CMACE - Yes (on Huddle) Cumbria report - Yes (on Huddle)	UHMB		Clinical		In Progress
	1.3	Is the gestational age and birthweight profile of the babies that died typical of the stillbirth / early neonatal death population?	HES linked to ONS CMACE reports Proton Review of Perinatal Mortality in Cumbria Report	HES - Yes CMACE - Yes (on Huddle) Proton - TBC Cumbria Report - Yes (on Huddle)	UHMB		Clinical		In Progress
	1.4	Was the Trust a national outlier at any point during the review period for other measures of substandard care not relating to mortality, for example: 1. Maternal complications e.g. emergency caesarean sections; prolonged second stage of labour; admissions to intensive care; postpartum haemorrhage; VTE; maternal readmission to (any) hospital within 30 days; maternal readmission to (any) hospital for sepsis 2. Neonatal complications e.g. injury to neonate; Apgar score < 7 at 5 minutes; term babies admitted to neonatal care; number of days of neonatal care; maternal readmission to (any) hospital within 30 days; neonatal readmission to (any) hospital for sepsis 3. Long term complications associated with birth trauma e.g. patterns of hospital readmission related to hypoxic brain injury; continuing outpatient care; admission to paediatric ward 4. Infections e.g. MRSA, C Difficile, Group A and B Streptococcus	HES CHAS Proton Evolution database PEER database NCAU database	HES - Yes CHAS - TBC Proton - TBC PEER - TBC NCAU - TBC	UHMB		Clinical		In Progress
	1.5	Was the Trust's 'normal birth' rate (i.e. spontaneous, vaginal birth without instruments, anaesthesia or episiotomy) higher than expected?	HES	Yes	UHMB		Clinical		In Progress
	1.6	On day of serious incident was the maternity unit adequately staffed in terms of numbers and expertise?	Breakdown of midwifery and medical staff who were on duty during that period - names, designations, shift periods. Numbers of deliveries during that period and outcomes		UHMB		Clinical/Governance		
	1.7	Was there evidence of routine communication between midwives, obstetrician and paediatricians?	Daily Labour ward meetings to review patients Guidelines and protocol meetings Perinatal mortality and morbidity reviews		UHMB		Clinical		
	1.8	Was there evidence of patient safety and health improvement activities across the Trust and in particular within maternity and neonatal services?	Maternity dashboard Early Warning Charts Midwifery Led Care Data Set and Audit		UHMB		Clinical/Governance		
	1.9	Who was the clinical manager on duty on day of serious incident and what is remit of manager?	Job description Lines of responsibility and accountability Minutes of team meetings		UHMB		Clinical/Governance		
	1.10	Have there been issues with midwifery and medical staffing?	Information on bank nurses, additional shifts, locum junior and senior doctors Staff performance / discipline Involvement of professional regulators eg NMC, GMC		UHMB		Clinical/Governance		
	1.11	Have budgetary and other financial pressures had an impact on provision of service?	Data on budgets, savings plans		UHMB		Clinical/Governance		
	1.12	Is there evidence that the Trust senior management team visited the maternity unit?	Reports of site visits Meetings with staff; specific issues discussed, decisions and actions		UHMB		Clinical/Governance		
	1.13	Is there evidence of visits by commissioners or other strategic / planning groups / or clinical network leads?	Minutes of meetings, correspondence		UHMB SHA/PCT		Clinical/Governance		
	1.14	Is there evidence of feedback from users on the quality of the service?	Patient satisfaction surveys, correspondence, complaints		UHMB Correspondence with families		Clinical/Governance		
	1.15	What was the methods in birth rates during that period and recruitment and retention rates?	HR information ERS data	TBC	UHMB		Clinical/Governance		

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	1.5	Was the Trust's 'normal birth' rate (i.e. spontaneous, vaginal birth without instruments, anaesthesia or episiotomy) higher than expected?	HES	Yes	UHMB		Clinical		In Progress
	1.6	On day of serious incident was the maternity unit adequately staffed in terms of numbers and expertise?	Breakdown of midwifery and medical staff who were on duty during that period - names, designations, shift periods. Numbers of deliveries during that period and outcomes		UHMB		Clinical/Governance		
	1.7	Was there evidence of routine communication between midwives, obstetricians and paediatricians?	Daily labour ward meetings to review patients Guidelines and protocol meetings Perinatal mortality and morbidity reviews		UHMB		Clinical		
	1.8	Was there evidence of patient safety and health improvement activities across the Trust and in particular within maternity and neonatal services?	Maternity dashboard Early Warning Charts Midwifery led Care Data Set and Audit		UHMB		Clinical/Governance		
	1.9	Who was the clinical manager on duty on day of serious incident and what is remit of manager?	Job description Lines of responsibility and accountability Minutes of team meetings		UHMB		Clinical/Governance		
	1.10	Have there been issues with midwifery and medical staffing?	Information on band nurses, additional shifts, locum junior and senior doctors Staff performance / discipline Involvement of professional regulators eg NMC, GMC		UHMB		Clinical/Governance		
	1.11	Have budgetary and other financial pressures had an impact on provision of service?	Data on budgets, savings plans		UHMB		Clinical/Governance		
	1.12	Is there evidence that the Trust senior management team visited the maternity unit?	Reports of site visits Meetings with staff: specific issues discussed, decisions and actions		UHMB		Clinical/Governance		
	1.13	Is there evidence of visits by commissioners or other strategic / planning groups / or clinical network leads?	Minutes of meetings, correspondence		UHMB SHA/PCT		Clinical/Governance		
	1.14	Is there evidence of feedback from users on the quality of the service?	Patient satisfaction surveys, correspondence, complaints		UHMB Correspondence with families		Clinical/Governance		
	1.15	What was the midwife to birth ratio during that period and recruitment and retention rates?	HR information ERS data	TBC	UHMB		Clinical/Governance		

2	2.1	Did the Trust Board have policies and procedures for effectively assessing the governance of its organisation? If not, why not?	Governance structures, policies and procedures		UHMB		Governance		
	2.2	Were these procedures adhered to during the period under investigation? If not, where were the failures in the system?	Minutes of meetings, correspondence		UHMB		Governance		
	2.3	What were the policies in place within the trust for dealing with complaints? Were these procedures satisfactory?	Complaints policies and procedures		UHMB		Governance/Trust Management		
	2.4	Were the procedures followed in all cases under investigation?	Minutes of meetings, correspondence with families		UHMB		Governance/Trust Management		
	2.5	What was the process for investigating clinical care? Was this process appropriate? Was the process followed in these cases?	Policies and procedures for investigating clinical care		UHMB		Governance		
	2.6	Is there evidence of a lack of transparency and honesty by the Trust when communicating with patients and their families?	Minutes of meetings, correspondence with families		UHMB		Governance		
	2.7	What procedures were used to inform commissioners and external organisations within the health system of the cases under investigation?	Correspondence with external organisations		UHMB SHA/PCT CQC Monitor Coroner Police GMC/NMC PHSO		Trust Management/External Response		
	2.8	Were these procedures adhered to? Is there evidence that the Trust failed to communicate adequately with SHA, CQC, Monitor, Coroner and Police?	Minutes of meetings, correspondence with external organisations		UHMB SHA/PCT CQC Monitor Coroner Police GMC/NMC PHSO		Trust Management/External Response		
	2.9	Did the NHS and its regulators respond appropriately to the information they were given on the cases under investigation?	Minutes of meetings, decisions, actions, correspondence External reports		SHA/PCT Monitor CQC GMC/NMC		External Response		
	2.10	Are the Governance structures and general procedures within the general part of the hospital replicated in maternity and is there always representation from Maternity at the senior meetings?	Governance structures, policies and procedures Minutes of meetings		UHMB		Governance		
	2.11	Can the Trust show they are now open and honest when an incident occurs with their families and informs them from the start an investigation will be taking place?	Current complaints policies and procedures		UHMB		Governance/Trust Management		
	2.12	Is there now a timely meeting within the Trust to raise incidents, if needs to be escalated externally and conform an RCA and full investigation with a specific lead needs to take place?	Current incident reporting policies and procedures		UHMB		Governance		

The Morecambe Bay Investigation

I. Process for undertaking case reviews

Detailed reviews of individual cases where the families haven expressed serious concern regarding the quality of care that their family members received will be a key element of the evidence required to address Terms of Reference 1 and 2.

The Panel has met with the families who believe that the care they received by Morecambe Bay NHS Trust was sub-standard and resulted in them experiencing unacceptable personal loss in tragic circumstances.

They wish answers to the following questions:

- What happened to mother and infant while under the care of Morecambe Bay NHS Trust?
- Who was responsible for their tragic outcome?
- What action has been taken with those who were responsible?
- Why have they not received an unreserved apology from the Trust?
- What action will be taken to prevent this occurring again at the Trust and elsewhere?

To address the allegations and the questions that have been proposed by the families the care that their family members received will be reviewed by the Panel with a focus on two specific aspects:

i. The standard of clinical practice that the family members received (ToR 1)
ii. The actions taken by the Trust in response to the concerns and complaints by the families (ToR 2).

II. Review of the standard of clinical practice that the family members received (ToR 1)

The process that will be adopted by the Panel is a modified version of the protocol for undertaking confidential enquiries that was developed by the University of Leicester[1].

Aims of the clinical practice review:

1. To assess the quality of maternity and neonatal care provision for identified cases.
2. To identify areas of sub-optimal care.
3. To review whether the Trust was following national and network guidelines and pathways in relation to the cases selected for review.
4. To identify any recurring themes for potential improvement in relation to neonatal care provided by the Trust.

Key review questions

i. Is there evidence of sub-standard care?
ii. On day(s) of concern was the maternity unit adequately staffed in terms of number and expertise?
iii. Is there evidence of routine communication between midwives, obstetricians and paediatricians?
iv. Who was the Clinical Manager on duty and what was the role of the manager?
v. Is there evidence of effective regular communication between the mother and immediate family members?

Cases identified for review:

a) All cases where the families have expressed concern regarding the standard of care that the mother or infant had received
b) A random sample of serious untoward incidents (SUIs)

Reviewers of clinical practice:

The clinical practice delivered for each case will be reviewed by a minimum of two clinicians from the Inquiry Panel.

Material that will be reviewed:

a) All medical maternity and neonatal records relating to the selected cases will be obtained and will include:
   - All notes from antenatal care, labour and delivery where relevant
   - All neonatal notes and nursing care charts for the care received

- All notes concerning transfer from and to network units

b) Relevant maternity and neonatal unit policies, pathways and protocols
c) Information relating to SUIs, complaints and patient feedback
d) Relevant workforce, training and education policies and practice
e) Background benchmarking data relating maternity and neonatal clinical outcomes within the Trust to corresponding national outcome data

The review process:

1. The panel members will review the medical records and highlight any areas where they considered that the care was sub-standard or where care was felt to be of particular excellence, to ensure a balanced approach.
2. The reviewers will complete a notable factors form previously designed and tested by Leicester University (see appendix 2)
3. Following the review of the medical records, the findings will be presented and discussed by the full Inquiry Panel
4. Emergent issues relating to how the service is managed and delivered will also be considered.
5. Evidence of sub-optimal care will be graded according to the scheme developed by the University of Leicester (Figure 1)

Reference for Standards of Care:

The benchmarks for standards of care will be the DOH Toolkit for Neonatal Services[2], the British Association of Perinatal Medicine – Service Standards for Hospitals Providing Neonatal Care[3].

The case record review should particularly refer to **Principles 2-5 in DOH Toolkit**:

Principle 2: Staffing of neonatal services.

High-quality neonatal services, including those providing neonatal surgery, rely on having an adequate and appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery.

Audit indicators: Documentary evidence of skill mix levels; workforce establishments and profile; and evidence of access to support services.

Principle 3: Care of the baby and family experience.

Family-centred care is a philosophy of care that helps families whose baby is in hospital to cope with the stress, anxiety and altered parenting roles that accompany

their baby's condition. It puts the physical, psychological and social needs of both the baby and their family at the heart of all care given. Ultimately family-centred care may enhance attachment between a baby and the family and result in an improved long-term outcome for both.

Audit indicators: Documentary evidence of appropriate policies; care pathways; information leaflets; documentation showing provision of leaflets; parent facilities; parent feedback; and independent national parent surveys.

Principle 4: Transfers.

A service is available at all times and to all units within a network, providing safe and effective transfers for newborn babies. This service should be additional to the delivery of in-patient care, should recognise the importance of family circumstances and should provide arrangements to undertake or facilitate transfers in all categories as part of its baseline provision.

Audit indicators: Documentary evidence of protocols showing referral processes; clinical records; incident reporting records; service level agreement/contract; guidelines and records for IUT; operational specification of service; audit of departure times; and annual reports.

Principle 5: Professional competence, education and training

Access to provision for education and training should be available to enable members of the multi-disciplinary neonatal team to be trained to a level of competence to enable the delivery of high-quality care.

Audit indicators: Documentary evidence of neonatal life support training records; records of audit of neonatal resuscitations; staff rotas; training plans and programmes; and records of training and qualifications.

Notable Factors

Adopting the Leicester University audit form, notable factors will be recorded, and comments on quality of care, relevance of sub-standard care and the questions what, when and who should be addressed (Appendix 1).

Finally an overall opinion of the Panel should be obtained and the quality of care classified as set out in Figure 1.

Figure 1: Overall grading of sub-optimal care and relevance to the outcome for the infant

Grade of sub-optimal care	Definition
0 - None	No sub-optimal care
1 - Minor	Sub-optimal care, but different management would have made no difference to the outcome
2 - Significant	Sub-optimal care, in which different management might have made a difference to the outcome
3 – Major	Sub-optimal care, in which different management would reasonably be expected to have made a difference to the outcome

References

1. Draper ES, Kurinczuk JJ, Lamming CR, Clarke M, James D, Field DJ. A confidential enquiry into cases of neonatal encephalopathy: Clinical governance in practice. Archive of Disease in Childhood 2002;87:F176-F180

2. Toolkit for High Quality Neonatal Services 2011. http://www.neonatal.org.uk/a/5350

3. British Association of Perinatal Medicine. Service Standards for Hospitals Providing Neonatal Care (3rd edition) August 2010. http://www.bapm.org/publications/documents/guidelines/BAPM_Standards Final_Aug2010.pdf

III. Review of the actions taken by the Trust in response to the concerns and complaints by the families (ToR 2).

Aims of the review are to determine if:

1. The concerns and complaints were managed appropriately through acceptable processes and procedures
2. The families were treated with trust and respect
3. Communication was timeous, transparent and honest
4. There is evidence of the Trust accepting responsibility and offering apologies where appropriate

Key questions

1. Did the Trust have policies and procedures for effectively assessing the governance of its organisation?
2. Were these procedures adhered to during the investigation of each of the families concerns?
3. What was the process that management adopted for investigating clinical care?
4. Is there evidence of lack of transparency and honesty by the Trust when communicating with patients and their families?
5. What procedures were used to inform commissioners and external organisations within the health system of cases under investigation?
6. Is there evidence that the Trust failed to communicate adequately with SHA, CQC, Monitor, Coroner and Police?
7. Did the NHS and its regulators respond appropriately to the information they were given on the cases under investigation?

Reviewers of Trust response to concerns and complaints by families

This review will be undertaken by the Panel members with particular expertise in management, governance and ethics.

Material that will be reviewed

a) All correspondence between families and Trust
b) All correspondence between the Trust and the families
c) Trust documentation relating to the complaints
d) Communications with external agencies that are specific to the complaints made by the families.

Review process

1. The relevant documentation will be reviewed
2. Key Trust personnel with responsibility for management and governance will be interviewed
3. Key personnel from relevant external agencies will be interviewed
4. Key issues arising from each case review will be considered by all Panel members

IV. Outputs from the case reviews

1. The Panel will draw conclusions and make recommendations that are specific to the concerns and complaints by each of the families.

2. Emergent clinical and management issues will inform the conclusions and recommendations that are specific to ToRs 3, 4, 5, 6.

APPENDIX 1

Case Number: ____

Notable Factors :

Care quality
E: Care quality excellent
O: No sub-optimal care
1: Minor suboptimal care
2: Significant suboptimal care
3: Major suboptimal care

Relevance of any sub-optimal care to the outcome
O: Not relevant
1: Possibly relevant
2: Probably relevant
3: Almost certainly relevant

What:
R: Failure to recognise problem
A: Failure to act appropriately
C: Communications failure
S: Failure to supervise
H: Any lack of human resource
E: Any lack or failure of equipment
O: Other (please specify)

When:
AO: Antepartum - outside hospital
AI: Antepartum - inside hospital
IP: Intrapartum
NNI: Neonatal - inside hospital
NNO: Neonatal - outside hospital

Who:
Type of Health Professional or carer involved (e.g. GP, Hospital Midwife, Obstetrician, parents). If more than one person for this factor, write as separate factors.

Grade of Staff:
Write grade next to relevant staff member (e.g. Consultant, SHO, G Grade Midwife)

No:	Notable Factor *Please be as specific as possible: give an explicit standard whenever possible. When criticising a course of action, be explicit about what was done and what should have been done.*	Care quality	Relevance of any sub-optimal care to the outcome	What	When	Who	Grade of Staff	Locum *Y/N*
1.								
2.								
3.								
4.								

Overall Grade of sub-optimal care and relevance to the outcome

OVERALL GRADE:

E: Care quality excellent
O: No sub-optimal care
I: Sub-optimal care, but different management would have made no difference to the outcome.
II: Sub-optimal care in which different management might have made a difference to the outcome (i.e. an avoidable factor of uncertain influence on outcome).
III: Sub-optimal care in which different management would reasonably be expected to have made a difference to the outcome (i.e. an avoidable factor that contributed to a poor outcome).

PROCESS FOR HANDLING RESPONSES TO THE INVESTIGATION'S NOTICE IN LOCAL PAPERS

Background

The Investigation placed an open letter from the Chairman in several local papers and their associated websites for a period of two weeks at the end of January. The letter invited anyone with concerns about the care they received in the Trust between 1 January 2004 and 30 June 2013 to contact the Investigation.

To date there have been 41 responses.

Respondents were asked to complete the Investigation's proforma to capture the details of their concerns / the incident.

Approach

The details provided in the proforma have been anonymised and summarised into the table annexed to this paper (**ANNEX A**). The responses fall into four categories. A description of each category and a suggested approach for the Panel to consider are outlined below:

Category 1:

Nature of concern / incident clearly falls within the scope of the Investigation's terms of reference.

For these cases the Panel is asked to review the proforma as part of the wider evidence review. The Panel are also asked to consider whether they wish to invite these individuals to provide oral evidence at a future Panel Meeting, as other families have had the opportunity to do.

Category 2:

Nature of concern / incident clearly falls out of the scope of the Investigation's terms of reference. The majority of these cases are outside of the terms of reference's timeframe.

In these cases the Panel should be aware that the Secretariat will write to the individuals thanking them for their contribution, explaining that the Investigation's work is confined by the terms of reference and that their information cannot therefore be considered by the Panel. Wherever possible the Secretariat will direct the individuals to other appropriate organisations to report their concern(s).

Category 3:

These are cases where it is yet to be determined whether the nature of concern / incident falls within the scope of the Investigation's terms of reference. The vast majority of these cases are non-maternal / neonatal incidents occurring within the timeframe but the respondent does not know whether the incident was categorised as a serious untoward incident.

The Panel is asked to consider whether these cases should be included as part of the random sample of incidents they review.

Category 4:

This category refers to individuals who have made initial contact with the Investigation but a completed proforma has not yet been received.

The Panel are asked to note that some individuals may decide not to provide the Investigation with any more detail. If a proforma is received they will be considered and placed into one of the three categories above and the Panel will be advised.

MORECAMBE BAY INVESTIGATION PANEL: ASSESSING THE EVIDENCE

As you will recall, we discussed at out Panel Meeting in November how the Panel should approach the evidence, and agreed that assessing the material would best be tackled as a joint responsibility. As we are now amassing a considerable amount of evidence, and facing constraints in scheduling additional Panel meetings, I would like to outline ahead of the next Panel meeting how we might tackle the next stage of the Investigation most effectively. If we can agree the principles in advance, the detail can be finalised at the meeting on 13 February 2014.

Background

There are currently over 1100 documents on Huddle in the 'evidence by case' workspace and a further 12 documents in the 'evidence by organisation' workspace. There are also documents in the 'MBI Panel' workspace, of which 7 relate to oral evidence from families.

The Investigation is now receiving evidence from the interested organisations. From the Trust and the Department of Health (as the legacy body for the abolished organisations), the quantities are anticipated to be large. The Investigation has also received evidence from NHS England, HM Coroner for South Cumbria and one of the Clinical Commissioning Groups. I am attending a meeting at the office of the Parliamentary Health Service Ombudsman to discuss how the Investigation can obtain relevant material from them.

As well as the amount of written material that we need to consider, we are facing significant difficulties in arranging Panel sessions to hear oral evidence due to understandably limited availability of Panel members. Unless we can overcome these difficulties there is a substantial risk to achieving completion to time, an undesirable outcome from the point of view of all concerned.

Proposed Action

I think there is little prospect of remedying this situation if we attempt to do everything as a single complete Panel, and suggest that we revert to the alternative option we discussed, that we work initially in sub groups on a number of emerging themes to make the maximum use of our limited resources and expertise. This would not substitute for a full Panel discussion of the key points and findings, but this would be done on the basis that the assessment had been done by the appropriate sub group prior to a full Panel meeting.

With that in mind, can I suggest that four Panel sub groups could address Investigation's six terms of reference:

- **Clinical** : Catherine, Stewart, Jacqui, Geraldine, Bill
- **Trust management**: Geraldine, Julian, Jonathan, Stewart, Bill
- **External response**: Julian, Geraldine, Jonathan, Catherine, Bill
- **Report**: Bill supported by Oonagh and Panel

In light of the significant workload, I have tried to spread sub group membership around reasonably evenly; any Panel member is most welcome to join any sub group session particularly if matters are likely to arise at the interface between different groups. It would be helpful if the Panel could nominate a lead for each sub group, who would co-ordinate any calls that might need to be made upon fellow Panel members for contributions and peer review.

Based on experience to date it is unlikely that we will be able to schedule additional sessions to enable all five panel members to be present every time, and sub groups will need to agree how to delegate responsibility for specific areas to ensure that absences are covered.

A proposed broad scope for each of the sub groups is set out below for discussion at the Panel meeting on the 13 February. These have been modified from the initial proposal in light of the helpful comments from Panel members last week.

Clinical

This group will look at individual case evidence to review the outcomes for mothers and babies, how the services were run and how incidents were dealt with in the immediate aftermath, including communications with affected families. It is anticipated the group will review relevant evidence from the Trust by case, including case notes and medical records, and hear oral evidence from patients/families, clinical and midwifery staff, senior clinical staff and others to be determined by the group.

Trust management

This group will examine the response of the Trust to incidents and the emerging problems, actions taken in response, how complaints were dealt with, how findings were communicated, and Trust governance including policies, procedures, response to incidents and action plans. The groups will review relevant evidence, principally from the Trust, North West SHA, PCTs and CCGs, and hear oral evidence from current and former senior staff from the Trust, SHA, PCTs and CCGs.

External response

This group will look at the response to adverse events in the Trust from external bodies including the CQC, Monitor, GMC, NMC, HSE, PHSO, North West SHA and the Department of Health, including policies, procedures and actions in relation to governance. As well as reviewing relevant documentation, the group will hear oral evidence from staff in the organisations identified.

It is clear that there will be overlap between some of the sub groups, and so Oonagh and the Secretariat will need to coordinate who is interviewed by which group and who attends to minimise the need for repeat attendances.

Next steps

Given your agreement in principle, at the **Panel Meeting on Thursday 13 February** we should aim to have the sub group composition and leads finalised and to have agreed the search terms. This will allow the Secretariat to log new evidence and ensure an appropriate allocation of responsibilities so that evidence is properly sifted and presented to the appropriate sub-group, while ensuring that everything is available on Huddle to all Panel members.

MBIPM 4.7

SEARCHING FOR EVIDENCE

THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

THE MORECAMBE BAY INVESTIGATION

Searching for evidence

- All evidence by organisation will be indexed with an MBI URN as soon as possible after receipt
- The index will be uploaded to Huddle and Panel members notified
- After reviewing the index, Panel members should request from the Documents & Evidence Team (DET), the documents they need to see loaded onto Huddle
- The DET will maintain a record of what evidence has been requested, and therefore be able to identify any evidence not reviewed
- A member of the DET will be allocated to each interested organisation and each sub group as the "go to" person

THE MORECAMBE BAY INVESTIGATION

4 digit organisation URNs

URN	Organisation	URN	Organisation
1001	University Hospitals of Morecambe Bay NHS FT	1011	Public Health England
1002	Department of Health (Legacy)	1012	NMC
1003	NHS England	1013	GMC
1004	Monitor	1014	PHSO
1005	Department of Health (Policy)	1015	CQC
1006	HM Coroner South & East Cumbria	1016	Cumbria Constabulary
1007	NHS Litigation Authority	1017	Family / Relatives
1008	Health & Safety Executive	1018	NHS North of England
1009	NHS Cumbria CCG	1019	National Institute for Health & Clinical Excellence
1010	NHS Lancashire North CCG	1020	Healthwatch England
		1021	CMACE

THE MORECAMBE BAY INVESTIGATION

Evidence requested

NHS LITIGATION AUTHORITY

1. The NHSLA's definition(s) of both an incident and a serious untoward incident (SUI) for the period 1 January 2004 to 30 June 2013.
2. A list of all such incidents and serious untoward incidents for the period 1 January 2004 to 30 June 2013 that were referred to the NHSLA following a claim for compensation against the Trust.
3. Any correspondence between the NHSLA and the Trust with regard to the Trust Board's reporting and actions in response to incidents and serious untoward incidents relating to the deaths of mothers and babies for the period 1 January 2004 to 30 June 2013 that have resulted in a claim for compensation being made against the Trust.
4. Any correspondence between the NHSLA and any other Trust to which patients were transferred from the University Hospitals of Morecambe Bay NHS Foundation Trust, where an incident or serious untoward incident relating to the death of mothers and/or babies occurred for the period 1 January 2004 to 30 June 2013, and which resulted in a claim for compensation being made against the Trust.
5. Any copies of the Trust's Clinical Negligence Scheme for Trusts (CNST) reports other than those already provided to the Investigation (April 2008; February 2011; and February 2013).
6. Any record of the Trust Board's actions in responses to, and any subsequent actions taken following receipt of, the following reports.

- The NHS Litigation Authority's CNST reports

that the NHSLA was made aware of.

7. Any other information you consider may be relevant to the Investigation in fulfilling its terms of reference.

THE MORECAMBE BAY INVESTIGATION

Index of evidence from NHS LA (1007)

Text used by organisation to identify document

Document identifier URN

MBI URN	CONTENT		PANEL REQUEST
1007/01	NHSLA Response letter to MBI 11122013	PDF	
1007/02	NHSLA Lvl 1 Assmnt Of UHMBNHSFT 20110222	PDF	
1007/03	NHSLA Maternity Clinical Risk Mgmnt Stnds 2012-13UHMBNHSFT Lvl 1201302	PDF	
1007/04	NHSLA CNST Maternity Risk Mgmnt Stds Rpt Of Assmnt Lvl 220080405	PDF	
1007/05	CNST Maternity Standards 2013-14	PDF	
1007/06	CNST Maternity Standards April 2005 (final) MBI Evidence submission	PDF	
1007/07	Morecambe Bay claims MBI Evidence submission	Excel	
1007/08	The Morecambe Bay Investigation NHS LA response 29-01-14	Word	

THE MORECAMBE BAY INVESTIGATION

Overarching Index for UHMB NHS FT (1001)

1001 = Organisation identifier
MB0004/XX = allocated by Trust
/XXX = allocated by MBI

MBI URN	CONTENT	
1001/MB0004/01/	Maternal / Neonatal deaths	
1001/MB0004/02/	Neonatal transfers	
1001/MB0004/03/	Incident / SUI definitions	Word
1001/MB0004/04/	Policies on: Being open / Incident management / Risk management / Maternity specific policy for procedural documents policies	PDF
1001/MB0004/05/	All SUI / clinical incidents 2004 – 2013	Excel
1001/MB0004/06/	All maternity & neonates incidents 2004 – 2013	Excel
1001/MB0004/07/	All SUIs for maternity and neonates 2004 - 2013	Excel
1001/MB0004/08/	All maternity incidents	Excel
1001/MB0004/13/	Minutes of North Lancashire Group	Word
1001/MB0004/15/	Patient and staff surveys	PDF
1001/MB0004/16/	Financial reports	Word / Excel
1001/MB0004/A/	Structures	PDF
1001/MB0004/B/	Synopsis of management/command structure for SUIs Jan 2004 – June 2013	Word

THE MORECAMBE BAY INVESTIGATION

EVIDENCE RECEIVED FROM LANCASHIRE NORTH CCG (1010)

MBI Ref	File ref	MBI URN	Content	Format	PANEL REQUEST
1010	EQ 1	001	AT response to new SUI Guidence- EQ1	Email	
		002	Sui policy EQ1 (1)	PDF	
		003	Sui procedure EQ1	PDF	
		004	Team flow chart - EQ1	Word	
		005	UHMB-Policy for the reporting and management of incidents including serious incidents requiring investigation - EQ1	PDF	
1010	EQ 2	006	StEIS reports - April - July 2013 EQ2	Folder	
		007	LNCCG memebers council feedback EQ2	Excel	
		008	SUI FIGURES TRANSITION-EQ2- UHMB only	Word	
		009	UHMB 2013 06 20 SIRI Agenda (6 2)EQ2	Word	
		104	UHMB communicationPROCESS -Sir panel closure email evidence EQ2	Email	
1010	EQ 3	010	04 06 13 QIC Minutes Final- EQ3	Word	
		011	04.06.13 QIC Item 7.2 SI reportable to StEIS- EQ3- UHMB only	Word	
		012	04.06.13 QIC Item 7.2 SI reportable to StEIS- EQ3	Word	
		013	4.6.13 agenda QIC- EQ3	Word	
		014	Action Sheet QIC 4 6 13-EQ3	Word	
		015	Draft Agenda for the UHMB Contract Quality and Performance Meeting- 10-01-13- EQ3	Email	
		016	Early Warning Flag - LQSAG 31st May 2013 -EQ3	Excel	
		017	Item 3 - Ratified Exec Minutes - 28 May 2013- CCG assurance process EQ4	Word	
		018	Lancs North CCG weekly SI bulletin 3.6.13(1) EQ3	Word	
		019	LSQAG-Safe six - pulled together from soft intelligence EQ3	Word	
		020	Neonatal Staffing Document-14.08.13-QF4		
		021	SI reportable to StEIS- UHMB SI Panel 16th May 2013 -EQ3		
1010	EQ 4	022	CCG 2013-06-25 - AF Quality Performance Exception Narrative- May 2013 EQ4	Word	
		023		PowerPoint	
		024	CCG 30 04 13 QIC AF RR refresh pres item 4 1- EQ4	Word	