Witness Name:
Susan Pemberton
Statement No: 1
Exhibits: [SP1 – SP4]
Dated: 16th July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SUSAN PEMBERTON

I, Susan Pemberton, will say as follows: -

Introduction

1. My full name is Susan Pemberton.

2. I am the Deputy Chief Executive and Executive Director of Nursing, Quality and Safety for the Countess of Chester Hospital NHS Foundation Trust ("the Trust").

3. I started in this role in February 2024 after being in a part time secondment role since January 2023.

4. My role involves ensuring high quality and safe services across the Trust, ensuring patient and family experience is at the heart of everything we do.

5. I'm professionally responsible for the nursing and midwifery disciplines.

6. Within my role, I am the Executive Lead for safeguarding children and vulnerable adults as well as being the Trust's Director of Infection, Prevention & Control.

7. As a member of the Board of Directors, and Executive Team I am responsible for providing continuity and focus to achieve the Trust's Goals.

Career

8. I qualified as a Registered Nurse in 1990 and started my career the same year at Salford Royal Hospital. My career at Salford Royal Hospital was from October 1990 to February 2010.

9. During my early career at Salford Royal Hospital, I held several staff nurse posts from October 1990 to October 1996. I was promoted to Junior Sister in 1996 and continued in this role until I was promoted to Ward Manager in 2001 and then Matron in 2003.

10. I became Lead Nurse for Medical Services in August 2005 until January 2007 and then Lead Nurse for Neurosciences until October 2007. This involved taking responsibility for:

    a. Operational management and leadership of nursing quality and clinical practice.

    b. Development of Ward Manager and Matron roles within the division.

    c. Implementation of robust infection prevention standards and outcome measures.

    d. Leading the implementation of governance and quality collaboratives across the Neurosciences division.

11. In October 2007, I became Assistant Director of Nursing and Quality which included:

    a. Operational and strategic management of the Greater Manchester Neurosciences Centre, Orthopaedics and ENT.

    b. Leadership of Quality Improvement programs with significant improvements achieved in performance results.

    c. Leading the nursing contribution to the development of the comprehensive stroke unit for Greater Manchester.

    d. Development of Consultant Nurse and Advanced Practice roles.

    e. Development, implementation, and review of nursing standards across the division with demonstrable results across Care Quality Commission (CQC) standards.

12. In February 2010, I moved to Liverpool Heart and Chest Hospital NHS Foundation Trust to take on the role of Deputy Director of Nursing and Quality. Within this role, I created the patient and family centred model of care together with the Director of Nursing. I was the lead for:

    a. Development of quality governance within the organisation.

    b. Emergency planning and preparedness.

    c. Quality Improvement.

    d. Development and introduction of the ward accreditation program.

13. In April 2012, I was promoted to Director of Nursing and Quality for Liverpool Heart and Chest Hospital NHS Foundation Trust. This is a specialist hospital which serves the population of 2.8 million. It was the first specialist Trust to be rated outstanding twice by the Care Quality Commission and consistently ranked number one in National Inpatient Survey and National Staff Surveys.

14. I was also Safeguarding lead and the Executive lead for patient safety, quality, and patient experience at Liverpool Heart and Chest Hospital NHS Foundation Trust.

15. I came to the Countess of Chester Hospital NHS Foundation Trust in January 2023 in a part time secondment role where I performed a dual role as Acting Assistant Chief Executive Officer alongside my Director of Nursing and Quality role at Liverpool Heart and Chest Hospital NHS Foundation Trust. This was to support the Acting CEO in delivering the Trust's improvement plan and specifically supporting the Director of Nursing in addressing key areas for improvement in quality and safety. During my secondment one of the key objectives was to commission a Trust wide "well led" peer review. This was undertaken by a multidisciplinary team and the draft report was presented to the Board of Directors on 18th May 2023. Following an unannounced inspection by the CQC in October 2023, a consolidated CQC action plan was developed incorporating CQC inspection feedback and the well led review recommendations was presented to the Board of Directors on 26th March 2024.

16. With effect from 1st February 2024, I was appointed to the substantive role of Deputy Chief Executive and Executive Director of Nursing, Quality and Safety at the Countess of Chester Hospital NHS Foundation Trust and commenced in post full time.

Questions posed by the Inquiry.

17. I provide this statement in response to a request dated 25 June 2024 under Rule 9 of the Inquiry Rules 2006. I have been asked to provide further information about the culture of openness and the operation of the duty of candour within the Countess of Chester Hospital ("Hospital") now.

18. I have been asked to:

    a. Provide an overview of current practice in respect of the Hospital's duty of candour and when parents or patients are told about errors made.

    b. Explain who is responsible for meeting with the parents of children or adult patients to discuss any medical failures or errors in the Hospital's care.

    c. Set out how many complaints have been received in the last 3 years which raise, either in terms or inferentially, a failure to be candid about what has happened with regard to a patient/s treatment.

    d. Confirm how many of those complaints have been upheld.

    e. Describe any remedial action that was required as a result.

    f. Confirm whether any involved referral to an external organisation or regulator.

Overview of current practice in respect of the Hospital's duty of candour and when parents or patients are told about errors made.

National context

The intention of the national duty of candour legislation (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) is to ensure that providers are open and transparent with people who use their services. It sets out specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

19. Under Regulation 20, in relation to a health service body, a 'notifiable safety incident' means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in:

    a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

    b. severe harm, moderate harm, or prolonged psychological harm to the service user.

20. NHS providers manage incidents through the Patient Safety Incident Response Framework (PSIRF) which was published in August 2022 by NHS England. This has replaced the Serious Incident Framework which was the previous national framework, published in March 2015, for implementation from April 2015. The national PSIRF supporting guidance, 'Engaging and involving patients, families and staff following a patient safety incident', prioritises compassionate engagement and involvement of those affected by patient safety incidents.

The Trust

21. Since January 2024 the Trust manages incidents (including patient safety incidents) through PSIRF.

22. I attach the following internal policies which align to the national guidance:

    a. **Exhibit SP2** is a copy of the Trust's Duty of Candour and Being Open Policy. – updated in April 2024.
    b. **Exhibit SP3** is a copy of the Trust's PSIRF Policy, effective from January 2024.

23. Incidents are reported through an Incident Reporting system called Datix which is used throughout the Trust. This system is available for all staff, via the Trust's intranet, to allow them to report a patient safety incident (without the requirement of a log in). I have described the process within Datix for the management and oversight of incidents below.

24. The Deputy Director of Nursing and Governance provides executive oversight of daily incidents at the 8am daily Senior Site Meeting. This meeting is attended by executives, clinicians, nurses, and other staff via teams each morning. Actions are recorded, reviewed, and updated at this meeting each day. Reviews of Datix reported incidents are undertaken to escalate any moderate and above incidents, themes, or areas of concern from the previous 24 hours. This meeting is an opportunity for information sharing and for immediate actions linking into Datix to be taken.

25. Weekly Patient Safety Learning Meetings take place. This meeting undertakes a review of the previous week's incidents, focusing on the themes of all incidents, concerns, complaints, organisational learning, and subsequent actions. This meeting is led by Deputy Director of Nursing and Quality Governance and attended by senior health care professionals across the divisions. Actions are formally noted and reviewed at each meeting.

26. A Weekly Learning bulletin is shared across the Trust to all doctors, nurses and trainees. An example of the bulletin from 5th July 2024 is attached as **Exhibit SP1**.

27. A Weekly Patient Incident Oversight Meeting also takes place, led by Deputy Director of Nursing and Quality Governance and the Deputy Medical Director and attended by Director of Nursing, Medical director and Divisional risk and Governance leads and divisional representatives (Divisional directors of Nursing, Operations and medical directors). This meeting undertakes a review of all moderate and above incidents on a rolling week basis and includes any urgent matters. Agreement is reached regarding the level of investigation required, timeframes for completion and oversight of action plans. Executive approval is also provided to completed investigations. This meeting is attended by executives and senior health care professionals across the divisions, with an invite also sent to the Integrated Care Board, Head of Quality and Safety Improvement. Minutes of this meeting are taken which are noted and reviewed at each subsequent meeting.

28. Monitoring of incidents which includes monitoring duty of candour actions is undertaken across a number of governance meetings from the divisions through to the Board of Directors. This is through the monthly Patient Safety Incident Report and the quarterly Integrated Incidents, Complaints and inquests reports which are received at Quality Governance Group, then to the Quality and Safety Committee (sub-committee of the Board chaired by a Non-Executive Director). The reports are then submitted to the public Board of Directors meeting.

29. The Board of Directors gain assurance regarding Duty of Candour via the Chair's report of the Quality and Safety Committee which is received by the Board of Directors following each Quality and Safety Committee meeting. This is a triple A report providing a summary of areas to Alert, Advise and Assure the Board of Directors.

Divisional

30. Daily review of incidents in the previous 24 hours are led by the Divisional Risk teams and senior managers. They ensure incidents are allocated to appropriate leads, nominate investigators, and allocate duty of candour responsibilities.

31. Any moderate incident and above has an initial duty of candour letter sent with a nominated point of contact and timeframe for completion of the investigation. Once the investigation is complete, the patient (or family) is contacted and offered a meeting at which the Trust's representative will present the findings of the investigation and share the investigation report. Any questions the patient (or family) has, will be answered in so far as possible or followed up.

32. The investigation team includes a number of healthcare professionals, from different areas of expertise, for their input.

33. Weekly Divisional incident meetings take place to review the progress of investigations and identify any themes.

34. The Divisional Director of Nursing approves Duty of Candour letters prior to them being sent to patients or their families.

35. Datix has a clear Duty of Candour section in which to record progress. All Duty of Candour letters are attached to Datix for storage and easy access. Divisional risk and governance teams ensure that this is actioned accordingly.

36. Each division is provided with a complaints and concerns report twice a week (typically Monday and Wednesday). Each division then holds a weekly meeting with the complaints team. This is chaired either by the Head of Complaints or Deputy Head of Complaints or deputised on occasion to a complaint handler where required. The Emergency Department has their own individual meeting due to the number of patients this service cares for which does translate to a higher number of complaints.

37. The meeting provides an update on the status of each case. An overview of performance is provided, and themes identified. This data is presented at the divisional governance meetings monthly for all Divisions, with the exception of Therapies Integrated Community Care where this is held quarterly due to the lower numbers of patient complaints. Complaints performance is monitored in line with the Trust's Complaints Policy and is RAG rated in accordance with the timescales for complaint responses. There is appropriate escalation to the divisions where there are risks for responses being overdue. Learning from complaints is also shared with the divisional governance meetings.

Explain who is responsible for meeting with the parents of children or adult patients to discuss any medical failures or errors in the Hospital's care.

Neonatal unit

38. As part of family integrated care, parents are always welcome on the neonatal unit, with no restricted visiting times. Facilities to allow a parent to sleep at the cot-side with a bathroom and meal are provided. Parents are encouraged to remain present throughout all clinical encounters with their baby. This includes taking an active part in ward round discussions and clinical decision making. These discussions can include an explanation of any medical failures or errors. Any questions that parents have, can be answered or an investigation into their concerns undertaken, with the results being fed back to parents.

39. Information regarding their baby's care is shared regularly by both medical and nursing staff. The consultant of the week is available to discuss their baby's care every day during ward rounds, informally in the "comfort zone" (where staff and parents can sit and get a

hot drink) and at other times during the day dependant on parent availability. This discussion may include addressing any concerns patients and/or their families have or notification of any medical failures or errors (if already known at this stage) as part of the implementation of duty of candour.

40. Any acute deterioration (including an escalation of care, change of respiratory support and need for infection screen) would be communicated to families as soon after they occur as is practical. This would include visiting parents on labour or postnatal ward and ringing parents who are at home. This initial communication is often undertaken by nursing staff. Medical staff follow up with further discussions with the parents as soon as practical. This discussion may include addressing any concerns patients and/or their families have or notification of any medical failures or errors (if already known at this stage) as part of the implementation of duty of candour. The verbal duty of candour discussions are recorded in both the electronic patient record and within the incident report on Datix.

Children

41. The process for children is similar. Parents usually stay with their child during their stay in hospital. Regular discussions by healthcare professionals (including doctors and nurses) regarding care and treatment take place throughout the day with the parents. This discussion may include addressing any concerns patients and/or their families have or notification of any medical failures or errors (if already known at this stage) as part of the implementation of duty of candour.

Adults

42. If a patient safety incident occurs, which includes a Never Event, the patient and/or family are informed as soon as possible following the incident and verbal duty of candour takes place. This discussion may include addressing any concerns patients and/or their families have or notification of any medical failures or errors (if already known at this stage) as part of the implementation of duty of candour.

43. The incident is reported on the Trust's Datix system and managed as described above.

Set out how many complaints have been received in the last 3 years which raise, either in terms or inferentially, a failure to be candid about what has happened with regard to a patient/s treatment.

44. All complaints data from 1st July 2021 – 8th July 2024 has been filtered with the theme 'communication'.

45. Two complaints were identified. Both relate to adult patients.

46. Both complaint investigations have been completed and were not upheld.

47. Both complaints will have response letters. All letters explain patient's right to appeal this decision and provide a point of contact. If the patient is still dissatisfied, they are directed to the Parliamentary and Health Service Ombudsman.

Confirm how many of those complaints have been upheld.

48. Neither of the two complaints were upheld.

Describe any remedial action that was required as a result.

49. As the two complaints were not upheld, no remedial action was required.

Confirm whether any involved referral to an external organisation or regulator.

50. Neither of two complaints have involved referral to the CQC or Parliamentary and Health Service Ombudsmen.

51. A family member of one complainant has independently contacted the police. The police confirmed that this is a matter for the Trust.

Latest CQC Report

52. Following our latest Care Quality Commission (CQC) inspection, which took place 17 October to 16 November 2023, an inspection report was published on 14 February 2024. See **Exhibit SP4**.

53. The CQC found that:

'the trust applied Duty of Candour appropriately. The trust's serious incident reports included explicit reference to Duty of Candour and details for how this had been carried out. The reports showed patients received an apology without delay after an incident had occurred. The trust monitored compliance with a requirement to complete the Duty of Candour within 10 days of an incident occurring.' (See **Exhibit SP4**, page 14)

54. The CQC inspected four acute core services across two locations provided by the Hospital. They inspected urgent and emergency care services, medical wards, maternity services and services for children and young people. The CQC found that staff understood the duty of candour across all four services:

'*They were open and transparent and gave patients and families a full explanation if and when things went wrong*.' (See Exhibit **SP4**, page 126)

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.

Signed: **PD**

Dated: 16th July 2024