THE MORECAMBE BAY INVESTIGATION

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

Thursday, 8 May 2014

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

Dr Bill Kirkup CBE, Chair
Mr Julian Brookes, Expert Adviser on Governance
Dr Catherine Calderwood, Expert Adviser on Obstetrics
Ms Jacqui Featherstone, Expert Adviser on Midwifery
Professor Jonathan Montgomery, Expert Adviser on Ethics

Ms Oonagh McIntosh, Secretary to the Investigation
Mr Nick Heaps, Deputy Secretary to the Investigation
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Panel Meeting

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CHAIR: I will formally get the meeting underway by welcoming everybody who has made it so far. Thank you for coming. We do have apologies from Geraldine and from Stewart. We are awaiting Jonathan's arrival, who is, hopefully, not too much further delayed.

Can I move on to matters arising from the last meeting? I think that the first one is feedback from the interview which was last Friday at a charming venue in Dalton. It was slightly on the twee side, more used to doing wedding receptions, I think, as opposed to interviews, however, I think that the interview itself was useful and satisfactory. I think that John Woodcock was very frank. On occasions he was giving us background that we did not know, about how he had been involved in the process, all of which I think is useful, and also about his perceptions of the reaction amongst his constituents to what had happened and to the setting up of an investigation. One theme that I think we have picked up before, which I think might be worth bearing in mind when we do some further interviews and examination of the documents and so on, is the intense scrutiny that there was of the sustainability of the configuration around about that time. There was a lot of attention being given to what services in Furness might be under threat from the sustainability point of view. Clearly, maternity services were one of those. From personal experience, I have certainly seen in at least one other locality, a long way away from here or from Barrow, sometimes people under those circumstances become very reluctant to share any information that they think might reflect badly on the unit, because they see it as accelerating the questions about sustainability. I did not pick up anything else that was wholly new apart from that. Perhaps, I could ask you, Oonagh, what you think.

MS McINTOSH: I think that one of the things that he was very helpful about was actually he provided the investigation with copies of his correspondence with Ministers and also all the PQs he has put down, some of which overlap with some of the work that that Hannah is doing, because he had actually asked for some data from the Department. He also talked about the fact that he had more communication with the PCT rather than the SHA and the PCT, not frequently but occasionally, provided him with packs of data about the Trust and about his constituency. He has not actually got those – or they are tucked away in an archive - but he said that we should be able to get them from the PCT. In our discussions with the Department we are going to be quite clear - he considered that that information would be absolutely readily available and should be there and he said that it helped him to know what he needed to do by

way of representing his constituents and challenging the authorities. We will be pursuing that. We thought that that might be quite useful for the external response team, in particular, and also the Trust response team, the sub-group.

(Mr Montgomery joined the meeting)

CHAIR: I apologise, we thought that we would just made a start. We are only on item 3 talking about the interview with John Woodcock.

MS McINTOSH: I was talking about John Woodcock and how the interview had gone. He actually talked about how he initially did not consider that the problems raised by his constituents were anything other than just terrible things that do happen, but, as the time went on, so he became more versed in the struggles they were having and, actually, that shifted his view completely. He was very honest about that. But that, actually, ties in, if you look retrospectively, some of the information that Hannah has been showing to the panel, where the stats did not ring any alarm bells, nothing would have registered, but, actually, if you looked at it, cumulatively, it might have done. He was very helpful and very open, wasn't he?

CHAIR: Yes. Thank you.

PROF MONTGOMERY: I do not know what has previously been said, but I think that the main thing that came out for me was that the tipping point seems to be the coroner's report in 2011. I don't know if people said that.

CHAIR: Yes.

PROF MONTGOMERY: His account, with hindsight, was that there was a pretty good dossier of evidence that James Titcombe produced, which he felt could have triggered his realisation of that earlier. It would be quite interesting to us to see what that looked like.

DR CALDERWOOD: Which coroner's report was it?

PROF MONTGOMERY: In 2011.

CHAIR: It was when James Titcombe had persuaded the Newcastle coroner that there should be an inquest. The Newcastle coroner initially said no, because there was nothing unexpected by the time that the baby arrived in Newcastle, but, of course, that missed the point that there had been potentially unexpected elements to care before the baby had got anywhere near Newcastle.

PROF MONTGOMERY: I think that the second thing that I picked up, and I think that we need to think about, was the reassurance he took by the fact that various other agencies seemed to have it in their sights. He particularly pointed out that the CQC, in his view, was looking at it and then it seemed appropriate for him to step back. The

other thing I think was the tension with the local community, which I think we are already aware of. He, as the constituency MP, felt there were a clear set of conflicting pressures of anxieties about the future of the hospital. We were asking him about the way in which he was briefed when he was elected and it was pretty clear that the SHA was not a significant part of that relationship, but the PCT had briefed him, which I think that we are going to try to track down. I think that he indicated that there had been some document, that he had been sent to brief him on health issues and that would be quite helpful for us to pick us. But the impression that he had, although he was careful not to commit anything without looking at it again, was that the big issues were about sustainability of the health system and that the quality issues around maternity and the services were not things that were particularly flagged up at the PCT for him coming in. I think that the other thing that I got from my notes was a question about whether we needed to see John Hutton, his predecessor as an MP, because he was talking about the point at which he came in and it may well be that John Hutton could tell us some things about how things emerged earlier.

CHAIR: That is absolutely helpful. I had not appreciated that the transition between John Hutton and John Woodcock had been relatively recent, so I think that that is relevant.

MR BROOKES: Is that John Hutton who was a Minister?

DR CALDERWOOD: Yes.

MR BROOKES: That was on his elevation?

CHAIR: No, his constituency was Barrow and, when he stood down, he was replaced by John Woodcock. But John had already worked with him as his advisor.

PROF MONTGOMERY: I think that that were the key things that I picked up.

CHAIR: I cannot exactly remember when the transition was, but it was ....

MS McINTOSH: 2010.

PROF MONTGOMERY: He said that his first contact with James Titcombe was June 2010 and that was around trying to get legal aid for the coroner's inquest. It clearly started as a very specific constituency issue about a particular person, and in some ways that is not that long for him to realise there was a systemic issue, if he did that within a year, compared to some of the things that we are seeing. I thought that he tried very hard to be open and honest. I thought that it was helpful information.

CHAIR: I agree. Thank you. The other major matter arising, I think, is negotiations with the PHSO.

MS McINTOSH: Yes, because it was ongoing when we last met and it was just to provide a bit of an update, because the Chair was in correspondence with the Ombudsman at

that time. Because of their statutory bar, they are unable to supply material to us, correspondence that they have had with other organisations regarding the investigation they carried out. Paul is going to cover that when we talk about evidence recovery a bit later on, but just to let you know that the Chairman has had correspondence with Mick Martin, who is their director of investigations, and, particularly because we were asking whether or not we would be able to interview people from the PHSO, the two people, the previous Ombudsman and a member of the decision-making team, have subsequently left the Ombudsman's office and correspondence has been sent on to them. We corresponded with the former Ombudsman and we are still waiting for a response.

CHAIR: We have not had a reply?

MS McINTOSH: No. And we are still waiting for a response from the Ombudsman's office about whether or not, if there are any current serving staff that you would like to interview, the Ombudsman would be able to put those people forward for interview. We just consider that that is just correspondence taking its time. It is not in any way problematic thus far. We are waiting to hear. It will be interesting to hear from the two individuals. We have only heard from one so far. It is ongoing and I will keep you posted. Again, that is of interest, I think, to all the panel.

CHAIR: You mentioned correspondence with other organisations. In a sense, that is less of a concern to us, because we will get the correspondence from the organisations.

MS McINTOSH: Exactly, yes, and Paul is going to cover that.

CHAIR: They have said, have they not, that they will supply us with the internal ...

MS McINTOSH: And they have supplied the papers regarding the two decisions not to investigate earlier, which the Ombudsman referred to in the reports they published in February and apologised. So the decisions were made at a very senior level and they have provided notes of those meetings. That is why we are in correspondence with previous post holders, because they would be people you might want to just ask about that.

CHAIR: But the outstanding issue is the question of interviews, particularly of the former Ombudsman and the deputy. Thank you. Are there any other matters arising?

MS McINTOSH: No, I don't think so.

CHAIR: Which takes us on to item 4, analytical update, which I think is your cue, Hannah.

MS KNIGHT: This presentation is in two parts, really, the first part is focusing on workforce data that has been supplied to us by the Health and Social Care Information Centre, taken from the electronic staff record. Then the second part is some trends in

stillbirth and neonatal death. That is taken from a combination of data sources and HES data provided by the Trust and I have linked the HES data to the ONS death register, so that we can get accurate information about neonatal deaths that happen after hospital discharge.

Starting with the workforce data, the electronic staff record came on line in 2008, so I do not have any data prior to this, although there was the annual census, an NHS staff survey, which I presented on before. Instead of taking data for every single month, I have selected March and September as representative months. I think that that is sufficient to provide the trends. The panel had asked for data at the most granular level and, ideally, by site and by individual pay band. What the Information Centre has been able to provide at this stage is non-disclosable data, so that is not always available at site level because it would risk identifying individuals. If we want to get a greater level of granularity than I am about to present, we will have to set up a data-sharing agreement, and in the current climate that could take some months. I am going to come back and ask you at the end of this presentation whether that is something you want to pursue.

We have talked about the issue of comparator trusts before and so, where I do provide comparisons here, it is either with the national mean or with a number of Trusts that have been selected on the basis of their size, in terms of the number of deliveries per year.

This data is by site at the Trust. In red you have got the Royal Lancaster Infirmary, in blue Furness General and in green Westmorland General. This is the number of full-time midwives during the period of 2008 to 2013.

MR BROOKES: Are these established posts or filled posts?

MS KNIGHT: You will see the note at the bottom, this is the number of contracted positions, so, when someone is temporarily absence or on maternity leave, that is not reflected in these figures.

PROF MONTGOMERY: Just to be clear then, the contract referred to there is the contract with the employee, so this will be staff in post - on establishment - although they may be absent from that post for all sorts of reasons.

MR BROOKES: You are right.

PROF MONTGOMERY: If we wanted to know what the Commissioners thought the establishment was, we would need a slightly different set of figures.

MR BROOKES: Yes.

PROF MONTGOMERY: If that is important, I don't know.

MS KNIGHT: This is the midwife to birth ratio full-time equivalent. Midwives, again, from 2008 to 2013 by site. So the birth numbers have come from HES and I have checked those against the data supplied by the Trust to ensure that we have actually picked up all births. This is all the midwives and these are all the pay bands together.

MR BROOKES: And the benchmark rates - the birthrate plus ...

MS KNIGHT: Catherine or Jacqui might be able to help with that.

DR CALDERWOOD: It would be about one in 28.

MS KNIGHT: Yes, that rings a bell.

DR CALDERWOOD: Jacqui might want to say more, but you have a midwife-led unit, the green one, that would not be unusual to have that low, because that is providing a different type of service. That is not a problem, the fact that that is sitting at 15 when you think it might be 28.5, which is the number, isn't it, Jacqui?

MS FEATHERSTONE: Yes.

DR CALDERWOOD: What is interesting I see, though, is that there is a very big difference between the two obstetric sites and, secondly, that, in fact, one of them is probably significantly better than average staffing.

MS KNIGHT: Yes. There is an increase between 2010 and 2011 at Furness General, so that they are now on or above the 28, which is the national benchmark.

PROF MONTGOMERY: Just to be clear, 28 is births per midwife?

MS KNIGHT: Yes.

PROF MONTGOMERY: This is just something about understanding that, when we present this, it is intelligible and in context.

DR CALDERWOOD: And they are looking at more, because it is the complexity and acuity of the women now. This is a very basic thing to work on.

PROF MONTGOMERY: The birthrate plus report ...

DR CALDERWOOD: The birthrate plus does look at everything, much more.

MR BROOKES: Do we split that out in terms of the newly qualified or experience or ...

DR CALDERWOOD: Yes.

MS KNIGHT: Here we go, the next page. This is the pay band ratio. I have bands 5, 6 and 7 by site. There are not very many band 5 midwives. Well, not any at all at Westmorland. There are a couple at the beginning of the period at Furness General and they seem to have phased them out at the Royal Lancaster.

MS FEATHERSTONE: My only interest on that was, do they not have band 5s or do they pay their newly-qualified at band 6? If you had a very newly-qualified working to a band 6, it would look, if you look, that there are lots of band 6s, but actually, your

skill mix would be very low; you would have some very junior members of staff covering.

CHAIR: That might reflect recruitment difficulties, might it? If they were struggling to fill posts, that might be one strategy to use to improve it.

DR CALDERWOOD: Yes.

MS KNIGHT: Unfortunately, I do not have any comparator data. I don't know whether Jacqui would be able to tell us if this is something that would be expected for a Trust of this size, that ratio.

MS FEATHERSTONE: It is nearly half of the band 7 and band 6. Certainly, that is a very high proportion of band 7s, really very much so.

PROF MONTGOMERY: But could that reflect the low turnover of long-serving staff? They were on band 7 and they would not have gone on to band 7 if they were recruiting now..

MS FEATHERSTONE: But you would have only a handful of band 7s and it would be a progression to go to band 6, so we have really got deadman shoes then.

PROF MONTGOMERY: I think that that is the question, isn't it? There is something about linking this with the turnover, because there is a big difference between the midwife-led unit, which may be just a couple of senior members of staff left and being replaced by a couple of junior members of staff.

DR CALDERWOOD: Yes.

PROF MONTGOMERY: I think there is a question for me around whether we extrapolate from this some understanding of long-term staff who have not moved on and have not refreshed their skills and have no experience of working elsewhere. If that is the explanation for why it looks so static.

MS KNIGHT: Moving on to overtime pay, I have highlighted the Trust in red on this slide and these are the comparator Trusts which have a similar total number of deliveries to Morecambe Bay. They have a quite significantly higher than average spend, total spend, on overtime pay and in the next slide you can see that most of that is accounted for by overtime pay for midwives.

PROF MONTGOMERY: That is overtime for midwives on the staff not agency?

MS KNIGHT: I am not sure. I would have to go back and check.

MR BROOKES: But that is not normally overtime, is it?

DR CALDERWOOD: No.

MS WRIGHT: There is a separate set of data on bank staff. Would that be the agency?

MS FEATHERSTONE: There is a difference between agency and bank. Bank is generally

within the Trust and then agency are midwives coming in that may never have worked there before, which, again, if you had a high proportion of that, that would be something to look at.

PROF MONTGOMERY: If one of the questions is have we got a small group of people who dominate the system, if they are the ones coming in over hours.

DR CALDERWOOD: I agree with Jacqui, this is an odd concept to me. There are a few hours of overtime but you would not expect that much. I don't understand that as a concept.

MR BROOKES: Especially given the staffing levels.

DR CALDERWOOD: Exactly.

CHAIR: Sure. It is interesting that the place which is even higher is the one that is just up the road.

MS KNIGHT: Yes.

CHAIR: I say just up the road!

MR BROOKES: In relative terms.

DR CALDERWOOD: We will have to look at it with the sickness absence rates.

MS KNIGHT: Yes, the sickness absence rates.

PROF MONTGOMERY: Has the HR director been longstanding or is that one of the posts that …

MS McINTOSH: There has been some turnover, but there are people who have been constant in HR.

PROF MONTGOMERY: It might be quite useful in one of our interviews just to ask them to take us through their take on these.

MR BROOKES: I agree.

MS KNIGHT: This slide on trends in overtime payments among midwives might be interesting to look at in relation to the sickness absence data that I will show you later. There has been a general upward trend over the time period. Now, sort of the highest level was since 2008.

Now we come to bank staff expenditure. There is very little for qualified midwives. Most of the bank expenditure is on support clinical staff.

PROF MONTGOMERY: There may not be qualified midwives who you could get there to do some agency-type things, but I do think that that is an interesting pattern. The overtime is perplexing and seems different from the other places.

MS KNIGHT: When compared to the other Trusts with a similar number of deliveries, the total expenditure on bank staff is in line with the average.

PROF MONTGOMERY: That is for the whole Trust?

MS KNIGHT: The whole Trust?

PROF MONTGOMERY: Just to be clear, this is not agency, this is just bank?

MS KNIGHT: This is just bank, so those who are zero contracted. That is how it has been defined.

MR BROOKES: Do we know what the agency pattern is?

MS KNIGHT: No.

PROF MONTGOMERY: So we have three different things, we have staff who are employed on substantive contracts doing extra hours, we have staff who are bank, on contract with the Trust doing bank, and then we may have agency.

DR CALDERWOOD: Hannah, can I just take that first slide, the total overtime paid for all staff groups? That is for the whole Trust.

MS KNIGHT: Yes.

MS CALDERWOOD: Of which the significant proportion is midwives.

MS KNIGHT: No.

DR CALDERWOOD: So the total overtime pay is for all staff groups throughout the whole Trust of which the vast majority is midwives.

PROF MONTGOMERY: Ten per cent of it is midwives.

MS KNIGHT: I am sorry, this is in maternity. It is all staff within maternity. It is the same for all of the Trusts, it is maternity staff.

MR BROOKES: So they have high levels of overtime and high levels of bank expenditure.

MS KNIGHT: Not high levels of bank expenditure when compared to ...

MR BROOKES: The four million is split by the ones in the previous graph, so a small proportion of four million.

MS KNIGHT: Four million is a small overall spend when compared to the other Trusts and out of four million only 20,000 or so is on midwives. The most was on support workers.

PROF MONTGOMERY: So it is the overtime that is the big thing out of what you would expect.

MS KNIGHT: Yes.

MR BROOKES: The bank staff overall, they rank fifth out of all these trusts. If you look at it in round terms, they are not low. That is the point I am trying to make.

MS KNIGHT: They are not low.

MR BROOKES: You have got high overtime expenditure and not low bank staff expenditure.

MS KNIGHT: Yes.

PROF MONTGOMERY: That could well reflect a recruitment problem for the geography.

MR BROOKES: Yes.

PROF MONTGOMERY: And it would be consistent. That is a general problem that gets resolved through bank. What is intriguing is that the midwifery ones seems to be resolved through overtime, which may play into the fact that people ...

CHAIR: Except they seem to have overcome the recruitment problem. We all think that we know it is there, but, if you look at overall staff numbers, the contracted staff are not there.

MR BROOKES: Yes. Average number of midwives, they have quite a rich skill mix between 6s and 7s and yet they have still got high levels of overtime.

DR CALDERWOOD: Which I think that we have to say is an odd concept; in midwifery to be paid for additional hours is not something that I am familiar with as a way of filling gaps in shifts.

PROF MONTGOMERY: Presumably, usually it would be time owing.

DR CALDERWOOD: Yes. That has no end of patient safety concern. That is the first thing you would say is someone working longer hours than they should be.

PROF MONTGOMERY: Does the NMC publish addresses of registrants? I am just wondering if we do a postcode analysis we could see how many midwives are registered and are living in the area.

MR BROOKES: It would be surprising if they did.

PROF MONTGOMERY: Doctors have a professional address. Nurses do not. I have in my head this sort of question, have you got a - this is not the right way to say it, certainly not in the report, but have you a small group of people who are, in a sense, holding the Trust to ransom? The Trust has no options, therefore you have got this odd pattern of paying extra for time which would be just thought to be within contract in other places and low turnover. I take the point that the levels look all right, but, if we think the turnover is low and we think that we have a trying and difficult culture, then the options for the Trust to break that are quite small.

MS FEATHERSTONE: Band 7s who have been there for quite a long time are quite a forceful voice together.

DR CALDERWOOD: But you would also wonder why has that not been made into a bank staff contract? The rates of pay are different.

PROF MONTGOMERY: You could have the same people, couldn't you, on a bank contract for the additional hours and ...

DR CALDERWOOD: Exactly.

MR BROOKES: I was going to say, if there are not the people around, then you can put those on a bank contract, so you are not risking safety issues in terms of employing people on extra overtime, but rather managing it more by the bank.

MS KNIGHT: Who would these support workers be? What type of person is that?

DR CALDERWOOD: I would take that to be healthcare assistants.

MS FEATHERSTONE: Yes, I would say a healthcare support worker.

PROF MONTGOMERY: Is that figure maternity or is that the whole of the Trust?

MS KNIGHT: That is in maternity.

MS FEATHERSTONE: I would say that is considerably high; considering healthcare assistants do not get paid that much, that is an awful lot of money.

MR BROOKES: To be absolutely certain, so that graph there is just midwifery?

MS KNIGHT: Maternity.

MR BROOKES: It is just maternity?

MS KNIGHT: Yes, for the whole period.

MR BROOKES: It is about four million, isn't it?

MS KNIGHT: It is four million in total which is reflected in this graph here. This is again maternity

DR CALDERWOOD: I wonder why they have chosen not to have those healthcare assistants on permanent contracts. Again, those would be lower numbers of people than midwives, it is not that there are vast numbers all being paid a small amount; that size of unit would have, maybe - what, Jacqui, you would only have one healthcare assistant per shift, would you?

MS FEATHERSTONE: Postnatal, probably, but I cannot quite remember how many beds, but, yes, you would have one in postnatal and we have one in theatre.

DR CALDERWOOD: It is a very small number of people.

PROF MONTGOMERY: Given that they are poorly paid, that is a lot of money.

MS FEATHERSTONE: It is an awful lot of money.

DR CALDERWOOD: I would just like to know what the concept was there rather than ...

MS FEATHERSTONE: And it goes back then to what the full-time equivalent of, you know, midwife per shift is.

MR BROOKES: I was just thinking, do we know what the shift pattern looks like? Do we know who is on the shift by group, routinely? That would be quite interesting to understand.

CHAIR: What we are doing is generating a lot of rich questions that we need to pursue in

interview. We can actually extract the questions from the transcript.

DR CALDERWOOD: I am wondering, Jacqui, would this be a concept, that, if you have a high number of senior people, are they then using a lot of healthcare assistants because they don't want to do some of the stuff that healthcare assistants do?

MS FEATHERSTONE: Possibly.

DR CALDERWOOD: But, of course, that potentially leads to a lesser level of care. I could see that if there are a lot of in-charge people and not enough soldiers ...

MR BROOKES: That is why I think we need to know who is on the shift and what the shift patterns are across the bands, because you could pick that up from there, because, if you could see there is a rich skill mix on these ones and lots of care assistants there ...

MS FEATHERSTONE: And what shift. Are we talking about days and nights as well because that that would be more worrying if it was ...

DR CALDERWOOD: And also what they are doing. Are the healthcare assistants trained up to do the temperatures and the blood pressures or are they ...

MS FEATHERSTONE: Listening in and doing various things. Yes.

DR CALDERWOOD: Again, what is the reliance on that group of staff for monitoring?

MS WRIGHT: I can drill down a bit more into the bank staff and the healthcare assistants to find out the trends and compare the spend on healthcare assistants with these other comparators. That is something I can do with the data I have got already.

DR CALDERWOOD: Do you see physical numbers of people in there?

MS KNIGHT: Yes.

DR CALDERWOOD: Again, some of this, though, is only going to be answerable at interview, because I suspect that it is a concept; it is a little bit like the tearing off of the CTG to take to show the doctor, which is not a concept I am familiar with, but it is clearly a concept that is adopted by the team there. I don't know that the data would give us an answer.

MS FEATHERSTONE: Practice is what you want to learn about.

CHAIR: Yes.

PROF MONTGOMERY: So we really want to generate these questions and ask the HR people if they could explain what their thinking was about what was going on.

MS FEATHERSTONE: And ask the midwives.

DR CALDERWOOD: Yes.

MS McINTOSH: We will pull the questions out of the transcript and link them with the slides.

CHAIR: Thank you.

MS KNIGHT: Moving on to the stability index, in red there is the total there. I will show you some comparisons with the other Trusts in the next slide, but this is just within the Trust, the stability of the different staff groups.

PROF MONTGOMERY: So how is it calculated?

MS KNIGHT: I think that it is the number of staff present at the end of the period over the number at the beginning of each period.

PROF MONTGOMERY: So 95 means that 95 per cent of people ...

MS KNIGHT: Who are still there.

PROF MONTGOMERY: Is it on the period between the two?

MS KNIGHT: In six months.

PROF MONTGOMERY: So September 2008 is back to June 2008.

MS KNIGHT: Exactly.

PROF MONTGOMERY: That fits the pattern of questions, doesn't it, that there is not much turnover?

MS KNIGHT: Yes, and particularly amongst the midwives, they have the highest stability up until around 2010 and then it dips slightly.

MS FEATHERSTONE: Yes, investigations and reports, etc, etc.

MS KNIGHT: Stabililty amongst the doctors in blue is somewhat lower, but still quite high. I am sorry, this is such a messy graph, but I have emboldened the Trust's line in red so that it stands out. You can see that it is more stable than most of these comparators when you look at overall stability. But there is this dip around 2010/11. When we just look at the stability among midwives, again, it is more stable than average, but there is a slight downward trend since 2010.

PROF MONTGOMERY: Just to check whether we need to ask some questions about the number of staff. If you recruit new staff, would that automatically put the stability down or ...

MS KNIGHT: No, because, I think the denominator is the number of people present at the beginning of the period and it cannot be more than one, so ...

PROF MONTGOMERY: If you put in someone in the period, then they are ignored for that period?

MS KNIGHT: I think that they may be in the next period. Now, this is sickness absence which we referred to earlier. This is calculated by dividing the sum total of sickness absence days, including non-working days, by the sum total of days available per month for each member of staff. This is all staff in maternity 2008 to 2013. The latest date we have is September 2013.

DR CALDERWOOD: To be above 5 per cent is high.

MR BROOKES: That is what I was going to ask. Thank you.

PROF MONTGOMERY: Except if you look at the comparators ...

MS FEATHERSTONE: Is this doctors then as well?

MS KNIGHT: It is all staff in maternity. I have it separate for midwives.

PROF MONTGOMERY: It does not look so high against that, does it?

DR CALDERWOOD: No.

DR CALDERWOOD: The only thing is that, I suppose, if you have got low numbers and people on long-term sick, it is your short-term sickness absence you might want to look at.

PROF MONTGOMERY: Yes, because the dip at the end could be because somebody who has been on long-term sick has now left.

DR CALDERWOOD: On small units, you know, with relatively small staff numbers overall.

PROF MONTGOMERY: Which is creating the volatility on other graphs. Theirs is relatively stable.

MS KNIGHT: Yes. Amongst the midwives, we had a peak in January 2009 and then a dip and it has increased quite considerably since March 2010, but then dropped dramatically in the later part of 2013.

PROF MONTGOMERY: I guess amongst our questions to the HR person is did they see this as a problem?

MS KNIGHT: Did they intervene? I know that it is something that they are recording on their maternity dashboard which has now been uploaded to Huddle. I have a couple of copies here which, unfortunately, are not in colour, but they are now recording on a monthly basis the staff sickness rates and monitoring it. Those were introduced in May 2012. That could explain that.

MR BROOKES: Did they give any explanation or it is just figures?

MS KNIGHT: No, it is a monthly rate.

MS CALDERWOOD: What is interesting is that at the time of the cluster of incidents their sickness rate is very low, actually, 2 per cent there.

MS KNIGHT: It tallies a bit with what I presented last time in the NHS staff survey, that they had reasonable staff satisfaction rates at the time of these incidents, but they were amongst the worst for hospitals in the country during the time at which the hospital was under scrutiny.

PROF MONTGOMERY: That may not tell us anything about the care.

MS FEATHERSTONE: Exactly. That is what I was going to say.

MS KNIGHT: So the question for you is whether the information that I have presented is sufficient and I have mentioned that I can do a bit more drilling down of the data that I have got already or do you want to set up a data sharing agreement to get all this data by site, which could take some months.

DR CALDERWOOD: I think that it is the interviews where we catch this. It is about the culture of this which we want to ask. More data, particularly with the time constraints, is not going to help us, necessarily, get those answers as much as speaking to people.

CHAIR: I agree. I think that this has generated the key questions for the interviews. I think they will give us the information that we want, where pursuing a granularity of information is not really going to refine the questions at all and it will not answer the questions either.

PROF MONTGOMERY: There is also a very big risk that we then get accused of having advantages that the Trust could not have had at the time. That would dilute the impact of any recommendation that we made. If it could only be done by this sort of scrutiny, it is unreasonable to expect it. Of course, what they did know and how they responded to that would be useful.

DR CALDERWOOD: Although, Jonathan, we would expect them to have a monthly report, not obviously other Trusts, but they must have some scrutiny of that.

PROF MONTGOMERY: Which is why I think they ought to be able to produce their analysis of these sorts of questions for us to see and that will enable us either to say, if they had that information, why didn't they use it differently or to say, if they had nothing, then it is very reasonable for us to say that you should have something. We should try and compare it to the sort of things that would be available in other organisations as opposed to what you can get out of the Health and Social Information Centre now. I think that we will get to the issue without needing to negotiate for two months to get data sharing.

CHAIR: Yes, I think that that is the point.

MS McINTOSH: The other point we need to bear in mind is that the data goes from 2008 to 2013 and your terms of reference are 2004. There will only be an interview when you are actually talking to staff who have been in post - especially midwives, if they have been in post from 2004 - that you can actually see whether that pattern is consistent.

CHAIR: Sure.

MS KNIGHT: That is the end of part one. Now, on to part two. I have not presented any

data on neonatal death before, because it took a while to get the linkage with ONS set up, but we had approval for that a few weeks ago. I will start with stillbirth. In blue we have got the national mean from 2004 up to 2011/12. We are still waiting for the 2012/13 data and that has been affected by the review that is now being carried out of the whole of the Health and Social Care Information Centre and they are not releasing any further data extracts until that review has been completed which puts us in a difficult position because we really need to look at the whole period and not just up until March 2012. I think that, if you could see if there is anything that you could do ...

CHAIR: I am going to be wheeled out, I can see it.

MS KNIGHT: This is the stillbirth rate at the Trust as recorded in HES. There is a huge spike in 2005, but then we are talking about very low numbers, so you do expect some degree of fluctuation. What is surprising is that no stillbirths are reported in 2008/9, 2010/11 or 2011/12. When we compare that with the data I received from the Trust, on the next slide, in green, you get a completely different picture and I think you cannot really draw any conclusions from this except that, perhaps, one of our recommendations needs to be that the data for the reporting of stillbirths needs to be standardised because this is impossible to ...

DR CALDERWOOD: We don't know what is going on.

MR BROOKES: It is as bad as it looks, is it? There is a massive significant difference between what the Trust is reporting and ...

MS KNIGHT: Yes, but the really confusing thing is that this has also come from the Trust, submitted to HES. This is what the Trust has recorded using its own maternity information system.

PROF MONTGOMERY: They have told HES the green one and HES thinks they have been told the blue - is that right?

MS KNIGHT: The Trust has told HES the red one. The Trust internally has this data.

CHAIR: It is not as if the gap is consistent, though. Sometimes it is under and sometimes it is over.

DR CALDERWOOD: The other thing is this zero return would make anyone entering that re-examine it. Even if you know nothing about what stillbirth rates should be ...

MR BROOKES: If we just check the scale, that means ... you have this point of a percentage, so over four in a thousand stillbirths are babies over ...

MS KNIGHT: 2500 grams. That is what HES says.

MR BROOKES: What is 2,500 grams in old money?

DR CALDERWOOD: It is five pounds seven.

MS KNIGHT: This is the cut off for low birth weight.

MR BROOKES: So these babies born start at this?

DR CALDERWOOD: They are at term.

MR BROOKES: How do we define term?

MS KNIGHT: It is over 37 weeks.

MR BROOKES: Do we know if the Trust and HES are using the same definitions?

CHAIR: It does strike me that there is some scope -- that is probably where the difference is.

MS KNIGHT: I have defined term and this cut off myself, because they actually give the gestation age in weeks of each baby so I have excluded those that are less than 37 weeks and I have excluded those that are less than 2,500 grams.

MR BROOKES: HES will have a definition of what you are meant to record.

MS KNIGHT: You are meant to record gestational age and birth weight of every baby whether it is alive or dead at birth.

PROF MONTGOMERY: We were hearing earlier that in some Trusts, in order for families to have funerals, you might not record something as a stillbirth, so there is scope for some differential definitions between Trusts, as well as scope for differences within the same Trust.

MR BROOKES: In which case you might expect that it might be lower than the other.

DR CALDERWOOD: You would then expect that to be reflected in the neonatal death rates generally, if your stillbirth rate is ... although that is intrapartum stillbirth, you are talking about stroke neonatal death, and those numbers should be infinitesimally small.

MR BROOKES: The key question is to explain the difference.

MS KNIGHT: I would be more inclined to believe the Trust's own data but even then in 2006 ...

PROF MONTGOMERY: On the Trust's own data, on their data they have two spikes that they should be worried about, shouldn't they?

MS KNIGHT: They are such low numbers that you would expect fluctuations, so to talk of it in terms of a spike ...

PROF MONTGOMERY: I am just thinking in terms of what they did in commissioning Fielding and the like. It is something about getting a story of what they thought those issues were which may be quite different from what we might think retrospectively they are. It is to understand their thinking.

DR CALDERWOOD: This is what happened, Jonathan, right back at the beginning when I

had looked into the different reports that had been done and the difficulty was with the small numbers. I don't think that it would trigger something. It is when you hear the detail of the cases rather than the overall numbers. I don't think that we could say that they should have been looking at that because the difference might be one stillbirth or one neonatal death from one year to the next.

PROF MONTGOMERY: Does that imply that our only real interest in this is why there might be a difference between what they report internally and externally, because that may tell us something about the quality of their governance?

MS KNIGHT: Yes.

MS FEATHERSTONE: They are below the national.

DR CALDERWOOD: We might expect that because they are ...

MR BROOKES: I think this tells us about how they deal with their data.

DR CALDERWOOD: How they record data, exactly.

CHAIR: It is data quality issues, yes.

MR BROOKES: I think that a lot will obviously be down to data quality issues in terms of how they are interpreting what HES wants and how they are interpreting what they need for their own ..

PROF MONTGOMERY: And how much they talk to themselves about the governance process. I think that we have other evidence that suggests that governance is not very well joined up. This is probably not a big part of that. We have got better evidence of that.

CHAIR: I think that that is right. I think that the other thing worth bearing in mind is I think that these are Trust-wide. So whatever is happening at Furness is going to be diluted by RLI, in particular, and Westmorland.

MS KNIGHT: I can actually stratify this by site for next time. I did not have enough time to do that for today.

CHAIR: Sure. I think that it would be interesting to see it for completeness, but in light of this I doubt that it is going to tell us anything significant.

DR CALDERWOOD: No.

MR BROOKES: The only thing that it is likely to tell us is, is it a problem with data collection from one site or both sites?

CHAIR: Yes, that is true.

MS KNIGHT: I am much more inclined to believe the neonatal death data, because this is linked with the ONS death registry report and the deaths have to be reported to get the death certificate. Again, the national mean is in blue. This is for all the Trusts. I could

split this up by site and circulate that as well. It shows below average neonatal deaths. This is all deaths within 28 days since 2005.

CHAIR: Is that all babies born within the Trust regardless of where they die?

MS KNIGHT: Yes, whether they died at home or in another Trust.

CHAIR: Or transferred ...

MS KNIGHT: Or before they were discharged, yes. All deaths. I have then split this into early and late neonatal deaths. The vast majority of the neonatal deaths were within seven days which is consistent with what we would expect. Then there are very, very small numbers of late neonatal deaths, again below the national.

PROF MONTGOMERY: How easy is it to plot the spikes? You have given us the national data, which obviously looks like a stable line.

MS KNIGHT: Yes, I can easily do that analysis.

PROF MONTGOMERY: I am just thinking that it reinforces the point that, actually, there may be nothing in this that would have alerted anybody, because the spikes are normal, but if you compare that to what looks like a very stable national line you might not take that view.

MS KNIGHT: Yes. Would you like to see this with the same comparator Trusts ...

PROF MONTGOMERY: Only if it is really easy to do.

MS KNIGHT: It is easy to do.

PROF MONTGOMERY: It would be an answer to the question that I just asked, they had two spikes, nobody thought about it, because there was nothing unusual.

MR BROOKES: I think that for completeness it would, but I think that we will see what we have seen before which is that it is all over the place.

PROF MONTGOMERY: That is the point, isn't it, if it is all over the place, then that is an explanation of why it doesn't trigger a particular response.

MS KNIGHT: This is a chart that I have presented before and it is for the whole period. I can also produce this per year, if it would be interesting to see the Trust's movement, but for the sake of having a big sample size I have included all years together for this slide and I have adjusted the stillbirth rate for gestational age, birthrate, the year of birth, to take into account that the stillbirth rate has been declining over this period; socio-economic deprivation, ethnicity and the sex of the baby. What you find here is that, actually, the Trust has a lower stillbirth rate amongst term babies (more than 2,500 grams) but we have already talked about all the data quality problems.

CHAIR: Exactly. The other thing that might be worth saying about that is that it is clearly over dispersed. You have not got a controlled process here. It is full of variation.

MS KNIGHT: The only true outliers are really these.

CHAIR: Special cause variation.

MR BROOKES: This is based on HES data?

MS KNIGHT: This is based on HES data.

PROF MONTGOMERY: If we look at this in the next one, in neonatal, they are back on the average there, so two together don't suggest that anybody looking at this would think they had a big problem.

MS KNIGHT: No. It would be these ones. To sum up, nothing that I have found so far has really shown, using routine based sources, that the Trust was an obvious outlier.

Finally, we have got this data from the Trust on Apgar scores. I have looked at term babies smaller than 2,500 grams with an Apgar score less than 7.

MR BROOKES: I am sorry, you may have told us before ...

MS KNIGHT: An Apgar score is the condition of the baby measured at one, five and ten minutes, although an Apgar at less than 7 at five minutes is generally used as an indicator to measure those babies who are not going to thrive.

DR CALDERWOOD: So they are at higher risk of longer term problems. It is not an absolute predictor, but it would be something that ...

MR BROOKES: Indicative?

DR CALDERWOOD: Indicative, yes, that a percentage of those babies will have problems ...

MR BROOKES: They will trigger a closer scrutiny.

DR CALDERWOOD: Absolutely.

PROF MONTGOMERY: These are not the very low birth weight ones.

DR CALDERWOOD: These are proper sized, but something has meant that they were born in poor condition, so this might be a reflection of quality of care in labour.

PROF MONTGOMERY: And, if you had this for a top-notch unit that you were very proud of, where would you expect this to sit?

MS KNIGHT: We do not have that data from HES, which means that it is very difficult to compare it, but, as part of my work for the LCOG, I have been collecting Apgar scores from 15 Trusts around the country and off the top of my head I think that it was around 0.8 for term live born, which is more than 2,500 grams. Does that sound reasonable?

DR CALDERWOOD: Yes.

PROF MONTGOMERY: Again, that does not demonstrate a pattern that would necessarily generate a serious concern.

MS KNIGHT: Not necessarily.

DR CALDERWOOD: I think back to the big numbers that Hannah has presented of the stillbirths, I think you might remember me saying that it was the type of stillbirth I was more concerned with, so the pattern of stillbirths which, again, we do not get from these big numbers. I wonder whether that might apply to this as well, what are the details of some of these low Apgar scores or the circumstances in which they occurred, rather than the overall numbers which rather dilutes the ... Rather than saying that this does not necessarily spike a cause for concern, it is the underneath, the detail of them, because the intrapartum stillbirths, regardless of whether that is an outlier numbers wise, the number of intrapartum stillbirths is concerning.

PROF MONTGOMERY: Thinking aloud, it feels as though we are likely to be saying that you would not get to the bottom of this by just statistical analysis. You need to know what they are doing in terms of root cause analysis or ...

MR BROOKES: Yes, I would agree. That was linking my point to the whole issue about their governance process. How were they using this information in terms of their audit and looking at cases ...

PROF MONTGOMERY: Actually, it would be perfectly acceptable for them not to use this type of information because it has not told us anything and it would be reasonable for an organisation to say that we don't believe we would learn enough from this to put the effort into doing it, but you don't expect them to be saying what we don't accept is to address that.

MR BROOKES: Yes, exactly.

DR CALDERWOOD: The Cumbria review of 2011/12 that showed it was the bigger babies at term that the stillbirths were. It appeared to be different from the other Trusts that they looked at, but they could find no explanation for that, but, again, that is where I would want to know when that report was published what did you do about that?

MR BROOKES: Exactly.

DR CALDERWOOD: Because it would not be up to the report to necessarily find the detail of that, but what did the Trust do, because it was different, the pattern of stillbirths was different.

MR BROOKES: You have to satisfy yourself that there is an explanation for the reason for that, even if it was that it just happened, but you would want to make sure that you had done the work.

CHAIR: Yes. Again, that is generating questions which will inform the interviews which we will find out the answers from.

MS KNIGHT: That is all from me for today.

CHAIR: Thank you. Are there any questions that we need to answer for you or have you enough to be going on with?

MS McINTOSH: I am quite pleased in a way that you decided to cover some of that in interview and not go into data sharing agreements, because I think the clock is ticking and a two-month data sharing agreement ... it would be good if we can cover those things in interview.

MS KNIGHT: I suppose what would be useful for me is that, if you have got an interview coming up and you are going to need a particular pack of data specific to that interviewee, just to have a bit of notice and then I can compile that to make sure you have that.

CHAIR: That will come out of analysis of the questions that we have generated this morning and what the data is that that is based on and sometimes the absence of data.

MR BROOKES: We have not seen any consistent things which are coming from the data which are so obvious that they raise specific risks. It is more subtle than that and it is more about what they did, isn't it?

CHAIR: Yes.

PROF MONTGOMERY: And I think there is an emerging thing about there may be a different type of governance requirement for small units than there would be for big ones and actually demonstrating that producing lots of graphs would not actually have helped them in this. It is quite an important thing for us to do given how attractive graphs are to people.

DR CALDERWOOD: And it works both ways.

PROF MONTGOMERY: And saying that, actually, we should not be saying to people in these sorts of units that you have to do lots of statistical analysis. We should be saying that they need to be thinking very carefully about how they would pick up on problems without that sort of support, because the numbers are too small.

DR CALDERWOOD: And I think that some of the detail about those processes in their morbidity and mortality ratings, or whatever they had, because I feel there are things that, having looked at a few notes, what level of quality of care indicators were they examining, because they have not changed practice over a period of time.

PROF MONTGOMERY: And there might be something about the possibility of you spotting that in your own unit. It might be simply be something about the fact that the only way of picking that up is to involve external people.

DR CALDERWOOD: They are the right people to do it, Jonathan. .

MS KNIGHT: The statistical data can work both ways, because they can be falsely reassuring, but they can also make people jump up and down and rant and rave when actually there is not a problem. It is a small numbers blip.

CHAIR: Yes, okay. Thank you, Hannah. Item 5 is the evidence gathering process and a progress update and I think you are going to help us with that, Paul.

MR ROBERTS: I am. We have written to 19 organisations originally and subsequently have written to another four or five, I think, the universities that provided medical staff training or delivered the training. From the original 19 that we wrote to, we now have 3,722 documents. That should keep you busy over the weekend! We have a further 80 emails to add to that that we got from DH policy, but, to be honest, most of them are not particularly relevant to what we are looking at, I don't think.

What I have done is I have done three annexes here, the first one, Annex A, is looking at all the evidence that we have asked for from these original 19 organisations. What you have got there is the evidence that is still outstanding. Whatever we have got is already on Huddle and what we have not got is listed here. Really, what we need now, of course, is for you to kind of look at what we have asked for. The right-hand side columns are the response that we got back from the organisations in some cases. We need to know whether this is information you still want in order for us to chase them up and provide the information. If it is information that you still want, we need it prioritised, because in a minute, when we look at Annex B, we have recognised that as you are going through looking at the evidence and examining everything, it is likely that there will be more information that you need to see and Annex B shows you about 50 different things that have been asked for by the Panel. Quite a lot of it is Jonathan's stuff. I think that what is disappointing is that we asked for that information on 14th March, a lot of it, from the Department and we still have not got it. I have some sympathy with the Department because they are looking at something like a few short of a thousand boxes of evidence from SHA and PCTs that were involved and none of the information that is in the boxes is indexed or catalogued and they are having to go through it a box at a time and go through it sheet by sheet to try and identify anything that might be relevant to the investigation. It is taking them a long time. The advice from the lawyers is that they need to redact it, so they are going through that process which is slowing them down. In some cases there is no consistency in what is being redacted, you know, for example, they will send us a letter that clearly has come from the Trust and they have redacted the chief executive's name, and then you look at another document and it has not been redacted,

so there is no consistency.

CHAIR: There is no excuse for redacting a chief executive's name under any circumstance. The address, yes, the telephone number, yes, but not the name.

MR ROBERTS: And, to be honest, it is only the Department that is doing any redaction. None of the organisations have redacted anything that they have sent to us. We have had discussions with GMC and the NMC, in particular, about that and we have satisfied them, we have satisfied CQC of the processes we have put in place, they are content with the way that this investigation is working and the handling of the evidence in terms of not sharing it publicly at this stage, but they are not redacting it and they are sending things that normally people might not get access to. It is a bit frustrating. A lot of the stuff that we have just got from the Department, there is about ten per cent of it, I think, that is duplication. Eighty per cent of the stuff that we just got from the DH legacy team relates to PCTs, 20 per cent of it relates to other organisations, none of it relates to the SHA. So far we have not got anything from them that is related to the SHA, which is a big worry.

CHAIR: Do we know who is dealing with this in DH?

MR ROBERTS: We do have contacts, yes.

MS McINTOSH: Steve Verden is the director responsible reporting to - well, there is a gap at the moment - the Director General. They have just announced a new Director General.

MR BROOKES: Is there not a transition team as well working ...

MS McINTOSH: This is the legacy team. They were dealing with the residual issues from the records.

MR ROBERTS: There is a bit of a worry. There is also a worry, I suppose. When I am asking you to look at this and see what you still want, we need it prioritised, I think, because I think that particularly for the Department and particularly for the Trust, the Trust, for example, have got a whole team of people lined up to find information and to gather information and provide it to us. I think that they are anticipating providing us with full medical records for something in the region of about 140/150 cases and the screening process that you are going through so far has landed about 20 that you want full medical records for, which has come as a surprise to them. It should be a pleasant surprise, we would have thought, but they seem concerned that they have got all these staff lined up and nothing to do.

MS McINTOSH: Some of that is the fact that we have not actually touched on SUIs yet.

MR ROBERTS: No, we have not.

PROF MONTGOMERY: So they cannot send them off to the warehouses to work through the SHA documents.

MR BROOKES: I was thinking they could have done some of the other Trust stuff which is still outstanding which actually I would quite like to see.

MR ROBERTS: There is quite a bit of stuff from the Trust that is outstanding. On this, it shows that they have not submitted names of people involved, but that is because we needed the full medical records to gather that information. I think that information will come, but there is a lot of stuff from the Trust in terms of board papers that we have requested and is still outstanding.

MR BROOKES: From my personal point of view, it is crucial and is stymieing what I can do, because I need that information, even if it is just the agendas at the moment, that allow me to identify which meetings - part ones and part twos - when these discussions happened and minutes, because some of it might not have been agenda'd. It gives us enough to actually identify where they were and what they were doing. I don't need every single paper of every single report.

CHAIR: I think that you are absolutely right, that has to be a priority. I think that the other thing - I know we have just been talking about it, but just to reinforce the point, we have got to get the SHA documents.

MR BROOKES: Absolutely.

CHAIR: Given the questions that we have been charged with asking, we have to have the SHA material.

MR ROBERTS: I think, in fairness, the letter that was sent on 14th March to the Department detailed a lot of information that Jonathan had asked for and, to be fair, I think what we have got from them currently is what they started to search through before they got that letter.

MS McINTOSH: That is still a two-month gap.

MR ROBERTS: Yes, as I was going to say, 14th March and we are now on 8th May and nothing in the letter that was based on what Jonathan has asked for has appeared. Even what we have got is not indexed, so we are still having to search through it.

MR BROOKES: The reason behind my other question about the transition team is that I thought it was a transition team of SHA staff who were managing that. because I thought that there was a transition team of SHA staff who were managing that.

CHAIR: So did I.

MR BROOKES: And I think that they might be better placed than maybe the legacy team in knowing where some of the stuff is.

MS McINTOSH: I think that there are two things about that. One is that that SHA team has significantly reduced. They were doing a lot of handover of estates issues and contractual issues and I think the Department is playing this, quite rightly I think, very straight and they are trying not to have any contamination between who is dealing with it ... they now own the material and it is now owned by the Department under the legislation and they will ultimately hand it to maybe NHS England or whoever the successor functional body is, so it is actually owned by the Department and they would not ordinarily get external people in. I think that they are concerned they might face a criticism and that is why Paul and I have been talking to Bill about the fact that there probably needs to be some conversations with the Department about how we might get around that, because, even material that has been provided for Jonathan's sub-group was sought in January and we have only recently received it and that is only a tiny percentage of the totality.

PROF MONTGOMERY: And they cannot use the same excuse over DH policy, for God's sake. That is not effective in this way at all. It should not be a problem for them to provide policy that they have been the authors of.

MS McINTOSH: I would say - and I think that Paul would agree with me - we feel that we have the full cooperation of Steve Verden and his team. I think they are struggling with the procedure in which they are having to operate and the lack of familiarity and the lack of resources.

MR ROBERTS: They have emailed us and said can we be a bit more explicit in terms of what we wanted and they want us to give them names. The difficulty is, actually, identifying those names. For example, we have asked for information from former NHS chief executives or their staff and they are saying, "Well, who were the staff?" If we knew that, we would tell you, but we don't know. We can identify the former NHS chief executives, because it is on the public record, but all the people that might have responded on their behalf is very difficult. They are asking us if we want to provide them with names of families that are involved so that they can search on the files, but the difficulty is which names do you give them, do you give them the 207 deaths, of which 84 of the - 202 it is now have been screened and 20 or 21 of them you want the full records for, so do we give them those names and will it generate anything that is relevant? It is difficult to say.

MS McINTOSH: And, if we did that, would we miss anything that you need to see or it might have just gone through to SHA channels that is not ...

MR ROBERTS: It is very difficult. The other thing is that the DH stuff is not all in one

place, it is in different warehouses in different bits of the country. Some of it is in the north west and some of it might be somewhere else. They are having to get the boxes sent. When they have identified what they want, then they are sent down to a central team in Richmond House. They are then sorting it out, then they are sending it off to the lawyers to determine what is going to be redacted. That is what is slowing up the whole process.

CHAIR: How much do you think this redaction process is contributing? It strikes me as such a simple roadblock to remove. It just needs somebody with the requisite authority to say that this is ridiculous, stop doing it.

MR ROBERTS: Nobody else is doing it, so there is no reason to do it. I think that it is slowing the process down. As I said, some of it is quite significant. There are whole pages that have been redacted and, if they have reacted people's names, then it does not help the panel in determining whether that is someone they might need to talk to.

CHAIR: Why on earth would they redact a whole page? Is there any clue? Do they give a reason why they have redacted?

MS McINTOSH: No, there is no reason, nothing.

CHAIR: It is ridiculous. I sense that we need to accelerate the wheel-out process.

MR ROBERTS: If you just look at the section from DH legacy, for example, in the material that they have sent to us recently, for item number four they have sent us six documents. For item number eight, they have sent us 25 documents which are SUIs, root cause analyses, serious incident reporting or action plans. Quite a bit of that was duplication and for number nine they sent us five documents. The rest of what they sent us does not relate to anything. There is a lot of information that we received that is not relevant. We have got information from the GMC so we need to now look at that and see how much of that is what they have been asked to send, which is why there is nothing in there. The information from the medical schools that we have contacted, we are expecting that towards the end of this month. How relevant that will be I don't know.

The second annex, Annex B, as I say, is the information that has already been requested by the panel, by different people on the panel, and the action that we have taken. Clearly, it is all outstanding yet, but you can see there that 14th March was all the stuff that Jonathan asked for, which is the bulk of it. That was even prioritised for them. We split it into two lists, one was high priority that we wanted as soon as possible and the other one was a lower priority. It was probably a 50:50 split.

MS McINTOSH: I think that the thing is, Chairman, the list that Paul is referring to now, the

meeting with Jonathan, we had a telephone conference which was at the Department's request, that we would try and prioritise and drill down further, and I actually recall that it was a Friday morning and we actually got Jonathan out of another meeting to do it. It is not that we are not trying to help them and it is very frustrating that having gone through that - and there was a significantly reduced list, a significantly fine-tuned list in comparison with the initial request, so we were trying to do some funnelling, but it is not helping in the end when you look at the time frame. I think the time frame is our big concern.

MR ROBERTS: We tried to be helpful in giving them a list of search terms early on, search terms that we compiled and, maybe, because we cannot put anything and everything on that list, so, for example, we identified the Trust that those had been transferred out to, so they searched on that, but, instead of searching on it and looking for things related to maternity or neonatal, they have thrown up anything to do with that Trust, so we have got documents that talk about the accident and emergency department at Barrow and the nomenclature, about whether it should be called accident and emergency or emergency department. We are prepared to chase up what is outstanding, but what I need is a steer. As I say, we have asked the Trust for information, particularly because the Trust have people on site waiting to do things for us. SUI is a big issue that we have not tackled yet.

MR BROOKES: But even in that we have already asked for specific SUIs by number and we have not had those. That is three. There is no reason why that could not happen. Geraldine and I and the others went through this list of things that we needed in terms of governance. It is not that long. I wouldn't have thought that it would have been that difficult.

MS McINTOSH: The benefit of having this discussion is that we know how ... The Trust has been talking to us frequently, so we can go back. They want us to prioritise further, but, in some defence of the Trust, the NMC, who have now re-opened some investigations, are putting the Trust under pressure asking for material that is of interest to the investigation as well and they are using their statutory powers.

MR BROOKES: Foolishly, I offered to go to the Trust, if they had all their board papers in one place, and pick the ones I wanted.

MS McINTOSH: Exactly.

MR BROOKES: Which they could then formally send to us, so it is not as if we are not trying to cooperate with them. If they have got people waiting to do some of the medical stuff that we are not at the point of needing at the moment, then they should

just perhaps re-prioritise.

CHAIR: I agree.

MR ROBERTS: We have even said in our team that it would be in some ways easier for us as a team to go to the Department, to the warehouses, where they have the documents, for us to search all these 900 odd boxes, because at least we might have a better idea ...

MR BROOKES: If we could remove the redacting barrier, that might be possible, but at the moment they will not want you anywhere near them.

CHAIR: Because we might see unredacted stuff.

MR BROOKES: You might see a name they don't want you to see.

MR ROBERTS: The alternative is if they got over that hurdle to just send us all the boxes.

MR BROOKES: Yes.

MR ROBERTS: And we could do something.

MR BROOKES: I hate to say this but we don't know what we don't know, at the moment. There is potentially going to be a whole second tranche of information that we require that we do not know yet, because we have not been able to get a complete picture in terms of the base one information.

PROF MONTGOMERY: Most of the things that we spoke about in our telephone conversation were the things that we thought would tell us where else we would need to explore.

MS McINTOSH: It is like the discussion that you had with John Woodcock on Friday. He is very clear that that pack of material would be readily available and would be helpful for us to see what he was working from. We came back and we had no confidence that that would be found.

PROF MONTGOMERY: He also indicated that he might be able to find it.

MS McINTOSH: Absolutely. And we will be talking to his office about that.

CHAIR: I think we should.

MR ROBERTS: I have a concern that all this outstanding evidence might have a significant impact on the ability to deliver a report in November.

MS McINTOSH: Yes, to have meaningful interviews, I think it is really difficult.

PROF MONTGOMERY: I think working my way through the CQC reports and things again, I think that we could say in the report that there is not much evidence that the SHA picked this up, but we want to find out more for us to be able to say that. And all we can say is the legacy people were unable to produce any evidence that they were focusing on it.

MR BROOKES: But there is a difference between knowing about it and not picking it up and not doing anything about it.

PROF MONTGOMERY: Yes.

MR BROOKES: That is the bit that ...

PROF MONTGOMERY: But I think that we are able to say that they failed in their oversight responsibilities. We cannot tell whether it is because they did not know or they knew but did not respond to it, but we can say that they failed to exercise the oversight.

MS McINTOSH: You can say that in your report and, if you were a family member and you read it, you would say, well, who is going to find out that and they are actually hoping that the Morecambe Bay Investigation will.

PROF MONTGOMERY: I agree.

MS McINTOSH: That puts pressure on the Department of Health because they will continue to pursue their questions.

PROF MONTGOMERY: Let us say that we pull Ian Cummins up and we say there is no evidence that you knew about this or did anything about it, you know, can you help us find something? I think that we can formulate a question that says that it is not acceptable, we have to say that the SHA has failed ...

MR BROOKES: I think that we ask them what they knew and, if they didn't know anything, that is a failing; if they did know something and didn't do anything about it, that is a failing.

CHAIR: If the SHA were still in existence, we would have a viable approach there, we could say to them show us what you knew, otherwise we think you knew nothing.

MR BROOKES: But we could say that and then we can say that we have to assume that you knew something unless you can tell us about it and push the onus back.

CHAIR: Except, because the organisation does not exist any longer, they do not have any access to 900 boxes in some warehouse somewhere, so they cannot.

MR ROBERTS: As I say, none of it is indexed or catalogued, it is as if they just cleared the desk and put them straight into the box.

MR BROOKES: I think that it is outrageous, because I know how much time we spent doing that, but that is a different organisation so ...

MR ROBERTS: The other annex is Annex C. It is a smaller one, which is about the PHSO. We have already talked about them not being able to provide anything and it is whether you want us to contact these other organisations that we have identified that may have some information relative to what the SHA ...

CHAIR: Yes, I think we do. I think that we want any correspondence that they had with the PHSO about this Trust.

MR BROOKES: I think that it is a simple question, isn't it?

CHAIR: Yes.

PROF MONTGOMERY: At the moment the PSHO reports are about the most useful we have got of the external bits, because they have accepted that they have not got it right and are, therefore, trying to put it right, so, actually, even if we got nothing else than that, that would probably give us some clues as to what we are trying to pursue.

MR BROOKES: The question is, is there anything on here that we ... I am not sure that there is.

MS McINTOSH: That we don't need

MR BROOKES: That we do not need.

MS McINTOSH: That is fine, because we can pursue it and I think that what we just need to do is, if we can give some thought to the prioritisation process and then we will run it past all of you and if we say from this we will prioritise and you need to just say yeah or nay.

PROF MONTGOMERY: Yes.

CHAIR: I did find one that I thought could probably be struck off the list which is the CHAI material.

MS McINTOSH: Which is under CQC.

CHAIR: For three months in early 2004. I think that the prospect of that adding anything to the saga is minimal. I would not lose any sleep if we did not get it; it is certainly not worth firing a lot of people at who could usefully be doing something else.

MS McINTOSH: It would be helpful if you could, once we are looking at the prioritisation, if you could go away and look at that table and if any of you find anything else that you think, actually, I am not sure that is going to add value, just let Paul know, because we can just take it out of the prioritisation that we are doing.

MR ROBERTS: My view was that, if it is not going to be relevant and not going to add anything to what you are doing, then we might as well not have them chasing that when they could be doing something else.

CHAIR: Another one I put a question mark against was NICE, correspondence between the Trust and NICE about the quality standards and guidance. NICE are not a regulatory body or a monitoring body. The chances of there being anything relevant in there is pretty small. It will just be we don't agree with this standard or how did you arrive at that or something like that, which doesn't help us at all.

MR BROOKES: There is a sort of order of organisations, isn't there, in terms of ... As you say, there is a second order in terms of some of these organisations which we are not going to consider, but there is the legacy stuff. We cannot do the external bit without DH legacy. The Trust is obviously critical, as are a couple of the other organisations. We can go through it, but it is difficult until we get the information to know whether or not it is relevant.

MR ROBERTS: Health Watch is ...

MR BROOKES: Health Watch is secondary.

MR ROBERTS: It is a bit of a problem because the Department are convinced that they have answered the question by saying, well, we have talked to the chair of that organisation and they might have something, but they might not.

PROF MONTGOMERY: One of the things that came out of the John Woodcock interview is that it doesn't sound as though any of that is very active in the area, because he was not really aware of it and I think that, if they had been active, you would have expected it to be one of the sources of information for him.

MS McINTOSH: What we just simply need is a letter that actually said we cannot find any material that is pertinent and relevant and, actually, that would close that down, but until we get that ... How do you address the terms of reference when you haven't got all the information?

PROF MONTGOMERY: The action might be to go back to them and say can you please confirm that there is no information that will be forthcoming.

MS McINTOSH: Yes.

PROF MONTGOMERY: And they pass that on. I no longer think that there is a whole load of stuff that we are going to find out from that having heard John Woodcock talk, because I think that, given what he knows now about looking back, if those were live organisations that were active, you would have expected him to have some conversations about what can I find out from you and there clearly were not.

MS McINTOSH: We have the chance to ask John Hutton the same questions and actually establish that. That would close it down, wouldn't it?

MR ROBERTS: Going back briefly to the DH legacy, the material that I have just referred to came to us in hard copy, so we have got three boxes that we have had to go through, which is far smaller than 900 odd. What we are doing is we are not scanning it. We are giving it a unique reference number, we are creating an index, we put the index on Huddle and then obviously we will tell you when we have done that. If you look at that, then anything that you want to see we will then scan that rather than

waste time.

MR BROOKES: A good idea.

CHAIR: That is fair. Is there anything else we can help you with today?

MR ROBERTS: No, I do not think so, thank you.

CHAIR: Thank you, Paul. Item 6 is the interview protocol. Oonagh, we are sharing the amended version for information, I think.

MS McINTOSH: Exactly, yes. I want to back up the point that Paul made that he has persuaded a number of organisations who ordinarily would not have released material to another body without any legal powers, the GMC and the NMC in particular, and the Trust and, actually, the revised protocol references the closed sessions that you will have with clinical staff if you were discussing a patient or indeed with management if you are discussing a disciplinary issue, because all of those organisations are very anxious, as are the CQC, but I think that the NMC and the GMC and the Trust in particular have raised their concerns about the handling of particularly sensitive material. Take the protocol away, that is kind of what we will be working to. Read it at leisure. What we are going to do with it now it has been agreed is that we will go to the organisations and this, obviously, will be going out to interviewees, but it will go to the organisations probably this afternoon or tomorrow for them to see. We anticipate some sort of exchanges with a couple of organisations because they asked for things that were over and above - the Chair considered - they were over and above what the investigation could or should accommodate. Some of those organisations will probably be quite disappointed that their requests have not been complied with, but we will manage that within the interview team, but it is just something to be mindful of, especially because in a moment Nick is going to talk to you about report authors. We are struggling to get the names of report authors from one organisation until they see whether or not we have complied with their wishes in the interview protocol. We have not complied with all of their requests, but we have reasons why we have not. We have also in place - and I think it was very important on Friday, when you did that introduction and you explained to the interviewee and to the families who were present why there was need for confidentiality and, if we just keep reiterating that it is about the messaging and just keep holding the line on that and keep monitoring and reassuring the organisations, then, hopefully, we can gain their goodwill on that front as well. That is what is going to happen.

MR BROOKES: Can I just double check? It is just that family bit of it. Are they fully aware of those issues about the confidentiality around disciplinary or medical cases in

the way that it was just described.

MS McINTOSH: The family bit.

MR BROOKES: The families, yes.

CHAIR: Not until it arises, no.

MS McINTOSH: And we are going to obviously share the protocol with the families as well. It will go on our website.

MR BROOKES: I am just thinking that it is about managing their expectations about being able ... I know that we have said all along - and Bill you have been very good at this - that there may be occasions where we need to do this, but it will still be about managing their expectations about being able to sit on all interviews.

MS McINTOSH: And there is a line. The only bit in the protocol where there is a word underlined is at that point, that all observers will be asked to leave the room and we have underlined "all", because we do not want them to think that that is just the person who is accompanying the interviewee, but it actually is the family members, too. We will explain it to the family members saying that you might want to talk to a midwife about more than one case and, therefore, it is inappropriate for them to be in the room. Rather than have people coming in and out ... you know, they have the chance to give their experiences to you in confidence and the same would apply to the interviewees when ...

MR BROOKES: I think that it is completely reasonable and I think that we have said it, it is just about reinforcement, because it could be a point of contention.

CHAIR: Yes. I think that the other thing is that I think there will be a general understanding about the need for patient confidentiality, perhaps less so about the disciplinary questions.

MS McINTOSH: Absolutely.

CHAIR: That will need to be carefully explained.

MS McINTOSH: Maybe you need to read the protocol, because I have actually given an example of a patient or a disciplinary just because I wanted to give an example of the type of thing.

CHAIR: I am sure that we need to do this because, otherwise, we will get people saying their lawyers will not allow them to talk about it and all that stuff. It is how we explain that so we don't have a problem at the time.

MS McINTOSH: The other thing is that there will be a recording of the open interview and then there will be a separate section for any closed session that you might have and that will not be relayed or replayed to any family member who opts to take that

approach.

CHAIR: Sure.

DR CALDERWOOD: What material would we be able to have available? I know that we are not going to be wanting, necessarily, to talk down to the level of case notes to people but for some of the clinical interviews some of the families have asked very specific questions. Are we going to be able to have the case notes of individual cases?

MS McINTOSH: If you have got material here and you need to show that material to somebody, then what we would do is, you would do the interview, the first part of the interview, which will be very general, you know, what did you do about the recording, how did you do it or what did you do, etc, etc, and then, when we got to addressing specific issues ... How I can see it running is that everyone would leave the room, you would then say to the individual, we want to talk to you about this document, go upstairs, we are going to go upstairs, we are going to give you half an hour or 20 minutes or ten minutes to look at it and then we will come down and then we are going to talk to you about it, because, actually, we are not going to send that document to them in advance because we cannot. We have made a commitment to the Trust that we will manage it. Or, if you said in advance, you want to ask them about X document, then we would get them here a bit early, they would have a chance to read it ...

MR BROOKES: That is sensible.

MS McINTOSH: We would do it that way, so that at some point they would have a chance to see the document and consider it, you are not just giving it to them just like that.

CHAIR: I think there are two different issues, though, are there not? One is we need to have the specific examples so that we can ask them general questions based on what we found out from specific examples. The other is where you want to pick up a specific clinical point about the management of a patient.

MS McINTOSH: And it would help the document management team if, when we confirm interviewees and dates, if you say, actually, we will want to ask Dr X or Midwife Y about family B, we know what documents we need, because then we can have them ready, and copies for you as well. Then we need to make sure we have a mechanism for getting them all back in, etc, etc. It is very boring and tedious on that front, but, actually, it is complying with the data protection point.

DR CALDERWOOD: And we were made aware by some of the families that there were some cases going through the legal system. Does any of our questioning impact that? Is there any difficulty there?

MS McINTOSH: I would have to ask the Trust that. I would have to ascertain from the families what stage they were at.

MR BROOKES: There is only one outstanding, is there not?

CHAIR: I think there might be more. I do not think that this ought to constrain us.

MS McINTOSH: It does not influence the litigation, does it?

CHAIR: It does not influence the litigation.

DR CALDERWOOD: But what we have said, will that be available then for lawyers to use later? If I made a comment about a CTG, would that be able to be used as evidence?

CHAIR: If it is in the report, yes. If it is in the agreed recording of the open interview that is available on FOI afterwards, then yes, but not necessarily to the timescale that would suit. I would not allow that to constrain us. We need to ask the questions that we need to ask and we need to come to the conclusions that we need to come to.

MR BROOKES: I agree, yes. It may be additional evidence for the lawyers, but, if it is a genuine and legitimate question, then we should ask it.

CHAIR: Exactly.

PROF MONTGOMERY: I think that you are okay in terms of any accusation that you have been careless and defamatory, because you will have qualified privilege because this is something that you are properly doing. If they tried to rely on your evidence, then you have another opportunity, don't you, to be called and consider it in light of anything new and additional that is available to you. It doesn't make it easy, but I do think that you are ultimately protected. It is just you don't want to go through the hassle of doing it.

MS McINTOSH: We will be anticipate that we will be redacting that transcript/record of the proceedings before we put it into the Departmental records, because it is nevertheless still personal sensitive detail. There will be redaction of that that we will have legal advice on.

DR CALDERWOOD: I would agree we want to ask what we want to ask, but there is a muddiness, I suppose, to it potentially because of other people with other agendas.

MR BROOKES: I think the muddiness is how it is used in future. I think that it is absolutely clear that we have the right to ask the questions that have arisen legitimately from the evidence that we are considering.

PROF MONTGOMERY: Do you think we should have a standard statement for the person who tries to, whatever the Americans call it, not to self-incriminate, who you want to ask a question about the reading of a CTG and they want to say "I don't really want to answer that question because I might get myself into trouble", we ought to have a line,

shouldn't we, that we say to everybody who says that, about their obligation to cooperate with the investigation?

CHAIR: Absolutely, and we are not part of a criminal investigation. Any litigation proceedings would be civil litigation and they cannot incriminate themselves.

PROF MONTGOMERY: It is probably worth having a very standard form of words that get said to everybody if that question is made so we are absolutely consistent.

CHAIR: Yes.

MR BROOKES: That is a good idea.

CHAIR: Thank you. Item 7 is the interview programme and we just alluded to the issues about report authors who we are hoping to be interviewing on 21st and 22nd. Nick.

MR HEAPS: That is right. It is a bit of a mixed report as you might expect. We wrote around to various organisations involved about a month ago. So far we have only got two definites for 21st and 22nd. One of those is Dame Pauline Fielding of the Fielding Report. We have just been given contact details for the other two authors of that report, who are Yana Richens and Professor Andrew Calder. We are contacting those to see if they are available, if you want to see them as well as Dame Pauline.

MS McINTOSH: Do you want to see them as well?

CHAIR: I think we do and then we see them altogether, don't we?

PROF MONTGOMERY: Yes.

CHAIR: I do not think there is any point in doing them sequentially. I think that we should ask the lead author whether she would want to do that or whether she would feel able to answer the questions by herself. She might feel that she would prefer one or other of them to be there.

PROF MONTGOMERY: We should be saying that we would like to see her, but, if she wishes to bring one of the others ...

CHAIR: Exactly.

PROF MONTGOMERY: Because we don't want to hold it up. We don't want to give an excuse for saying that we cannot see her that day. Which day is she due to come?

MS McINTOSH: We are looking at 21st and 22nd.

MR HEAPS: The other person that has been confirmed as available is the author of the CQC report. They are not releasing that person's name as yet, but they are available to speak to you. At the moment we could schedule one for 21st and one for 22nd and then, if we get any more people confirming, we can place them around that.

CHAIR: Or we could schedule both of them for 21st and, if we don't get anybody else, then we can pack in at close of play on 21st.

MR HEAPS: You are confident that you can get through both of them in the same day?

CHAIR: Yes. We have got to do better than one interview a day otherwise we are going to be here until next Christmas.

PROF MONTGOMERY: It would help me not to have to negotiate with UCL to be on the telephone for the exam my students are sitting on 22nd, so it would be really good to be able to get back on 22nd.

CHAIR: But bearing in mind that we have got 22nd available, if we can line up some more people ... We have already established a principle that although it would be great to have everyone there, we don't have to.

PROF MONTGOMERY: But I particularly don't want to miss those if I can possibility avoid it.

CHAIR: Yes, no problem.

MR HEAPS: Do you want me to run through the others, which have various degrees of responsiveness. The person who we are advised would be able to talk to us about the Gold Command report is on a fairly lengthy period of sickness at the moment. I have contacted other people in NHS England and enquiries are ongoing, like early today. Hopefully, they will get back to us.

CHAIR: Who led the Gold Command?

MR HEAPS: It was produced by the SHA, so Anthony Kealey in NHS England said that he would help to identify who the authors were and at the moment it looks as though it is with the NHS England area team, which is actually based in Preston. I am just waiting to hear back from them.

MR BROOKES: I notice that the Gold Command stuff was on your list of evidence as not being received yet. There is an issue there about what we have got and what we can ask without having had some of the evidence. It is just getting the sequencing right.

MR HEAPS: The NMC, we have not heard anything back from them at all. I sent a reminder last week and chased them up again this week. And Monitor are not being particularly helpful, but we have had some correspondence with them.

CHAIR: Right.

MS McINTOSH: What we have not included on that list is the Grant Thornton report, because it is not in our terms of reference and some of the organisations have real concerns about the Grant Thornton report.

MR MONTGOMERY: In that it is outside of our time scale.

MS McINTOSH: It is outside of our time, yes.

PROF MONTGOMERY: But we need to use as the basis on which we ask lots of questions

so that we can read it into our terms of reference.

MS McINTOSH: Exactly. It provides the information.

CHAIR: It provides the basis for asking questions of the CQC and possibly others. All right, anything else on that one?

MR HEAPS: No, that is it.

CHAIRN: Thanks, Nick, you will keep us posted in the run up to 21st and 22nd, so we know.

MR HEAPS: Sure will do. I think that we can ink in 21st definitely because we have at least two interviewees to get through that day and I will see what else I can do.

PROF MONTGOMERY: The 21st is the next time at which we are interviewing?

CHAIR: Yes.

DR CALDERWOOD: I was just wondering the clinical staff will need six weeks' notice, so we are looking then at them - you know, if you have not got people having responded ...

MR BROOKES: Unless the Trust was prepared to release them.

MS McINTOSH: Six weeks notice ...

DR CALDERWOOD: To be released to come.

MR BROOKES: Unless the Trust is prepared to waive it.

MS McINTOSH: Also that is why we said that we would do interviews in Barrow and the Trust are very pleased about that. We can try to get around some of that, not all I don't think.

DR CALDERWOOD: It is just the clinical commitments that will need to be cancelled.

CHAIR: I know.

MS McINTOSH: The approach that we have taken is asking people for their own unavailability, so let us know what dates you definitely cannot do and we will fit in around the calendar of dates that we have got when we can see people. Then we have to find a venue and things.

CHAIR: Okay. Any other business? [No from all] Thank you. Date of the next meeting is Thursday, 12th June, the same place and the same time, probably. Thanks everybody. That means we are now free to crack on with some assessments and sub-group work or make whatever use you can of the time.

MS McINTOSH: If you can give Paul any help with the prioritisation, then you could spend some time reading that after your lunch, and that would really be helpful.

PROF MONTGOMERY: Yes.

MS McINTOSH: Thank you.

(Adjourned until the next meeting on Thursday, 12th June 2014)

Report from the Clinical Sub-Group for Panel Meeting on 8 May 2014

The main work of the Clinical Sub-Group has been to undertake a clinical practice review of Maternity and Neonatal Services within UHMBT Trust.

The aims of the clinical practice review are:

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 / pathways in relation to the selected cases.
4) To identify any recurring themes for potential improvement in relation to maternity and neonatal care provided by the Trust.

Sources of cases include:

a) An overarching dataset of all cases of maternal, perinatal and neonatal deaths within UHMBT during the period of the Inquiry – January 2004-June 2013.
b) The cases relating the families who attended meetings with the Inquiry Panel
c) Additional cases that were investigated by Cumbria Police
d) Cases who responded to a request by the Inquiry Panel in the local media for further information.

Progress to date:

I. In the original file from Cumbria Constabulary there were 31 cases. Of these 4 cases were not pursued by the police, and 4 cases are out with the scope of the Inquiry. Of the remaining 23, 21 cases have had a full review and 2 cases are awaiting review.
II. 23 families responded to the advertisement in the local media for further information on concerns regarding maternity and neonatal care. All of these cases have been screened and 6 have been identified for a full review.
III. 202 maternity, perinatal and neonatal deaths were reported to have occurred in the Trust between January 2004 and June 2013, 57 cases have now been screened and 11 have been identified as requiring a full review
IV. The details of the 19 cases that are currently awaiting full review are available on Huddle under the Clinical Sub-Group Workspace

Ongoing work

1. Continue to screen cases, approximately 18-20% of cases are being selected for a full review, therefore a further 25-30 reviews may be required.
2. There are several themes already emerging which relate to clinical practice, clinical risk management, communication and network working.
3. Prior to interviews with clinicians and managers from the Trust there needs to be an opportunity for the three Sub-Groups to exchange and corroborate information.

Stewart Forsyth