Witness Name: David Alan Evans
Statement No.: 1
Exhibits: DAE/1 – DAE/5
Dated: 29.03.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF David Alan Evans

I David Alan Evans, will say as follows: -

1. Aspects of my Curriculum Vitae relevant to the Terms of Reference of this inquiry are set out in Appendix 1 below. I am a retired Consultant Obstetrician & Gynaecologist and have held a wide range of appointments at Trust, Regional and National level.

Systems for ensuring the safety of neonates.

2. In my experience as both a Medical Director and a Trust Chief Executive the best system which I experienced for ensuring the safety of neonates was one which was in place in the former Northern Region from the late 1980s until the early 2012. This was a system established by Professor Sir Liam Donaldson when he was the Regional Medical Officer. Termed the Regional Maternity Survey Office, (RMSO). It was a small unit with a nominal lead by a Consultant Obstetrician and also input from an Academic Epidemiologist which scrutinised all stillbirths in the Northern Region, collected other data on Obstetric, Midwifery and Neonatal clinical practice, held an annual meeting and produced an annual report. It was a collaboration between the 13 Maternity and Neonatal units across the Region reaching from Teesside to the Scottish Border. This was at a time when everything was paper based. The case notes of all stillbirths were brought to the central office as soon as possible and always within a few weeks of the event. They were copied and anonymised for personnel and unit. Every 6 to 8 weeks, depending on numbers, a multi-disciplinary panel would meet to scrutinise the cases usually 4 to 6 in a day, depending on complexity. The panel members would come from a range of relevant backgrounds to include Obstetrics, Neonatology, General Practice, Midwifery, Neonatal Nursing, Diabetic Physicians and Specialist Nurses and Midwives or any speciality judged to be necessary and relevant by the Clinical Lead. All panel members had been trained in the use of the audit tool which was applied. Each panel member would lead on one case, but all would contribute. Close scrutiny was applied and all aspects of care would be considered. An overall assessment was made and agreed by all members. Should any significant issue or assessed shortfall

in practice be identified, it was the role of that day's chair to break the anonymisation and contact the unit immediately. This was a major collaborative process and everyone working in the Region knew that all stillbirths would be scrutinised in this way. The annual meeting was always oversubscribed, the annual report was circulated widely and was essential reading. There was a waiting list of people volunteering to take part in the panels. Everyone shared their learning from this process. I felt that this gave all who were working in the service reassurance that all stillbirths had been subject to a timely, high-level expert scrutiny and any issues would have been identified. It also allowed Trust Boards to be shown that all cases were suitably assessed. The only shortcoming was the few cases where the notes had been taken by a Coroner. These could not be included in the usual prompt manner but would be viewed after the inquest was completed. Originally hosted by Newcastle University, it was subsumed at the time of major organisational change into the Public Health Observatory where its life was short and it was stood down. I felt that this was a great loss as the National programme which was established, the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) did not scrutinise all cases to the same level but was targeted to specific issues eg. Diabetic Pregnancy. This was not locally owned and did not use a large panel review system. The RMSO system was in essence very simple, provided excellent assurance of safe clinical care and followed trends in changing clinical practice. With current computerised systems, this type of locally owned scrutiny could I believe with great benefit, be very easily re-established across England

The role of the Medical Examiner.

3. The establishment of this post in every Trust was repeatedly delayed centrally and was slow to start. I knew several colleagues who had been trained and passed assessment to take on the role only to reach their retirement before the post existed. It was not in place when I left the NHS in 2017 but is now functional. This is designed to provide a level of scrutiny to all deaths, including neonates in each unit to give assurance to Trust Boards. I have no knowledge of how this is working, but in principle it appears to be a good development.

My experience of mortality review at Northumbria NHS Foundation Trust.

4. Whilst Medical Director at Northumbria and seeking to provide the sort of scrutiny which I had experienced working with the Regional Maternity Survey Office (Para2) to all deaths, we established a system for case-based mortality reviews overseen by a Mortality Review Group. This was a long process over several years and began with a major programme to improve Clinical Coding and Data Quality. Any system of high-

level Trust wide review can only be successful if the data which it reviews is a true reflection of clinical practice and outcomes. Clinical Coding is required by National rules to be completed within a very short time of discharge, target 24 hours. This means that codes are sometimes applied and centrally registered before all final diagnostic information is available. These are the rules to follow but the system is recognised to have its faults. It can be made to work to its maximum efficiency by collaboration between clinicians and coders. The Trust invested in training for Clinical Coders and also for clinicians as to the importance of key words and phrases used in case records to assist in coding and also introduced for a time a feedback form for clinicians to view the codes which had been applied to the cases at the time when they were writing discharge letters and suggest any revisions. This greatly improved data quality and allowed for meaningful high-level review of trends and outliers. We began with weekly meetings of Medical Director, Chief Nurse, Informatics Manager and Chief Operating Officer. We spent the afternoon reviewing all deaths, including neonates. After a year or so we had an established system which could be simplified to an on-line review of the data by the same group. We expanded the group to include a Non-executive Director of the Trust. This was an important development which I will expand upon in the next paragraph. This group took on the role of Safety and Quality and reviewed not only deaths but all critical incidents. We had developed a team of trained investigators from both General Managerial and Clinical staff. The group would determine which deaths and incidents they wished to subject to a detailed scrutiny and a team would be appointed. Any critical incidents identified were subject to an immediate detailed review but for other cases we set a six-week deadline to allow for the taking of statements etc. The team reported their initial findings back to the panel after two weeks so that the grading of the incident could be reviewed and any further actions needed could be assessed. The monthly report of this group was agenda item 1) for the Trust Board and a detailed report of all its workings was given. Any issues were subject to scrutiny by the whole Board. I believe that this system gave a high level of assurance to the Board and pre-empted the work which the Medical Examiner was eventually placed to perform.

5. A copy of the Minutes of the Safety and Quality Committee of Northumbria Healthcare NHS Foundation Trust 8 May 2015 illustrate this type of report (Exhibit DAE/1 [**INQ0017451**]).

The important role of Non-executive Directors.

6. I believe that Non-executive Directors (NEDs) of Trust Boards have a vital role in providing challenge, support and expertise to all safety and quality systems. In my role

as an assessor for The Royal College of Obstetricians and Gynaecologists (RCOG), The Care Quality Commission (CQC) and the Regulation, Quality Improvement and Assessment Authority (RQIA) in Northern Ireland I have been involved in reviewing Trusts with issues and shortfalls where a striking feature to me was the lack of Non-executive Director involvement. This role must be greater than attending Board meetings. I believe that I was very fortunate at Northumbria to work with a group of NEDs who relished involvement at every level. The Board to Ward programme was an excellent scheme which gave a formal and structured introduction to clinical areas and groups of staff. In a Trust the size of Northumbria with 9 inpatient units and 9,600 staff this could involve a whole day spent visiting our furthest unit in Berwick upon Tweed. It was the informal links with staff which followed which I believe gave the wider staff body a link to the Trust Board which was accessible and approachable. A report of a Board to Ward visit or a patient story always preceded the formal Board agenda. (By way of example I exhibit A Report of Board to Ward Visit (NTGH)– 9th July 2018 (Exhibit DAE/2 [**INQ0017452**]).). As Medical Director I had to make a presentation at every Board meeting and expected to be challenged and made to justify any statements. That was a great incentive to me. Their backgrounds included Nursing, Social Work leading to being a Local Authority Chief Executive, a statistician from a local industrial research unit, a corporate accountant, a retired headteacher and the former leader of the local council. This range of experience meant I could both draw on their knowledge for help and guidance but also know that any challenge or question to me was based on a solid experience and understanding. A key development shortly after we became a Foundation Trust was a study day for the Board and all General and Clinical managers delivered by the Trusts' solicitors on the duties of Trust Boards, NEDs and the implications of the Corporate Manslaughter Act. This was a sobering day and any discussion of safety thereafter had their full attention and support.

Doctors and managers working together.

7. I took part in a broadcast for the Nuffield Trust in 2016 giving my views of how Doctors and managers could work better together. I am pleased that a lot has changed since that time. I believe that close collaboration between Doctors and General managers does have a positive impact on patient safety. Training Doctors to be managers does not need to involve them having a detailed understanding of financial, legal and human resource management matters. Rather it should build on their strengths and clinical knowledge to allow them to work together with fully trained professional managers. The Master of Business Administration degree which the NHS supported and which in the North East was delivered by Durham University meant that we had a team of highly

skilled managers who knew the benefits of joint working. I will describe the approach which was taken at Northumbria Trust initiated by the Chief Executive, Mrs. Sue Page CBE in the early 1990s who embarked on developing a clinically led trust. It is clear to me from my assessor roles as listed above that not all Chief Executives and Trust Chairs want clinically led systems or even a high level of clinician involvement in management. Central command and control systems are still apparent in many Trusts. The Northumbria approach was described as having Clinicians and Managers "joined at the hip" or acting as a "Chimera", the aim being that the whole would always be greater than the sum of its parts. This was borne out in practice. A joint training scheme was established which ran as an annual rolling programme. The first year was provided by a University Department of Medical Leadership, but thereafter we established a small faculty and delivered it ourselves. I attach a copy of the Leadership Development Programme –Course Programme January 2008 – November 2008 (Exhibit DAE/3 [INQ0017453]).. I emphasise that this was Clinical Management not just Medical Management. In our clinical directorate structure at various times a physiotherapist managed Musculo-skeletal services, a speech and language therapist managed stroke services, a clinical psychologist managed Diabetes and a specialist nurse managed services for Parkinsonism. All were trained then selected at competitive interview. The Directorate structure allowed both clinical and general managers to take joint ownership of decisions. The staff body recognised that these were difficult jobs and supported the people who took them on. We developed a system within the directorate structure where we aimed that everyone should have a voice and a clear route by which any concerns could be raised. This was a process which developed over many years but gave us a firm foundation for our major change programme which I will describe below.

The role of the Medical Director.

8. In its most literal meaning, the role of the Medical Director (MD) is to provide medical direction to the Trust Board. This was to allow planning for future service developments, give advanced warnings of their likely costs and implications for the Trust. Manpower and workforce planning was a constant pressure as Trusts implemented the full effects of the European Working Time Directive (EWTD) which changed the entire way of working for all grades of medical staff and required significant changes. At Northumbria, Safety and Quality of services was a joint responsibility between MD and Chief Nurse. This was a high priority and quite rightly took up a lot of my time. For part of the time, I was not working for the Trust but as an agent of the professional regulator, The General Medical Council. (GMC) This was in the role of Responsible Officer or senior accountable professional. This oversaw the

process of Medical Revalidation and annual appraisal. This was a significant new development and, in many ways, changed the relationship between the Trust and its senior medical staff in a positive way. Again, this process was made much easier by the quality of performance and outcome data which we were able to provide for individuals. This related back to our investment in Clinical Coding. In my role as an assessor, I always felt very sad when a practitioner said to me "don't believe what the Trust says about me, I have everything which I do written in this book." That happened on 8 occasions. Clinical data must be accurate and freely available for any type of scrutiny to work. Other functions could be described as pastoral, offering support and guidance when asked, helping to develop newly appointed senior staff and mediating in disputes or disagreements. Within the North East, the 9 Medical Directors met each month. We all took on an area of specialist knowledge eg. Revalidation, workforce planning, clinical training, private practice rules and regulations etc. We were able to call on each other's expertise with great benefit. I became involved in mentorship of newly appointed Medical Directors across the UK. I believe this helped greatly and I wish that it had been available for me. In leadership terms, I could only ever lead by consensus and with the support of the clinical staff. "First among equals" was a sound principle. I believe that I had in some ways an easy task at Northumbria as we embarked on a whole service change. People wanted to be led and to know that their needs and concerns would be heard. The Trust serves 500,000 people spread over the largest geographical area of any English Acute Trust. This runs from the River Tyne to the Scottish Border and from the East Coast into the mid-Pennines. It had 3 district general hospitals, 6 Community Hospitals and a raft of community clinics and health facilities. To continue to run that distribution was impossible, not least because of the EWTD as described above. We planned for and then embarked on a scheme to centralise the Emergency Care streams from the 3 hospitals onto a new-build central site located at a hub of the major road network as opposed to in the centre of towns. The 3 units then transformed into elective facilities. this was a process which took over 10 years but was a great unifying theme for everyone.

Training for Medical Leadership.

9. It is apparent that the opportunities for training in medical leadership have improved greatly sine I began my journey in the early 1990s. The production of "The Medical Leadership Competency Framework" by Prof Peter Spurgeon of Warwick University established a common set of standards which were accepted by both the general Medical Council (GMC) and the Joint Academy of Medical Royal Colleges. (JAMRC). The current version of this is exhibited (Exhibit DAE/4 [INQ0017454]). I was fortunate to

be asked to be part of a small group which assisted him in this task. The establishment of The Faculty of Medical Leadership and Management (FMLM) has also unified training and established quality standards. Whatever training is available, the structure for leadership within each trust – usually Clinical Directorates- is different in some way in every Trust which I have visited. The desire of senior clinicians to be led will vary. I described above the unifying grand plan at Northumbria, but providing Medical Direction and leadership in a Trust with difficulties and which is struggling to survive must be a very difficult task. The desire of senior clinicians to be led is not always present. Becoming a consultant is still described as taking on independent practice and for some this has a very literal interpretation. The assumption of individual responsibility for the safety and quality of their work is key. This goes back to the ability to produce high quality data to inform discussions. The use of frequent external reviews, peer comparators, National standards of best practice and the open scrutiny of all outcome data is essential. At Northumbria we had drawn experience from team visits to Kaiser Permanente in San Franscisco where their approach to safety and quality and performance of individual clinicians was impressive. At Jonshopping in Sweden, we learnt of their collaborative team-based approach to safety and the complete commitment at all levels to have two roles, to complete your job to the best of your abilities but also to always try to identify ways to do it better. At New York Presbyterian Hospital we saw their "Patient Safety Fridays" where a faculty of trained safety reviewers from each clinical team visited another clinical area on a Friday afternoon and reviewed all of the safety critical systems and the last weeks performance. This "fresh pair of eyes and a critical friend" approach worked extremely well. All of these were incorporated into the Northumbria approach to safety and Quality with good effect.

Freedom to Speak Up and whistleblowers.

10. In my role as an assessor for a number of bodies I have seen examples where whistleblowers have been ignored, victimised and treated in a way without any attempt at a fair process. This was certainly shown in the Review of West Suffolk Trust and also in Northern Ireland where concerns had been raised and ignored until a local General Practitioner aired doubts as to the quality of care. Despite the National initiative in establishing the post of Freedom to Speak Up Guardian in 2014, I saw units in 2023 without such a post. I have also seen Trusts where the gap between the clinical workforce and senior management is huge. On visiting a Trust as an assessor and finding that the management corridor is plush and well-furnished while the clinical areas are neglected tells a story in the first 5 minutes. There needs to be an easy and

safe route for all staff to raise concerns. I have described above the important role of Non-Executive Directors. Trust Governors are another group who are approachable and a safe route for anyone with concerns. They have a direct route to trust Chairs and also to the Chief Executive. Still however, it appears that some management systems do not have the maturity to welcome whistleblowing and to say "thank you for bringing this to our attention, we will sort it out" but rather wish that concerns had been kept hidden. The system we developed at Northumbria gave everyone a voice through the Clinical Directorate structure. This reported into a unifying group which I believe was unique to us. Termed the Clinical Policy Group (CPG), it was a large monthly meeting attended by all clinical and general managers, Board members and some local General Practitioners. I exhibit a copy of an Agenda for a Meeting of the Clinical Policy Group Friday, 8th July 2016 (Exhibit DAE/5 [INQ0101378]. As a large Trust, it reached up to 100 members. It was established to be "the keeper of good clinical governance" and was the main decision-making body and a forum where everyone could have a free discussion of any concerns. It proved very successful. As it matured, I believe that it became in effect the heart and soul of the Trust, a place where everyone knew that everything was being done correctly. I know that we could not have achieved the major service changes we brought about without its unifying influence. I do not believe that there is a common or unifying culture in the NHS. Beyond the obvious that everyone wishes to do the best for their patients, every trust which I have visited is different. Within a Trust, each ward, speciality and clinical team will have their own ethos and way of working. Drawing people together to a common purpose can be extremely difficult. I have described Northumbria's clinical change; without such a scheme many units remain fragmented. Medical staff have very different reasons for applying to a particular unit. For some it is the academic and research work which attracts them. For others there may be a family connection to an area or unit. For some it is the possibility of developing private practice and for some, they just want a job. This mixture of aims and goals makes for a very varied senior workforce and uniting them can be challenging. We would like to believe that services are always designed and run for the benefit of patients. Sadly, I have seen examples where they were run solely for the benefit of the doctors.

Professional regulation for senior managers in the NHS.

11. This is a necessary development which I support and at the time of producing this statement it is about to be considered by a Parliamentary Select Committee. As I saw with the introduction of Medical Appraisal, agreeing on the metrics is very difficult.

Selecting and training the reviewers is also challenging. The need for accurate and reliable data as I have repeatedly mentioned is key. It needs to be put in place.

Systems for appointing managers in the NHS.

12. At Northumbria, based in part of what we had seen at Kaiser Permanente in San Franscisco we set out to change our recruiting method. The standard NHS model was an Appointments Advisory Committee (AAC) with pre-interview visits, phone calls from backers and referees and a 20-minute unstructured interview. We wanted to do better. We engaged Edgecumbe, a psychology practice based in Bristol. They worked with both the GMC and NCAS. They advised a system based on best industry practice. With the development of structured and assessed post-graduate clinical training it was possible to know that people completing a scheme successfully could actually do the job. That aspect of the old system was no longer required. We introduced a competency-based process. A detailed job description was made then a set of competencies required for the post were agreed and weighted accordingly. We ran a two-day process where on day one, applicants underwent a psychometric assessment provided by Edgecumbe. They then had a formal tour of the unit and meetings with the clinical teams. The second day was a structured interview lasting up to 2 hours with a short break mid-way. The panel of 6 comprised clinicians, general managers and a senior medical manager. The panel viewed the psychometric assessment report and considered the need for any modification to the previously agreed questions. This proved a great success and was later extended to cover general Manager and Executive posts.

Future developments

13. The establishment of Integrated Care Boards as the guiding structures for the NHS I view as a very positive development. Many of the functions which had been provided by Regional Health Authorities, particularly in the field of scrutiny and audit were a sad loss. There is now the possibility of their re-introduction.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: _____

29th March 2024

Dated: _____

APPENDIX 1:

Qualifications:

MB.BS Newcastle	1978
M.R.C.O.G.	1984
F.R.C.O.G.	1997

Appointments

Consultant Obstetrician & Gynaecologist, Northumbria Healthcare Trust 1988 –2015

Interim Chief Executive, Northumbria Foundation Trust. 2015 - 2017

Trust Appointments:

Medical Director 2003 – 2015

Associate Medical Director 2001 – 03

Clinical Director Obstetrics & Gynaecology 1994 – 2001

Caldicott Guardian 2001 – 2015

Secure Information Responsible Officer 2010 - 2015

General Medical Council Responsible Officer 2012 - 2015

Chair, Emergency Care Centre Project Development Board 2008 - 2012

Named Doctor for Child Protection 2004 – 2011

Lead for Risk Management 2004 - 2011

Lead for Patient Safety 2006 - 2012

Chair, Information Governance Committee 2001 - 2015

Chair, Clinical Policy Group 2003 - 2015

Chair, Capital Planning Group 2004 – 2015

Member, Foundation Trust Application Team

Chairman, Drug & Therapeutics Committee 1998 – 2003

Regional Appointments

Member, North East Clinical Senate 2013 - 2015

Member, Regional Medical & Dental Workforce Planning Group 2008 – 2011

Member, SAS Doctor Advisory Group 2010 - 2015

Member, Senior Education Advisory Group 2007 – 2010

Member, NE Leadership Academy Steering Group 2009 -2015

Honorary Fellow, NE Leadership Academy 2010 -2015

Member, Regional Coaching Panel 2010 -2015

Member, Working Time Directive Steering Group 2007-2010

Member, Regional Drug & Therapeutics Committee 2003 - 2007

Member, Regional Maternity Survey Office Steering Group &

Contributor, annual report 1997 – 2012

Member, Regional Information Governance Group 2001 - 2007

National

Member, New Models of Care, Workforce Advisory Group 2015 -2016

Member, Keogh Review, Workforce Group 2013 - 2015

Member, Monitor Senior Clinical Advisory Group 2012 – 2015

Member, Monitor Mentoring panel 2013 – 2015

Member, General Medical Council Reference Community 2009 – 2014

Obstetric Assessor, National Clinical Assessment Service 2004 – 2015

Assessor Trainer, National Clinical Assessment Service 2008 – 2015

Member, RCOG Professional Standards Assessment Team 2007 – 2015

Trainer, RCOG Professional Standards Assessment Team 2009 – 2015

RCOG nominated Clinical Expert NICE Intrapartum Clinical Guidelines programme 2014

RCOG nominated Clinical Expert, Maternity Services Review Group

Buckinghamshire CCG 2014 – 2015

Invited Clinical Expert, Maternity Service Review, Northern Trust, Antrim 2013 -2014

RCOG nominated Expert Assessor, Care Quality Commission 2013 – 2014

NCAS nominated Clinical Expert, Director General of Health RO Ireland. 2014 - 2016

Member, RCOG Revalidation Committee 2011- 2014

Revalidation Lead, RCOG, 2010-2015

Co-opted Clinical Advisor, NHS Co-operation & Competition Panel 2010 - 2013

Regional Chair, National Confidential Enquiry into Maternal & Child Health, Diabetes

Programme 2006 – 2007

Member, National Confidential Enquiry into Stillbirth & Deaths in Infancy programme 2001-

2006

Member, NPSA Maternity Patient Safety Forum 2010 - 2012

Member, IMAS Clinical Support Team 2009 – 2015

Member, National Council of Caldicott Guardians 2002 – 04

Clinical Assessor, N.H.S. Ombudsman 1997 – 2002

Education

North East Leadership Academy programmes 2010 –2015

Examiner for Finals, Newcastle University Medical School 1998 – 2013

Undergraduate Admissions Selector, Newcastle University Medical School 2003 – 2020

RCOG College Tutor 1993 -1999

Examiner for Diploma R.C.O.G. 1997 – 02

Examiner for Membership R.C.O.G. 2002 – 2013

Preceptor, RCOG Emergency Gynaecology Training Programme 2007-2011

Mentorship

I have mentored 7 Medical Directors over 11 years, two of whom have become Trust Chief executives

After retirement

I led two RCOG invited reviews into maternity services at :

Cwm Taff Trust 2020

Scunthorpe and Grimsby Trust 2021

I worked with RQIA in Northern Ireland on two projects:

A review of the work of a Consultant Neurologist at Belfast Trust 2022-2023

A Review of the system for reporting and investigating Serious Untoward Incidents in Northern Ireland 2023

I acted as Medical Director advisor to the NHS England enquiry into West Suffolk Trust 2022-2023