THE MORECAMBE BAY INVESTIGATION

Tuesday, 4 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes - Expert Adviser on Governance
PROF Stewart Forsyth - Expert Adviser on Paediatrics
PROF Jonathan Montgomery - Expert Adviser on Ethics

ALAN JEFFERSON

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(At 3.30 p.m.)

DR KIRKUP: Hello, thank you for coming.

MR JEFFERSON: My pleasure.

DR KIRKUP: Please take a seat and help yourself to some water if you like.

MR JEFFERSON: Thank you.

DR KIRKUP: I'm Bill Kirkup, I'm The Chairman of the panel and I'll ask my colleagues to introduce themselves to you?

PROF FORSYTH: Good afternoon, my name's Stewart Forsyth, I'm a paediatrician and Medical Director from Dundee.

MR BROOKES: I'm Julian BROOKES, I'm currently the Deputy Chief Operating Officer for Public Health England, but was previously Head of Clinical Quality at the Department of Health.

PROF MONTGOMERY: I'm Jonathan Montgomery, I'm PROF of Healthcare Law at University College London and Chair of the Health Research Authority and in the past I've chaired PCTs and SHAs and provider[?] Trusts.

MR JEFFERSON: Okay.

DR KIRKUP: You'll see that we're recording proceedings, and we're producing an agreed record at the end.

MR JEFFERSON: Fine.

DR KIRKUP: You may also know that we've invited family members to be present as observers of interviews. As it happens, we don't have any here this afternoon, but they may listen to recordings subsequently.

MR JEFFERSON: Yes.

DR KIRKUP: You'll also know that we've asked you to leave behind any mobile phones and laptop, tablets, recording devices, just to emphasise that nothing goes out of the room until we're ready to produce a report with all the findings in context.

MR JEFFERSON: Fine.

DR KIRKUP: Do you have any questions for me about the process?

MR JEFFERSON: No.

DR KIRKUP: In that case, I'll start off with a very general question and then hand you over for a while. That is, can you tell me when you start at CQC – or I think, in fact, previously at CSCI.

MR JEFFERSON: Yes.

DR KIRKUP: And what you did?
MR JEFFERSON: Okay. How far do you want me to go back?
DR KIRKUP: When did you start with CSCI? I guess that would be the best?
MR JEFFERSON: At the start of the organisation in 2004.
DR KIRKUP: Okay.
MR JEFFERSON: I'd been the ~~Region~~ Regional Director for the National Care Standards Commission prior to that.
DR KIRKUP: Okay and what did you do at CSCI?
MR JEFFERSON: Northwest Regional Director, the same role as in CQC.
DR KIRKUP: Okay. So you – that – how can I put this? That sort of evolved seamlessly into the same role at the CQC?
MR JEFFERSON: Yes.
DR KIRKUP: Okay. And that would've been at the start of CQC in 2008?
MR JEFFERSON: 2009.
DR KIRKUP: 2009, sorry.
MR JEFFERSON: April 2009.
DR KIRKUP: Yes, thank you. Quite right. Okay, and you worked at CQC until...?
MR JEFFERSON: Until 31 March 2010, but in actual fact, I stood down from the Regional Director post in February 2010.
DR KIRKUP: Okay. Can you tell us why that was?
MR JEFFERSON: It was an internal reorganisation. The CQC decided – they'd had nine regional directors; they decided to reduce to seven and to combine the northeast and the Yorkshire and Humberside regions into one region; therefore there were three people, two jobs. I was ready to retire anyway, so I took voluntary redundancy, and that change was accompanied by a number of other organisational changes and they wanted the incoming regional director, Sue Macmillan, to be the person who actually dealt with the staff changes arising from that.
DR KIRKUP: Okay. The timing of that would've been just in the run-up, towards the registration of NHS providers?
MR JEFFERSON: That's right, that's correct, yes.
DR KIRKUP: Okay. Jonathan?
PROF MONTGOMERY: Thank you. Did you have any contact with the Trust before you went to CQC in April 2009?

MR JEFFERSON: No.

PROF MONTGOMERY: Fine, so we can start with April 2009, I think?

MR JEFFERSON: Yes.

PROF MONTGOMERY: And it would be really helpful to know, as you were inducted into that role – inducted yourself, I don't know if there was anyone to induct you other than yourself – what did you learn about Morecambe Bay Trust?

MR JEFFERSON: Okay. The starting point was when we took our posts as Regional Director when we were given a briefing by the Regional Director of the Healthcare Commission, who actually ended up as the Yorkshire and Humberside Regional Director so was still around – a briefing on what was then, I think, 65 Trusts in the region.

PROF MONTGOMERY: Just so we don't get it wrong, the name of that person?

MR JEFFERSON: I honestly can't remember. Subsequently I have remembered she was called Jo Dent.

PROF MONTGOMERY: We will be able to work it out, I suspect.

MR JEFFERSON: I mean, I hope I'm going to be able to help you, as I put in writing to you; it's five years ago since all this happened, and when you retire, you put an awful lot behind you and delete it from the memory banks. So I will do my best.

PROF MONTGOMERY: So 65 Trusts?

MR JEFFERSON: Yes, Morecambe Bay was not one that any particular attention was drawn to, so as far as I was concerned, until the spring of that year, there were no particular issues relating to Morecambe Bay.

PROF MONTGOMERY: And how does that develop, because your team develops concerns about Morecambe Bay doesn't it in the course of that year?

MR JEFFERSON: Yes, I mean, I think it is worth – I'm sure the panel is very aware – but it is worth reminding you that the region consists of 65 Trusts, 23 local authorities, where the performance assessment was relevant, and something like 4,000 registered care services, mainly social care services, but a couple of hundred healthcare, voluntary sector, independent sector services. So, the majority of the interface with any individual service was not in any way by the Regional Director. Almost the whole of the linkage with Morecambe Bay throughout the time I was involved was by the Assessor, Dawn Hodgkins, or Julia Denham, whose role as Area Manager gave her responsibility to kind of

oversee the health and social care market in Cumbria. So almost at almost every point, I was working through supervising them and not directly the case.

Two things came together, prompted by James Titcombe's – raising his concerns about the death of his son. One being, he communicated as I understand it, directly with CQC and that would've been dealt with at the local level. But he also communicated with Monitor. As you know, at the time, Morecambe Bay was in the process of seeking Foundation status, and Monitor contacted, via our headquarters – contacted our headquarters to find information out about our assessment of the organisation in the light of Mr Titcombe's concerns. So, my line manager would have been seeking information from me and equally, I would've been seeking information from Julia Denham.

It also became clear, quite quickly in that process, that there were a number of other seriously untoward incident reports, that linked to the maternity unit. I believe there were five at the time. And that caused CQC to question whether these all had a common thread, and so temporarily the Trust became rated as 'Red', so we could pursue our investigations. From that point on, it kind of – at a strategic level, I was aware, until the point I stood down, of issues surrounding the Trust, from time-to-time, talking to Monitor, talking to the Health Service Ombudsman, and dealing with email correspondence with Mr Titcombe.

I think the only point that I directly intervened was on one occasion in September 2009, when I, accompanied by Dawn Hodgkins and Julia Denham, went and met with the Chief Executive and ~~DR KIRKUP~~ Chairman, to express concerns that they were not taking the action plan that they'd developed in relation to maternity seriously enough, and I kind of went in to remind them that a registration process was beginning to start, and that if they hadn't taken action, this could be difficult for them.

PROF MONTGOMERY: It would be really helpful to have as much as you can remember about that meeting?

MR JEFFERSON: Okay. So, the five of us were there. My abiding impression of it – and it was not particularly unusual at the time – was that they – the two of them didn't particularly appreciate the likely impact of registration on any

Trust. And that was an experience that we'd had in 2001 with local authorities whose services became subject to registration. They really – until it actually happened – weren't in a position to see that it would actually change relationships. They were partly unsure that actually this was going to be a major change for them. The other abiding issue was they seemed more concerned by the fact that the delay in Monitor's processing their application was likely to lead to a need for a further set of due diligence work, and I do recall them telling me that I was going to cost them a quarter of a million pounds as a result of the delays that we were causing. So I don't think they were very focused on the issue that was concerning us. At the end of the day, I guess I left them with the gypsy's warning that there was a registration process coming up and they really ought to implement the action plan that they had told us a few months previously they were going to implement, but where there was no evidence of it happening.

PROF MONTGOMERY: What had prompted the creation of the action plan?

MR JEFFERSON: The action plan had been prompted – well, I guess it went in two directions. It was prompted by the external evaluations and investigations that the Trust had commissioned, but it was also prompted by CQC at the Assessor level indicating that one of the things that was required to remove the Trust rating from 'Red' was evidence of how they were going to respond to the issues that had by then been identified within maternity.

PROF MONTGOMERY: Do you recall which external investigation that action plan was related to? We keep uncovering new ones?

MR JEFFERSON: Do you mind if I – it was the Charles Flynn Report.

PROF MONTGOMERY: Okay.

MR JEFFERSON: In particular. I think, again, the fact that the day-to-day detailed evaluation of the Trust was being dealt with by Dawn Hodgkins, Dawn Hodgkins is really the person who can answer that question. But my awareness was of the Charles Flynn Report, which very clearly identified issues that no doubt we'll talk about, about the shortcomings within maternity that had impacted on the death of Joshua Titcombe, it appeared.

PROF MONTGOMERY: Was your impression that they knew the detail of that action plan?

MR JEFFERSON: [*After a short pause*] The broad headings – my impression was that it had been discussed in greater detail with Dawn Hodgkins who was at the meeting. But the discussion was of the broad headings, and the broad headings, as you're probably aware, were communication between paediatrics, obstetrics, and maternity; communication between the three main sites of the hospital within maternity; and the implementation of a new recording system. So the conversation I had was at that broad level and really, saying – and at that stage, we were not asking for anything earth shattering. It was at the level of, 'You need to have some meetings, you need to be able to show agendas and minutes of meetings' and so on. We weren't asking for anything earth shattering at that stage. And what I was saying was, 'Those are the things we need to see'.

PROF MONTGOMERY: I'll be very clearly, I was asking about your perception of whether they knew the detail, not whether you personally knew the detail, because I can see that your team would –

MR JEFFERSON: What I was saying was that the discussion was at that broad level. And the detail, no we didn't address.

PROF MONTGOMERY: And did they indicate to you how they planned to take that forward? You've raised the question that they need to take the action plan a bit more seriously than they appeared to be doing. Did they offer you any comfort in thinking they were going to do that? If so, what?

MR JEFFERSON: I don't think they did. I think the conclusion of the meeting was a statement from me on behalf CQC that this is what we need to have evidence, and that Dawn Hodgkins would be regularly liaising with the Trust to ensure that it was happening. We certainly talked about meetings, and the need for them to be able to submit to her evidence that those meetings were taking place in the form of agendas and minutes.

PROF MONTGOMERY: Was there any discussion about them commissioning further external reviews?

MR JEFFERSON: Not that I recall.

PROF MONTGOMERY: And –

MR BROOKES: Just on that, I'm just interested, was your impression you'd been asked to attend the meeting because the discussions were unsatisfactory

between your colleagues and the Trust in terms of moving it forward, and you'd been brought it in to re-emphasise the point?

MR JEFFERSON: Yes, very much so.

MR BROOKES: So clearly there wasn't satisfactory progress being made?

MR JEFFERSON: Absolutely.

MR BROOKES: And was it a feeling that it was because they didn't feel it was important or...? I'm just trying to understand why you've got an external report saying, 'There are problems with your service', you wouldn't want to improve them. Did you get the feeling they were not signed up to the actions, I suppose?

MR JEFFERSON: Yes, I think that's a reasonable assessment, that they were on a plane that was around, 'How do we get Foundation status', rather than wanting to address the issues that CQC wanted them to address.

MR BROOKES: Thank you.

PROF MONTGOMERY: You said that you had raised in your minds the obvious question that we're asking ourselves as well, about the possible connection between this group of SUIs maternity services. You mentioned the Titcombe case being a particular prompt around that time, did you get an impression that DR KIRKUP and Chief Executive had a view on whether there was a general problem with maternity services or whether there was a set of specific things?

MR JEFFERSON: By the time the meeting took place, which I believe was in September 2009, the Strategic Health Authority had reviewed the six serious, including the Titcombe one, so five others and the Titcombe one, and had informed CQC that they didn't think there was a connection between them, and therefore by that stage, they were not high on CQC's radar. I'd been briefed by Julia Denham about that and the briefing – and I really cannot remember the detail of any of them – indicated that the serious untoward incidents were quite different in terms of causation; and that there was no common thread in relation to that. But what we did have arising from the Titcombe case was the view that the three shortcomings that I've talked about hadn't been resolved and therefore there was every possibility that a similar incident could occur again unless those issues were properly addressed.

PROF MONTGOMERY: How could there be a similar incident if there was no common thread in the other ones?

MR JEFFERSON: Sorry, a similar incident to the Titcombe case –

PROF MONTGOMERY: Oh, I see. But the other ones were all, in your view – were all unrelated?

MR JEFFERSON: That was what the Strategic Health Authority told them, and my view was to accept the briefing. I'm not medically qualified, I'm a social worker by background. I had no skill to be able to evaluate whether they had or not. But the Strategic Health Authority had evaluated them and had produced a report for CQC which I didn't ever see, which was seen at the appropriate level within the region, saying they were not linked. Somebody called 'Brown' did it, I believe.

PROF MONTGOMERY: Angela Brown?

MR JEFFERSON: Yes, that's right.

PROF MONTGOMERY: That's what we've been spending some time trying to understand who in the SHA communicated that, that's really helpful, that Angela Brown – okay, I think before that date in September, there'd already been some communication between your team and the investigations team about Morecambe Bay?

MR JEFFERSON: Yes.

PROF MONTGOMERY: Could you tell us about that and how it arose, take us through what happened and how it was closed down?

MR JEFFERSON: I can try, but it is important to say that that was all done at a ~~low~~ lower level than I was, and I had no part in it at all directly. The Assessor, Dawn Hodgkins, when she looked at the evidence, with her experience as one of the three of us who had previously worked for the Healthcare Commission considered that it may reach the – the situation may have reached a threshold for full investigation and referred the matter through to the central investigations team. The outcome of that was that – and I'm sure there were lots of referrals to the central investigation team – it didn't reach the threshold that they held for investigation.

PROF MONTGOMERY: What was your understanding of why it didn't reach the threshold?

MR JEFFERSON: I didn't have such an understanding.

PROF MONTGOMERY: Okay, so your team is anxious enough to think that there was at least a question to be raised nationally. By September, you'd got a 'Red' rating on the risk –

MR JEFFERSON: The 'Red' rating came as soon as – some months earlier, I think probably in May, when the information about the five additional serious untoward incidents came.

PROF MONTGOMERY: And how is that 'Red' rating revisited, because it becomes 'Amber' at a point in time?

MR JEFFERSON: Yes. I think – is it helpful to share my understanding of what that 'Red' rating meant because I think it's frequently been referred to as a risk rating. In my view, it was actually an indication of – if you like to put it colloquially – where on the radar of the organisation that organisation was at the time, in terms of a need for additional oversight. The 'Red' rating very frequently was an indication that something new had come in, needing some investigation so it was not uncommon for there to be a serious untoward incident and report for it to be discovered following intervention that it was an entirely natural occurrence, and for the rating to be changed quite quickly. So it wasn't an assessment of organisational risk. It was about how much work was needed.

The rating changed to 'Amber' I think in August 2009, at which point the Trust had produced a written plan about what it intended to do to deal with the three issues. It was then, by September, become clear that they'd produced the plan but they weren't implement it, which is why I became involved. So the factors that led to removing the 'Red' rating and moving to the 'Amber' rating were first of all the report that said the six serious untoward incidents were not a cluster of similar matters; and secondly, the production of an action plan to deal with the issues arising from the Titcombe case, via the Charles Flynn report.

PROF MONTGOMERY: And was that decision about 'Red' to 'Amber', is that a local decision or is it taken by CQC centrally?

MR JEFFERSON: It was a local decision. There was a regular, monthly meeting that I chaired that looked at all the 'Red' rating – well, all the 'Red' and 'Amber' – all the ones that weren't 'Green', in effect – and received progress reports from the Assessor.

PROF MONTGOMERY: And what would be the norm about the number of 'Red' ratings that were to be discussed at that meeting. 65 Trusts, how many of them would be 'Red' or 'Amber'?

MR JEFFERSON: It wouldn't just be Trusts, it would be all the health related services, so it would probably be 250, 300. And there would be probably be, from memory, perhaps 10 or 15 that we discussed. Many of them were the private sector ones; at the time we had a number of laser clinics that were operating without proper authorisation and so on.

PROF MONTGOMERY: Okay. Can you tell us a little bit more about the contact with Monitor, because you said two things came together: Mr Titcombe raising issues locally, but also Monitor coming to you after he'd raised them with them?

MR JEFFERSON: Yes. I suppose the context is that there were a lot of new organisations working together and at the time we're talking about, I don't think there existed clear protocol with Monitor. That came, I think, later on that year. But in terms of the investigations that Monitor were making in relation to Foundation Status, they began to liaise with CQC as part, I guess, of their broad brush, looking for whether there were any contraindications. They appear to have become aware of the organisational risk profile, and it appeared, and again, the rationale for it is not anything I can explain, but it appears that Monitor decided that until an organisation had a 'Green' organisational risk profile, then they wouldn't be granted the Foundation Status. So they sought information. Generally speaking, their information was sought through my line manager, Amanda Sherlock; though from time-to-time, at Amanda's request, I spoke directly to Miranda Carter. And, I guess the line was, Monitor understandably wanting to know when the matter would be resolved, and us saying, 'How long is a piece of string? It will be resolved when the Trust is meeting the expectations that we've got of them'.

PROF MONTGOMERY: So I could understand why people might be confused that the 'Red' rating means that this is something called a risk profile?

MR JEFFERSON: Absolutely, and I wouldn't argue with that for one moment. But it wasn't done as a result of a comprehensive risk assessment, a comprehensive risk review. An organisation could become 'Red' on the

basis of something that sounded very serious being notified to us, and needed investigation.

PROF MONTGOMERY: How frequent was the contact with Monitor, then? So you move from 'Red' to 'Amber', but that isn't going to be good enough, for what you describe they need to get to 'Green'?

MR JEFFERSON: That's right. I think contact between Monitor and CQC was fairly frequent up until around about August, at the point when the rating became 'Amber'. Monitor were pushing for a date when it was envisaged that it would become 'Green', and the line I was taking was, 'We just don't know'. I communicated that in August with Amanda Sherlock, and wrote her a memo at the time which compared the situation to the situation that both of us were much more familiar with, dealing with councils and social care authorities that were failing over the long-term to meet their obligations. Basically, they could stay in that position – it wasn't at the time called, 'Special measures', but effectively that, until they'd put things right.

MR BROOKES: Sorry, could I ask on that, I'm just interested: you said they were pushing for a date?

MR JEFFERSON: Yes.

MR BROOKES: How much were they pushing? Was it something that you felt they were – acceptance that this was something you needed to make a decision on, or was there quite a lot of pressure for a date that the issues would be resolved and the date was set?

MR JEFFERSON: I felt there was quite a lot of pressure. I can remember writing in the email to Amanda Sherlock, 'We should not be guided by a gun at our heads from Monitor'. So I think that must've been indicative that I felt there was a lot of pressure.

PROF MONTGOMERY: Did you have a sense that there was some of the pressure on the Trust, or was the pressure on you to set a date? Because part of what you describe is, it's up to the Trust to do the job?

MR JEFFERSON: I didn't have a sense of that at all.

PROF MONTGOMERY: And what about the SHA, were they part of those discussions at all about the timetable?

MR JEFFERSON: Not with me.

PROF MONTGOMERY: Okay. Thank you. You had various communications with Mr Titcombe, before and after that September date. Talk about – get the timeline because we've seen various things that you have written or emailed, but there's clearly a conversation going on about what CQC can and can't do, in relation to his complaint. Can you just take us through that?

MR JEFFERSON: Yes. It's perhaps helpful to emphasise – and you'll be as aware of this as I am – that up until the 1 April 2009, the Healthcare Commission had had responsibility for investigating complaints. The first contact from Mr Titcombe was probably six weeks into the life of CQC and six weeks into the life of that transition. It was an issue that had happened – the death of Joshua Titcombe was in the timeframe of the Healthcare Commission – so part of the process with him was to try and emphasise the fact that CQC had no legal powers, no remit and no intention of doing a complaint investigation; and trying to help him understand how a regulatory authority used a notification of a concern. And, there was a thorough investigation which led to identifying the three issues that we've already referred to, and to a view that the Trust had not taken action to make sure that that could never happen again, and that as far as CQC were concerned, then, the value of his complaint had been met, if you like. It didn't satisfy him, understandably, but from a regulatory point of view, his concern had done its job and we were taking action on it; and trying to help him understand that we weren't going to look at it in greater detail to ask – to answer some very legitimate questions that he had about what had happened on – you know, in detail at the time.

So it was really about that, and towards the end, actually, I wrote to him – I suppose, December, January, basically a letter that was aimed to close things down, and say, 'We have done all we can. We have taken on board the things that were identified by the death of your son and we have concerns that we're following up'.

PROF MONTGOMERY: Can you say a bit more about – we have the letter, so obviously we're able to read it for ourselves, but it doesn't sound as if you've said, 'It's over'. In terms of investigating his complaint, you're saying, 'That's not for the CQC', but you told us that you're not yet satisfied?

MR JEFFERSON: Yes, I'm talking about the investigation of his complaint being over. We'd taken out of his complaint the information we needed as a

regulator and we'd identified the issues that I think were set out in the letter; that we would be continuing to monitor progress in meeting those and that the registration process was coming up and that would be taken into account in the registration process.

PROF MONTGOMERY: And you talk in the letter about a number of possibilities, including not licensing at all –

MR JEFFERSON: Yes.

PROF MONTGOMERY: Including compliance requirements, conditions –

MR JEFFERSON: Yes.

PROF MONTGOMERY: So, in December time, those remain open questions?

MR JEFFERSON: Yes.

PROF MONTGOMERY: And it would be really helpful to understand how those questions were asked and how you get to the stage, slightly after you take your retirement, when there's registration without any conditions? So a blow-by-blow account of the thinking, decision making that went through those few months would be really, really helpful?

MR JEFFERSON: Yes, this is going to be a very short answer, because I actually had no part in that. What happened originally was the Regional Directors were cited in the development of the process. CQC had appointed a national – on a temporary basis – a National Director to oversee the registration of the NHS, and the re-registration of the 26,000 care services, Linda Hutchinson. She was tasked with designing the processes and they were shared with the Regional Directors. There had been a very strong statement from CQC that this was going to be a very, very thorough and comprehensive process; and kind of back in December, and earlier in that – in December, when I wrote to Mr Titcombe – earlier than that when I spoke to Kate Hudson, the Ombudsman, that was on the basis of the assurances Regional Directors had been given that this was going to be a very firm process –

DR KIRKUP: That involved Regional Directors?

MR JEFFERSON: Well, I'm coming onto that. It was then – we were asked to nominate a member of the regional team to take a lead in the process, and that was Julia Denham who had a great deal of experience in regulatory activities from her previous roles, and actually was managing the regional social care registration team at the time. The application forms which I think

had to be in by the end of January went to the centre. The plan was that at the centre, there would be a collation of information that would identify, when read against the application form, areas that needed further exploration, and that the Assessor would provide that information, send it back to centre, and would be working with Julia Denham and her equivalents in the other regions, to make decisions. Now, bearing in mind it was the end of January when the registration applications had to be in, there was then a period where the central team did that evaluation. It would have been the middle to the end of February before that evaluation had been done, at which point I stood down and took no further part in the management of the region. I was there in a supernumerary capacity and in fact, for over half the period, was not there at all, because I was using up annual leave. So there was never a discussion with me about the detail of Morecambe Bay application, or any other application. I only – I think I'm right in saying this – the only information I obtained about any of the process, other than – in the very early stages, saying to Julia Denham, 'Are the applications coming in? Have we got what we need? Have you got enough staff to deal with what you need?' The only point at which there was a discussion with me was on my last day in CQC, when I had a lunch party and said, to Julia Denham, 'Have you got to where you need to get to? Have you got all the registrations done?' and she said, 'Yes'. I said, 'Have we got a lot with conditions and what about Morecambe Bay?' and she said it had been registered without conditions. As far as I know, during that time, that is the only conversation I had about Morecambe Bay or any registration.

PROF MONTGOMERY: Were you surprised by the answer to that question?

MR JEFFERSON: Yes.

PROF MONTGOMERY: So what would you have expected would have needed to have changed from the time you were involved in order for the registration to have made sense to you without conditions?

MR JEFFERSON: One of the speculative questions that had been asked around the region for some time was, there were clear issues in maternity. If there were clear issues in maternity, was it possible that there could be issues elsewhere within the Trust. The information that we had – there'd been the standards-based assessment in the summer, which didn't show anything

conclusive; there had been the annual health check in October, which from my recollection, showed a small number of areas of non-compliance, but compared with some other Trusts in the region, nothing of too great seriousness. But again, none of that actually allayed the possibility that there could be issues elsewhere.

PROF MONTGOMERY: And those processes were self-assessment processes, is that right?

MR JEFFERSON: By and large, yes. Or using data that was available for – within CQC headquarters. Yes, so I would've anticipated that there – the registration process would have been used with considerable rigour in relation to Morecambe Bay and bearing in mind that Julia Denham was the Assessor – was the Area Manager whose responsibility was Morecambe Bay, and who was at the time, sharing some of the concerns that I had, would've made sure that it was a rigorous process.

DR KIRKUP: Did you ask her about that when she told you?

MR JEFFERSON: In the context of a leaving party, no. I have asked her about it since. And what she told me – I don't know what she's told you – but what she told me was that she didn't think the process was rigorous enough.

MR BROOKES: Just for information, can I just understand, you talked about the role of Julia Denham; you also mention and Assessor. Can you tell me a little bit about that, because I'm not sure – who was the Assessor and how did they – what was their role exactly? Who was assessing?

MR JEFFERSON: Okay, the Assessors was the name of the frontline worker in the Healthcare Commission. These were fairly senior people. My understanding is that Dawn Hodgkins, the Assessor had, in her previous role, had been the matron of a BUPA hospital, so a reasonably experienced and senior person. There was a mismatch between the structures of the Healthcare Commission and the structures of the Social Care Inspection, where the frontline inspectors were much lower paid people. But what the structure was, that there were locality-based teams, managed by a team manager who was managed by the area manager. The area manager, as well as the regulatory management responsibilities had this performance assessment role in relation to health and social care economies of areas. So, Dawn Hodgkins

the Assessor, dealt with the day-to-day contact with the Trust at practical levels, within the context of the Healthcare Commission systems.

MR BROOKES: So is that just one Assessor?

MR JEFFERSON: One Assessor, yes.

MR BROOKES: So when we get to the registration process, there isn't a new Assessor who gets brought in? This is Dawn Hodgkins again?

MR JEFFERSON: As far as I know, it would have been.

MR BROOKES: So there's an Assessor who knows the organisation?

MR JEFFERSON: Yes.

MR BROOKES: And I assume their role is to quality assure the returns that are coming in, as part of their role, would be to make sure that what's been submitted by the Trust is an accurate representation of the position?

MR JEFFERSON: I really – I would be speculating because I didn't see the application forms; the process was managed by Julia Denham linking with the centre –

MR BROOKES: But in general, that's –

MR JEFFERSON: That is what I would've expected, but I can't tell you whether that actually happened.

PROF MONTGOMERY: Can I take you back to the December letter?

MR JEFFERSON: Yes.

PROF MONTGOMERY: And ask you what you thought was likely to happen? So you describe very carefully the processes to Mr Titcombe, and the options that are being considered. What was your personal expectation of would come out of that?

MR JEFFERSON: By this point, I had been regulating social care services for nearly 25 years, and on the basis of that experience, I would've expected that it wouldn't have been too difficult to find some broad conditions that were around communication, and around interdisciplinary working, that could be imposed on the Trust that would actually produce a handle that could be used in the future if progress wasn't appropriate. I would've expected that that would have had an impact of ensuring that there would be some fairly early inspection activity in the Trust after registration, because the existence of compliance conditions would've given a level of priority.

PROF MONTGOMERY: So just reflect back what I think I've heard. You lead the September meeting, and you're not convinced they are taking the action plan with the seriousness that it deserves; you don't anticipate that they will have remedied that quickly; you write in December of the steps you're still going to take longer, and what you anticipate your regulatory action - is to give yourself an opportunity – you seek an opportunity to stay involved in it, and that would be the purpose of conditions?

MR JEFFERSON: Yes.

PROF MONTGOMERY: That's very helpful. Can I take you back to the Ombudsman and the discussion with Katherine Hudson, on – can you say how you became involved in that and take us through the conversations?

MR JEFFERSON: Clearly there are two separate decisions to be made: decisions about what CQC were going to do with the information and decisions about – what the Ombudsman was going to do with the complaint. What I did was ensure that Katherine Hudson had a clear understanding of the findings that we had made, the three areas of concern, the expectation that we would be monitoring an action plan, and the fact that registration was coming up, the discussion was at the back-end of 2009. And at the time, when I genuinely believed that we were talking about a rigorous process, that we would impose some conditions on the Trust. So, the conversations I had with her made it clear that the decision that the Ombudsman said, was the Ombudsman's decision about a different issue. I think one of the things that, again, you'll be aware of is that somehow many of the records relating to Joshua Titcombe had gone missing, and that made it particularly difficult to conduct a detailed investigation of what happened during that period. I know that we had some discussion about how difficult it was going to be to pursue the matter further. The direction of travel, I guess, at the end of the conversations we had was that it was unlikely that the Ombudsman would pursue the issue. As they saw it, we had identified the broad issues from the process, were on board with them, were trying to make sure they would be sorted out, and that from the CQC point of view, the Ombudsman's investigation would be that that case would be unlikely to add anything to the conclusions that we'd already made. I think it then fell down to a consideration by the Ombudsman's office about whether, in the absence of

records, they could actually take the matter a great deal further. But that was clearly for them to decide.

PROF MONTGOMERY: So just to be clear about the CQC's side of that conversation, this is something that is actively under consideration in your mind, at this stage. We've heard about what actually happens a bit later on, and the rigour or lack of rigour?

MR JEFFERSON: Yes.

PROF MONTGOMERY: But at the point of having that conversation, you're clear in your mind that the expectation is that the CQC thinks this is an open file, if you like, as opposed to a closed file?

MR JEFFERSON: Absolutely.

PROF MONTGOMERY: Okay, and did you get a sense of how the Ombudsman's office saw it, in this role. I appreciate it's a decision for them. I'm just wondering whether, in the same way as you would've given an indication to Katherine Hudson –

MR JEFFERSON: As I said, I think what she was saying was, she didn't what, if they conducted an investigation, what it would add to the conclusions that CQC had already made in terms of what the Trust needed to do to ensure it didn't happen again.

DR KIRKUP: Was there a conversation about a CQC investigation into systemic failures?

MR JEFFERSON: [*After a short pause*] There was reference to systemic failures. At that point, nothing in my mind was leading to the idea that we would conduct an inspection around systemic failures. If that was picked up, it was around a thorough investigation with a registration application, not a separate investigation.

DR KIRKUP: And was there any mention of a potential CQC investigation from the Deputy Ombudsman?

MR JEFFERSON: Not that I recall?

DR KIRKUP: Okay.

PROF MONTGOMERY: Did you have any contact –

MR JEFFERSON: Sorry, can I just add something to that? One of the – going back to – well, to the point that the issue was referred to the CQC investigations team, one of the things that Sarah Seacombe[?], the head of the team, had

said was depending on the outcome of the Ombudsman investigation, we might be in a position to look at it again. What had happened in the intervening period is that, in effect, the central investigation team had been disbanded. I have subsequently been informed that it didn't actually cease to operate until around about March 2010. It was finishing work off. But from the summer of 2009, CQC – Amanda Sherlock was saying to the Regional Directors there would be no more referrals to this team because it's going to be disbanded. So as far as I was concerned by the end of the year, it wasn't an option to refer it back to them, because they were closed for business. But there had been reference in the past to the possibility of the investigations team reconsidering its decision. But that was on the assumption it would have – it would exist to do that.

DR KIRKUP: It's a hypothetical question, but I would like to know what your impression at the time would've been of the need for a re-referral to that team? Did you believe at that stage that you knew everything there was to know about what had gone wrong at Morecambe Bay, and therefore you didn't need an investigation? Or was this, because the team had been wound up and couldn't do it any longer?

MR JEFFERSON: It just wasn't an option to consider.

DR KIRKUP: But if it – I'm asking a hypothetical, I know. But –

MR JEFFERSON: I think my hypothetical answer to your hypothetical question would probably be that I would've seen what arose from the registration process first. That there was, in my mind at the time, going to be a comprehensive investigation of the totality of the operation, through the registration process.

DR KIRKUP: And would that be sufficient to identify any potential systemic failure?

MR JEFFERSON: I think, again, to look at – the question with systemic failure elsewhere in the Trust, not just in the maternity unit. And the evidence that we had was pointing in the opposite direction; it was that they'd had the standards-based assessment in the summer, which a small number of standards had shown a fair degree of compliance, the annual health check had not shown any major concerns; so actually, we were probably – and we had been informed that the serious untoward incidents weren't linked. So

actually, it would appear that, by the end of the year, we were further away from having concerns than we were at the beginning of the year.

DR KIRKUP: We appear to have a mismatch of expectations here: that from what you've told us and from what we already know, the Ombudsman's office is saying, 'This is evidence of systemic failure', and you're saying, 'No, it wasn't.' How was that communicated in that conversation? Because you appear to have left that conversation with different impressions?

MR JEFFERSON: I believe what was said was, there was evidence of systemic failure in maternity. That we had no evidence of that at that stage of systemic failures elsewhere in the Trust. That is what I believe I was saying at the time.

DR KIRKUP: And therefore, in your view, you already knew all there was to know about the systemic failure in maternity? Tell me if I've got it wrong, but that's what it sounds like to me? There was nothing more to be gained from investigating maternity, you already knew what the issues were?

MR JEFFERSON: We believed that the issues were about multidisciplinary working, working between the different sites, and about recording, yes.

DR KIRKUP: Yes, and that the action plan would address those?

MR JEFFERSON: Yes.

DR KIRKUP: Yes, thank you.

MR JEFFERSON: And this was – sorry – this was on the basis that we had been told by the Strategic Health Authority that the other serious untoward incidents were not evidence that supported additional issues around systemic failure.

DR KIRKUP: I want to come back to that one, shall I do it now? I think I will do that one now. Did you challenge on what basis the SHA came to that conclusion?

MR JEFFERSON: Did I?

DR KIRKUP: Yes.

MR JEFFERSON: No. As I've already told you; I have no qualification to challenge those decisions.

DR KIRKUP: That's on the understanding that it was something to do with the clinical picture. Why would it be something to do with the clinical picture? Aren't the underlying causes of untoward incidents in healthcare, as in social

care, to do with human factors more often than not? Aren't the linking features behaviour, teamwork, communication, multidisciplinary working? Wouldn't you be familiar with that from social work?

MR JEFFERSON: You're asking me to comment on a report that I didn't see, that was dealt with at the appropriate level within the organisation –

DR KIRKUP: I'm asking you whether you challenged the decision?

MR JEFFERSON: No, I didn't. I was convinced by what I was told.

DR KIRKUP: And you've said a couple of times that the reason for that is that you're not a clinician and therefore, that you accepted that that judgement is based on the clinical information? Does that not surprise you that that sort of decision is purely based on a clinical picture?

MR JEFFERSON: [*After a short pause*] I'm trying to cast my mind back a very long time at information that I have largely put behind me. But I think the way it was discussed with me was in relation to the presented problems, '*X* had a stillbirth', or that kind of thing, and it did not reinforce the view that there were wider issues. With the benefit of hindsight, it maybe should have done, but at the time, it didn't.

DR KIRKUP: If you'd been doing a comparable bit of work in relation to social services, let's say child protection, and *Case A* had involved a child being struck; and a *Case B* had involved a child being burned; and *Case C* had involved a child being starved. The presenting picture is different but the underlying problems are likely to be the same in each case? Is there not a parallel there?

MR JEFFERSON: There probably is, but I emphasise the fact that the role of a Regional Director did not enable me, with the other 4,000 services in the region, to look that closely at that. But that should've been dealt with, and as far as I knew, it was dealt with by the people nearer the point, when asked the question, 'Is there an issue?' and they said, 'No, we don't believe there is.'

DR KIRKUP: Yes, I know, and it wasn't your decision to make; I absolutely accept that. I'm merely probing at the extent to which you sought to understand what the underlying factors were that led to that decision, because looking at it from where we're sat, it does seem a pretty insubstantial decision, that I

think we would all have been surprised to have seen at the time that we'd had that information.

MR JEFFERSON: Well –

PROF FORSYTH: Can I ask a question, do you have a medical advisor? I mean, if you obviously get an issue such as this, which clearly there's an important clinical aspect to this particular service and the report on the service, would you not seek advice from a medical advisor? Do you think this is a reasonable conclusion?

MR JEFFERSON: CQC had medical advisors, had a panel of specialist medical advisors. There would have been nothing to stop the local team from seeking such advice -

PROF FORSYTH: But what about yourself? If this comes to your desk –

MR JEFFERSON: The report didn't come to my desk. In the context of one-to-one sessions, 'How are we getting on with Morecambe Bay, what is happening with those other referrals', 'We have been told by the Strategic Health Authority that there isn't a link between them and therefore we are looking at the issues that arise from the James Titcombe case', at the time seemed a perfectly reasonable line to take.

DR KIRKUP: That's the bit that I'm struggling with, because your emphasis is on the clinical picture, in the very parallel field that you know an awful lot more about than I do, you accept that the clinical picture isn't everything; it's the underlying human factors involved?

MR JEFFERSON: But I was not the one holding the ring on this case; I was the one holding the ring on the region. My principal role, as I told you right at the beginning was responding to enquiries from my seniors and enquiries from the other people that were around, from Mr Titcombe and so on. This was not – and clearly, when we sit here today, it's a very different picture than it was in 2009, which was not the most pressing thing happening in the region in terms of healthcare or in terms of social care. There were lots of other things that were requiring more of my time.

MR BROOKES: Again, speculation, but just on that point as well, if the report had come back from the Strategic Health Authority saying the six had been linked, what would your approach have been?

MR JEFFERSON: I think it is likely then, that at that point, we would've been talking to the investigations team, because there would have been more evidence to suggest there was a problem. And I think there was at that stage an understanding that the region didn't have the resources to conduct a full-scale investigation of a hospital.

DR KIRKUP: Did you have regular meetings with the SHA?

MR JEFFERSON: Occasional meetings; I think I had about four during the 12 months, or 11 months I was in post.

DR KIRKUP: Did you discuss Trusts in general, Morecambe Bay in particular?

MR JEFFERSON: We discussed Trusts in general; I can think of other Trusts that took more time, because there were more issues. There were a number of Trusts in Manchester where there were issues; there was another Cumbria Trust where there was a much bigger issue that we discussed.

DR KIRKUP: Okay.

PROF MONTGOMERY: Who in the SHA did you meet with?

MR JEFFERSON: I either met with the Chief Executive or with Jane Cummings, or occasionally with Angela Brown. Angela Brown, I had known from previous roles in the region, when she was in a much less exalted position.

PROF MONTGOMERY: And you talked about the fact there were other Trusts that you talked about more. I didn't quite catch whether you did talk about Morecambe Bay or not?

MR JEFFERSON: I really can't recall.

PROF MONTGOMERY: Okay.

MR JEFFERSON: To get to the point, it was very high on Mr Titcombe's radar; it was much less high on the radar on the organisation as a whole because the substantiating evidence wasn't there. The question was still unanswered in mind, 'Is there more to this?' and rightly or wrongly, looking forwards and not backwards, I saw the regulatory process, the registration process, as the means of beginning to tease that out.

PROF MONTGOMERY: Thank you. Just before we go back to the conversation with the Ombudsman's office, there's a couple more questions I had about that, I wondered whether that now – because I appreciate you wouldn't have seen it at the time – you've seen the Fielding Report? No particular reason why you should but you may have done out of interest?

MR JEFFERSON: The Fielding Report is which one?

PROF MONTGOMERY: Is the report that was commissioned shortly after the meeting you had with DR KIRKUP and Chief Executive and reports in 2010...?

MR JEFFERSON: No, I haven't.

PROF MONTGOMERY: That's fine. There were a couple of questions I had about the conversations with Katherine Hudson from the Ombudsman, about how it arose, to have that conversation and whether there were any things that followed it up. So, how did you come to have a conversation with Katherine Hudson? From what you've described, it wouldn't be a conversation you'd have regularly?

MR JEFFERSON: I think it was at the request of Amanda Sherlock. My understanding, retrospectively – and it certainly wasn't my understanding at the time – one of the difficulties is that there's been lots of reports including the Grant Thornton report that I have read, but my understanding was that there was a separate set of discussions going on between the Chief Executive of CQC and the Ombudsman that I knew nothing about. There was also clearly, conversations going on between [Cynthia Bower?] and Amanda Sherlock which must have informed that, and if I recall correctly, Amanda Sherlock said to me, 'There needs to be a detailed discussion with Katherine Hudson and it seems silly to do it by proxy, why don't you have a conversation with her?'

PROF MONTGOMERY: Did you have a conversation with Amanda Sherlock about what was going to be covered and what you had said in that discussion?

MR JEFFERSON: I think it's possible it arose in a one-to-one, but I can't be absolutely sure.

PROF MONTGOMERY: So do you know whether she shared your expectations of what would happen in the registration process, for example? You've given a pretty clear picture that – of your expectation of the fact that that registration process would lead to something, whether it was conditions and you've communicated that to Katherine Hudson. Did you communicate that to Amanda Sherlock?

MR JEFFERSON: I can't imagine that I wouldn't have done. I mean, it was a very clear view in my mind.

PROF MONTGOMERY: And did Amanda Sherlock get a brief from you about what you had said to Katherine Hudson, did she...?

MR JEFFERSON: I think she did. I really can't recall.

PROF MONTGOMERY: And did you hear any more from Katherine Hudson after that?

MR JEFFERSON: No.

PROF MONTGOMERY: Thank you.

MR JEFFERSON: I think, to add, on very many issues, Amanda Sherlock and I were communicating by email; we were having monthly one-to-ones, which were not shared recordings – a shared recording didn't exist. I can't imagine that we wouldn't have rounded it off, but I can't stand here hand on heart and say, 'Definitely'. It seems inconceivable that we wouldn't.

PROF MONTGOMERY: There's a series of other people that you may or may not have had contact with, who have appeared in some of the discussions. For example, we know that Mr Titcombe suggested to the Health and Safety Executive that they spoke to you. Did they contact you at all?

MR JEFFERSON: I have no recollection of that, no.

PROF MONTGOMERY: And did you have any contact with board members of the CQC? We've seen suggestions that someone might have tried to contact you...?

MR JEFFERSON: I spoke to a board member of CQC long after I left, a couple of years after.

PROF MONTGOMERY: Can you tell us what you spoke about and what you said?

MR JEFFERSON: She just wanted to know my perceptions of the case, and I told her nothing that I haven't told you this afternoon.

PROF MONTGOMERY: Okay, that's helpful.

MR JEFFERSON: Kay Sheldon was the person.

PROF MONTGOMERY: Thank you. And I think the last thing I wanted to understand was the handover process when you retired. You told us about your farewell celebration and the very brief conversation you had then, but what was the process for handing your portfolio on to your successor?

MR JEFFERSON: It was an extremely rushed process. I mean, that's the first instance. I think it was around about 9 January that Regional Directors were told that there was the intention to reduce from nine to seven. I had never

made any – never given any doubt that I hadn't particularly wanted to join the CQC and would liked to have been made redundant then. The conversation I had with Amanda Sherlock at the point she notified me of the forthcoming announcement late in the day that there would be this change hinted that, if I wanted to go, then that would be the time that it would happen. It therefore – the right number of people wanted to go; other people didn't want to go, so there was no need for competition. It was expedited as quickly as it could be, went through the formal process and I waived every right that I had for further consideration, for other jobs and so on. And it was actually resolved, I think, in five weeks, with the formal notification.

I had a conversation with Amanda Sherlock about whether I should leave at the end of February or whether I should leave at the end of March. She suggested I stayed until the end of March, just in case – as part of the registration process – she needed a spare pair of hands. As I said, there were other changes at a lower level that were going to involve interviewing people, giving people new jobs and so on, and the view was that that should be done by the new Regional Director, who was already a Regional Director, a Yorkshire and Humberside Regional Director. My recollection was that we had a handover meeting, which basically covered some views of the people she would be working with and some information of the issues that were on the Regional Director's desk at that time, which included a discussion about Mr Titcombe – not a discussion about the Trust as a whole, but a discussion about Mr Titcombe's case. I think one of the issues in the northwest, is that I'd been, effectively, the regulatory lead for about 15 years. For 10 years, I'd actually been the Regional Director, and for five years previously, I'd been head of the informal regional inspection unit heads team.

Therefore, I think everybody, including Sue MacMillan recognised there was going to be quite a big change which was going to leave a gap for a number of staff who I'd worked with for many, many years, and we agreed that, rather than a slow handover, we would actually have a day where we said, 'From this day, Sue is the Regional Director', and it was left that, for the remaining five, six weeks, whatever it was, I would be available to her to have any discussions she wanted, and likewise, once I'd gone, would be. But we had a complete change. I became supernumerary, went on holiday

for two and a half weeks, had some other holiday, and virtually was not in the region at all.

PROF MONTGOMERY: So at that point, your expectation was there'd been a rigorous assessment of the applications that were just, at that stage, coming in?

MR JEFFERSON: Yes.

PROF MONTGOMERY: And that it was probably that Morecambe Bay would end up with some regulatory action?

MR JEFFERSON: Yes.

PROF MONTGOMERY: How would Sue MacMillan have known that that was your expectation?

MR JEFFERSON: She was aware of – in terms of discussing the Mr Titcombe issue – the main focus was – and I spent some time trying to close the matter down as far as his complaint was concerned, and the concern was that on many occasions, somebody new comes in and it all starts again. So some of that was in relation to that. But I'm pretty sure that in the process of that, there would have been a debate on the issues – some information about the issues arose. But the clear expectation was that Sue MacMillan would have comprehensive briefings from her six area managers, including Julia Denham, who was leading the registration process for the region and who was very familiar with the process, and who was a very experienced regulator.

PROF MONTGOMERY: Were there any other Trusts in your region who were likely to get registered with conditions, in your mind?

MR JEFFERSON: Advising from the annual health check, the North Cumbria Mental Health Trust had received the best possible use of resources rating, and the worst possible quality of service rating, so that was clearly an area of concern. There was one of the Manchester Trusts that was causing some difficulties; and there was, I think at the time, and unresolved issue around another one of the Manchester Trusts around some deaths in the theatre. So, there were – you know, a number of possibilities.

PROF MONTGOMERY: Thank you, and would you have had any discussions with Sue MacMillan about the conversation you had with Katherine Hudson and the Ombudsman's involvement?

MR JEFFERSON: No, again, by then, it appeared to be an issue that had been resolved. The conversation with the Ombudsman had been several months previously; the letter to Mr Titcombe had been a couple of months previously. The issue was, this has been something that involved the Regional Director more than would normally have been the case. You can count the number of individuals that I dealt with on one hand in that year, so it was exceptional from that point of view.

PROF MONTGOMERY: Thank you.

MR BROOKES: I just want to clarify a few things in my mind. I think we've covered quite a lot of the ground, but just a quickie first to start with: we mentioned the Fielding Report, which I absolutely understand you didn't see. Were you aware that the Trust had commissioned an additional external report into maternity services?

MR JEFFERSON: I don't think I was at the time.

MR BROOKES: Okay.

MR JEFFERSON: Again, this is sometimes getting the chronology right. I think I became aware of it after I'd left CQC, partly as a result of the Grant Thornton investigation.

MR BROOKES: Okay, so you weren't personally aware of it; you'd no idea whether or not Julia Denham or others were aware of it either?

MR JEFFERSON: No.

MR BROOKES: I'd like to just touch on the process of registration again, just so I've got it clear in my mind. I understand the role of the Assessor, I understand the role of Julia Denham. It's the bit in the middle, the central bit which I'm just wanting to be clear about. You mentioned [Lynn Hutchinson?] had come in and designed a process which you had had some sight of, certainly in the early stages. Was that process in your mind, systematic and rigorous as you had had it portrayed to you?

MR JEFFERSON: I think it had the potential to be. As you're probably aware, there had been almost a dress rehearsal in 2009 when the first part of the Health and Social Care Act had come into play. The NHS Trusts were registered in terms of their hygiene arrangements. Following the registration, which was a paper declaration exercise, there had been a series of inspections in the first year that had found very many instances where what had been declared was

not actually happening on the ground. That was in the organisational knowledge. Therefore, the expectation was that the investigation around what was declared would be much stronger than it had been and that there would be some activity by the Assessor, actually looking at things in the Trust.

MR BROOKES: So let's see if I've got this right: there would have been a series of forms, submissions that the Trust would make in – as evidence that it was compliant?

MR JEFFERSON: Compliant, yes.

MR BROOKES: It would be compliant, but that would be looked at both by the Assessor and with the inputs of the local – in this case, Julia Denham – and there would be assessment made centrally as well?

MR JEFFERSON: Yes, because as you're aware there was the huge amount of data that goes into Finsbury Tower which was the basis for the annual health check previously.

MR BROOKES: Yes, and that information would be transparent and open? What I'm – there's two things I'm trying to get – I'd like to understand if we step back and look at it, we would be able to see the logic of the decision that was made in terms of their qualification with the documentation they had got, which is one thing –

MR JEFFERSON: Yes.

MR BROOKES: And the other thing I'm just trying to get to the bottom of is, was it a robustly designed process which was poorly implemented, or was it a process with flaws that could naturally lead to an outcome which wasn't necessarily what you would've expected?

MR JEFFERSON: Yes. The answer to that really rests on the extent to which there was a – locally, the Assessors actually evaluated the centrally-collected evidence, and I just don't know what happened there. From my point of view, and – I can't imagine that if I hadn't become supernumerary and stood down, I wouldn't, by the end of February, have been having conversations with Julia Denham about, 'What do you mean, we're not thinking about putting conditions on Morecambe Bay, go look at it again', virtually. I just can't grasp that. But I wasn't in post; I didn't do that. I left the issue to the new, incoming Regional Director who had somebody there who knew all the issues only too

well, that was in a central position. I don't know whether she asked those questions or not.

PROF MONTGOMERY: Just to be clear, to answer my question, you left the post and handed it on, but you didn't specifically hand that question on to her in any sort of handover process?

MR JEFFERSON: No, as I said, the handover was the people she was working with and the issues that were on the Regional Director's desk, in the knowledge that she would have one-to-ones with her six staff who were responsible for 4,000 care services, 65 Trusts and 23 local authorities with a range of issues to resolve. It wouldn't have been practical, it would've been a handover that would've gone on for weeks.

MR BROOKES: From your understanding, and I accept it was earlier on in the process, but from your understanding of the process, though, that was going to be taken, was there any triangulation expected with other organisations? So, for example, was it just purely on the data that had been provided by the Trust and the information that was within CQC or was there a triangulation with the SHA, with Monitor or other organisations who might have relevant information about that organisation?

MR JEFFERSON: My understanding was – well, CQC had things called 'risk summits', and the Healthcare Commission had risk summits, which brought together and recorded a range of information from stakeholder organisations. That would have been taken into account. The expectation was that being taken into account was any complaints, any concerns that had been expressed. So it would've been an analysis of the full range of information that was available to CQC. In a world, though, where the systems were still very much developing, none of the IT systems were exceptionally – fit for purpose at the time –

MR BROOKES: So apart from paper evidence which might come from risk summits or other parts of other organisations as part of the data gathering, there wouldn't be a discussion saying. 'We're considering no qualification on this organisation'? What's your view?

MR JEFFERSON: As far as I know, Julia Denham was going down to London, having those discussions, and I think it's also worth saying that things like the

outcomes of risk summits were, as far as I knew, on the IT system. It wasn't paper evidence as such.

MR BROOKES: Thank you, and just one final thing from me, just for information. Am I right in assuming that a qualified Trust would not have gone forward for FT until that qualification was removed?

MR JEFFERSON: I think that's likely because a qualified Trust would not have been a 'Green' Trust. If Monitor chose to continue to say, 'We can only register a Trust if it has a "Green" organisational risk profile with CQC', then it wouldn't have done. My understanding is that the move to the 'Green' status came after the registration decision was made.

MR BROOKES: Thank you.

DR KIRKUP: Okay, there's a couple of references in the correspondence to the Ombudsman not having decided whether to investigate yet, which clearly positioned this as a significant decision in the CQC's scheme of things. What difference does the Ombudsman's decision to investigate Mr Titcombe's complaint or not, what difference does it make?

MR JEFFERSON: I think by the time we got to the end of the year, it didn't make a lot of difference at all. I think it was – just in terms of signing the thing off, if you like, it was an unresolved issue.

DR KIRKUP: It did seem to feature fairly prominently in correspondence earlier on in the year, around July and August? It seemed to be something that loomed as fairly significant in the CQC's –

MR JEFFERSON: I think that's probably true at that stage, because by then the outcome of some of the external evidence was still being evaluated and the Trust didn't produce the action plan that it didn't implement very quickly until August. Therefore, I think it was a bit more of an issue by then. But by the time I had a conversation – the final conversation with Kate Hudson towards the end of the year, then it was no longer of great significance other than it was something that hadn't been decided, which perhaps in the relation with Mr Titcombe was significant, because if – when Mr Titcombe learned that the Ombudsman wasn't going to pursue his complaint, then that clearly closed an area that, for his purposes, could have been very important in resolving the many questions that he had. I can remember him saying on one occasion in an email to me that he worked in the nuclear power industry and

the nuclear power industry would never get away with the sketchy investigations that the Trust had undertaken as far as he saw it. So he was looking for something with greater rigour, and it wasn't going to come from CQC because CQC had used the information it had provided in an appropriate way for a regulator.

DR KIRKUP: I want to come back briefly to the point about the Ombudsman's expectations of the outcome and CQC's expectations of the outcome. The Ombudsman, from their point of view, are being pretty clear, that they expect the CQC to undertake a robust process. 'Robust' is the word that's used?

MR JEFFERSON: Yes, and I can –

DR KIRKUP: Does that equate to, 'Probably put conditions on registration, and that will give us a handle to keep looking at them', is that a robust process?

MR JEFFERSON: The robust process would be a thorough investigation of the registration application.

DR KIRKUP: You say, 'Investigation', I'm not sure I understand –

MR JEFFERSON: Assessment, okay, assessment. And again, I think it's necessary to try and think the context we were in at the time. We were in the context where the powers to make a health authority were do something were very, very limited – to make a Trust do something were very, very limited. Once registration took place, there were very clear statutory powers to act. And the registration was the beginning of the process, so it would've been, as I said earlier, my assumption towards the end of the year, when I'd been assured this was going to be a very thorough process – and the evidence I was getting was supporting that – was this would be a thorough process, and that it would be followed up by some fairly rapid inspection activity of Trusts that weren't fully compliant. That would've been the start of the process of being able to test out this question that was in the back of my mind, is there stuff elsewhere in this organisation, have evidence of this at the moment, that we should be looking.

DR KIRKUP: What's your view of where that process went awry then? Because that clearly didn't happen?

MR JEFFERSON: [*After a short pause*] Well, I think one answer to that is that the process wasn't as rigorous as it was promised to be.

DR KIRKUP: Why not?

MR JEFFERSON: [*After a short pause*] I really can't answer that without speculating.

DR KIRKUP: You've had a fair amount of experience in the organisation and its forerunners. I would've thought you'd be pretty well placed to have a view about why that happened?

MR JEFFERSON: You could argue that we were weeks away from a General Election, I don't know but that might – given the position that the government had taken with the National Health Service to actually – to actually learn that a large number of Trusts were non-compliant with minimum standards would have been embarrassing, but at the end of the day I don't know. I was not part of that process; all I can say is that it started off with an expectation that it would be very rigorous. One of the things that reinforced that to me – coming behind the registration of the NHS Trusts, was the re-registration of 26,000 care services. The expectations that were being set in the last months I was there for that process, in terms of thoroughness were, in my view, completely unrealistic.

So, I was actually saying, as probably the only person in the organisation who'd actually seen the previous re-registration when the Care Standards Act came in, saying, 'You're not going to be able to achieve this, you should do this, that and the other'. So actually, I was arguing for a less rigorous process that was pragmatic and realistic for social care, where I had a great deal of experience. With that in mind, if they were wanting to be very, very thorough with social care, then it would have been – not a unreasonable expectation for me that their protestations of what they intended to do with 350-ish NHS Trusts would not be too difficult to achieve.

DR KIRKUP: In fact, there were quite a number of NHS Trusts which were registered with conditions, I can't remember the exact number, but it was something like 10 or 12%.

MR JEFFERSON: Yes, that information – the first I knew of that was – the Grant Thornton people told me that. The Grant Thornton people told me that on the actual cohort that Morecambe Bay was looked at, it was the only one that didn't have conditions. I don't know if that's true or not, but I found that astonishing.

DR KIRKUP: It doesn't quite fit with your previous explanation that there was pressure to have no Trusts registered?

MR JEFFERSON: Well, I don't know. I kind of wondered at the time whether it was politically influenced, but, like what I said: it's speculation. I don't know.

MR BROOKES: Just on that, I understand entirely where you were in terms of what you knew about the process. Have you talked to any of your regional colleagues, because they lived through the process of – there must have been a feel – or I would be surprised if there wasn't a feel in the organisation about the rigour, the engagement with the right people at the right level within the organisation who knew those organisations well? Was their input being valued? Was it something that had gone into a black box and the answers came out the other end? Was there any discussion like that? Did you get any impression what your colleagues felt?

MR JEFFERSON: I haven't spoken to any of my Regional Director colleagues since I left.

MR BROOKES: But during the February time, I accept you were on holiday for some of that, but some of that time, you were there for some of the time in the run-up to the end of March. Did you get any sense on that that they were being fully engaged in the process?

MR JEFFERSON: [*After a short pause*] I must have met with Sue MacMillan, but other than that, I didn't meet with any of them after I stood down. I stopped going to the national management meetings, and I didn't meet with any of them.

MR BROOKES: Okay.

DR KIRKUP: Anyone?

PROF FORSYTH: Just a final point: just going back to what we're here to investigate, something happened in a small hospital, a small Trust and a small hospital. We've been listening to a high level of organisations, CQC, Monitor, SHAs, etc. Do you think there was a time, particularly with all the changes going on, people just couldn't see the wood for the trees? They were actually missing what they were meant to be doing, and that is to ensure that healthcare is of satisfactory quality?

MR JEFFERSON: I think the problem, in my mind, is that the inherited systems from the Healthcare Commission that were based on making statements about compliance had been found to be wanting, which is why they had introduced the Health and Social Care Act. We were in a year when a new system was

being introduced that had not been clarified; we were in a year when a new organisation was trying to find its feet; we were in a setup where the monitoring of the Trust was undertaken by one person. The Trust that I'm a non-exec director at had an inspection in the summer that had 60 people at it, and that was for one of the smallest Trusts in the country. You know, the expectations were very, very different then, and the systems weren't fit. The first year of CQC was a process of trying to devise systems that were fit, in circumstances that didn't always help that happening.

PROF MONTGOMERY: Okay.

DR KIRKUP: Anything else you wanted to say to us?

MR JEFFERSON: I don't think so.

DR KIRKUP: Okay, thank you for coming.

(Meeting concluded)

THE MORECAMBE BAY INVESTIGATION

Friday, 28 November 2014

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

Before:

Dr Bill Kirk– Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Dr Geraldine Walters – Expert Adviser on Nursing

DR GEOFF JOLLIFFE

Transcript produced by Ubiqus
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(At 10.14 a.m.)

DR KIRKUP: Thank you. Hello and thank you for coming. My name's Bill Kirkup. I'm The Chairman of the Investigation. I'll ask my colleagues to introduce themselves to you.

DR WALTERS: I'm Geraldine Walters and I'm director of nursing and midwifery at King's College Hospital in London.

DR JOLLIFFE: Good morning.

DR WALTERS: Good morning.

MR BROOKES: And I'm Julian Brookes. I'm currently deputy chief operating officer for Public Health England, but was previously head of clinical quality of the Department of Health.

DR JOLLIFFE: Well, good morning and good luck.

MR BROOKES: Having our moments, yes.

DR KIRKUP: Don't mention Ebola.

MR BROOKES: Yeah, don't mention Ebola.

DR KIRKUP: You'll notice that we're recording proceedings.

DR JOLLIFFE: Yeah, that's fine.

DR KIRKUP: And we will produce an agreed record at the end. You may also know that we've opened interviews to family members as observers. As it happens, we don't have any here today –

DR JOLLIFFE: No one today.

DR KIRKUP: – but they may listen to the recordings.

DR JOLLIFFE: Yes, sure. Okay.

DR KIRKUP: You'll also know that we've asked you to hand in any mobile phone or laptop or recording device.

DR JOLLIFFE: Yeah, they've got the lot.

DR KIRKUP: Okay. That's just to reinforce we don't want anything to go outside the room until we're ready to produce the report with everything in context. Any questions?

DR JOLLIFFE: Okay. So I shouldn't discuss it at all?

DR KIRKUP: Exactly, yes. Quite so. Any questions from you about the process?

DR JOLLIFFE: No. It's only the piece of paper. Just I do it in every meeting normally, just if I can – if you're talking quickly I can scribble, just to remind me. As I said to Nick[?], I've got the attention span of a gnat, so I could

quickly forget.

DR KIRKUP: Okay, not a problem. Do please feel free. I'll start with a general question, and that is can you tell us when you started working in Cumbria and what have you done? What were your connections with Morecambe Bay?

DR JOLLIFFE: Sure. Well, I went to Barrow in 1982. I qualified in 81 and needed to do my GP training and I thought the Lake District would be a nice place to get a GP job, which it would be. Did my training in Barrow, 82 to 85, and then I took a job in Barrow because I fell in love with the place. It's a really nice place to live and work. It's not what you imagine and, you know, it's got some real gems about it, so stayed ever since. Took a job in general practice and I'm still in general practice, but I've slowly become involved in this type of work, commissioning, over a long span. I started in 1988 as medical adviser to South Cumbria Health Authority, which, of course, was in reorganisation to dissolve then, and then I was involved in Bay PCT, and then I went to Cumbria PCT, and I've worked my way through various, sort of, jobs like this.

DR KIRKUP: Okay. And are you involved in the clinical commissioning group now?

DR JOLLIFFE: So I'm now in – I'm the GP clinical lead for Barrow, so I work with a team of GPs and managers in Barrow, and I'm – that's a subset, a locality we call it, of Cumbria CCG. So I then go to the centre, I have some central responsibilities. So I sit on the GP leads executive committee if you like.

DR KIRKUP: Yeah. Okay, that's great. Thank you.

MR BROOKES: Thank you for that. So I just want to go through some of that in a little bit more detail. So you were a medical adviser to Cumbria PCT.

DR JOLLIFFE: Yes.

MR BROOKES: When was that?

DR JOLLIFFE: Well, I joined Cumbria PCT as it was formed, as – that would be – would it be 2006? Where are we now? Somewhere round there. So whenever it was formed I was approached to see if I wanted to become part of it, of the GP. And in those days we weren't official commissioners. We were attached to the PCT and –

MR BROOKES: So were you part of the PEC for example?

DR JOLLIFFE: I was part of the PEC, yes. So, absolutely, yes. I wasn't – Sue Page approached me, but it was the – I think they'd got some medical leadership in and then I was approached to see if I was interested to represent Barrow.

MR BROOKES: And what was your role?

DR JOLLIFFE: Principally to work for the good of Barrow and help with the commissioning decisions in Barrow, but also to then come together on the PEC to try and shape decisions from a clinical perspective that the PCT was trying to make. So in those days I think I didn't have a more specific – I have more specific roles, central roles, now, but in those days that was the key thing.

MR BROOKES: So you weren't leading on a particular clinical area, for example?

DR JOLLIFFE: We didn't work like that when we started. We're working like that now. So for instance now I lead on end of life care for Cumbria. I attend the health and wellbeing board. I sit on the governing body as a GP. So they'd be my key central roles now, but in those days there were only one or two people that had specific roles. There was a doctor who had a role around prescribing, Dr Rudman[?], and of course – and fairly early on we had a medical director in the form of Mike Buick[?], who had central roles, but the GP leads out in the periphery, the six GPs in the six localities, didn't have many specific central roles.

MR BROOKES: So was it your – I'm just trying to understand the role, because it's different in different places.

DR JOLLIFFE: It is, and it's changed.

MR BROOKES: And it's changed, yes. About that time I was director of commissions in a PCT, so – but it was different from what you've described, so I just want to be clear. So would you responsible to bring to the PCT clinical issues relating to your patch. Was that the role or was it –

DR JOLLIFFE: It's part of the role. I think a lot of the time we spent in the early days was around working – trying to work with the public and trying to work with our GP members, and trying to work with our local clinicians. Relationships were poor, you know, things were – there wasn't a lot of connection in the locality. GPs had got used to the days of local health groups and primary care groups, and I can't remember which one came first now but there was – but I was in both of those. And they'd liked that local touch, and a local person who they could deal with, and Barrow in Furness formed a natural community. That was the concept of having localities, So, you know, I don't know much about Carlisle or Whitehaven, but I know quite a lot about the people of Barrow, and

I know most of the GPs. I've grown up with them. I've worked with them. So the idea was to bring that local intelligence and connection. And that was my – the main thing I perceived.

MR BROOKES: You mentioned relationships were poor. The relationships between who were poor?

DR JOLLIFFE: I think relationships were poor between primary and secondary care, between commissioner and providers. I think within providers relationships were poor between managers and clinicians. The relationships were poor between different parts of Morecambe Bay. So Furness and Lancaster didn't particularly get on very well, and I still think it's an issue.

MR BROOKES: Didn't get on, the GP groups didn't get on?

DR JOLLIFFE: No, no, didn't get on with each other, you know. I think there was a key issue in the early days of Morecambe Bay that, you know, one of the key – the things which stood out before they were an FT were they were no good at cross Bay working. So a service fell down in Barrow, the clinicians from Lancaster wouldn't come and cover it. It was just, 'No'. And we had one clinician who famously would come as far as Ulverston, which, I don't know if you know where it is, but it's 10 miles away. They would do a clinic there, but they wouldn't come to Barrow to do a clinic. They would then drive to Barrow, do their dictation where the secretary was, and go back to Lancaster. And that's just a – that was just typical, so poor cross Bay working. The senior management didn't link with the senior doctors. In fact, there weren't many senior doctors giving real leadership in my view.

MR BROOKES: Okay. And you mentioned – you said that that was before FT. Was it – just to be clear, was – the trust came together before it became a foundation trust.

DR JOLLIFFE: Oh yes, yeah, yeah.

MR BROOKES: So did you see more cross Bay working then?

DR JOLLIFFE: No.

MR BROOKES: No.

DR JOLLIFFE: No. I saw very poor cross Bay working. We were asked this specific question by Monitor. We were – I was –

MR BROOKES: As part of the FT application?

DR JOLLIFFE: As part of the FT application I went with, I think – Sue Page was

definitely there, Nigel Maguire might have been there, I think John Ashton was probably there. It's a long time ago, but I think they were there and a couple of other people. And they asked whether we thought they should be an FT, and we unequivocally said no, because of those five reasons.

MR BROOKES: We're aware of that meeting. That would be quite interesting to hear your views. So you were very clear?

DR JOLLIFFE: We were very clear. They weren't fit to be an FT. And actually I'm very clear that when they became an FT I think they became worse. Sorry, in their application and their pursuit of being an FT I think things deteriorated a lot.

MR BROOKES: So the formal recommendation from the PCT, because that would be the group, you were there as part of your advisory role for the PCT –

DR JOLLIFFE: Yes, I was.

MR BROOKES: – at that time, to Monitor was it wasn't fit to be a foundation trust.

DR JOLLIFFE: Absolutely.

MR BROOKES: And on what grounds was that?

DR JOLLIFFE: The grounds were the cross Bay working wasn't any good, the clinical leadership wasn't any good, the linking of the clinicians with the managers wasn't any good, there was very poor working with the commissioners. And we'd tried very hard in those first couple of years – I was very naïve as a commissioner. Maybe experienced as a GP but naïve, but I tried very hard to make relationships and it was difficult. And I don't think they worked with the public. I think they were the five things that I certainly remember saying.

MR BROOKES: Okay. Were you involved in any discussions in that capacity with the Strategic Health Authority about their foundation trust –

DR JOLLIFFE: I was. Well, no, no, not about their FT application, no, but I was about the general state of healthcare in Barrow and Cumbria.

MR BROOKES: Okay. Could you just summarise? Could you just tell us about that? That would be really helpful.

DR JOLLIFFE: I went to the SHA, I think, on three occasions in Manchester in probably the first three years, probably. I might have been the year after. It might have been seven, eight and nine. It could have been six, seven, eight. I'm not sure, but I went three times because we had very much bigger

problems than what's emerged now. We had specific problems around North Cumbria. North Cumbria is in a mess now and was in a mess then, and we're overspending to the tune of 30 million. And every year the SHA said, 'Just give them the money', and every year that just blew a hole in our – that was our spare money to do everything. And I, from Barrow, went to plead the case that Barrow – I said – you know. I did get a bit emotional, but I said something like, 'It'll be people bleeding on the streets before you and the SHA do anything about this'. I said, 'We need investment in Barrow now'.

MR BROOKES: Okay.

DR JOLLIFFE: And basically the whole thing is the hospital struggles because of lack of primary care investment. Primary care investment is very low in Barrow. We have the lowest – we've got the lowest investment of any area of Cumbria and it was true then, it's true now. And I said, 'Unless you' – 'If you keep on that 30 million into North Cumbria, it's going to keep shoring up a rotten regime, when actually it needs terminating and sorting out. And I think that's proved – I think the case has been proven since. I said, 'And that 30 million would buy oodles of primary and community services in Barrow, and prop up Morecambe Bay', but wasn't in the same problems, in my view, at that stage.

MR BROOKES: So just so I understand, so for two or three commissioning rounds your commissioning plans originally would not have included the kinds of investments in North Cumbria that were required?

DR JOLLIFFE: No, but every year we were told by SHA to put the money in.

MR BROOKES: Okay. Who at the SHA would you meet with?

DR JOLLIFFE: Well, certainly Mike ~~Farrah~~Farrar [Dr Joliffe spelt this Farragher] ~~Farrow~~ was there, and a chap called ~~[Mark Hodgin?]~~ Mark Ogden?, who I think was in finance. And there usually would be the representatives from the – there was the representatives from the trust on one occasion, the North Cumbria trust were there, and I think representatives from Morecambe Bay were there at at least one of the meetings. I can't –

MR BROOKES: So it would be a meeting led by Mike Farrow at the SHA?

DR JOLLIFFE: Yes.

MR BROOKES: So he was at all of those meetings?

DR JOLLIFFE: Yeah, and he subsequently came to the PEC, subsequently,

because – after we'd made our point, and I made the point to him again about the – at the PEC I said, 'You can't keep doing this'. I said, 'You've got to find a different way. You can't keep propping up North Cumbria. You're not achieving anything'. Because all they were doing was supporting bad habits, because every year North Cumbria thought, 'Don't have to change because we'll get 30 million again', and they did. And our view – and Sue Page held out quite firmly for it, but we got instructed to pay, so she held out for us not to pay it.

MR BROOKES: Okay. So moving back from that, in terms of the commissioning within the PCT at that time , what was the plans for maternity services?

DR JOLLIFFE: I don't really know. Don't really know.

MR BROOKES: You weren't involved in that?

DR JOLLIFFE: I weren't – I wasn't involved. It wasn't on my radar. I mean, I didn't have a special role, and I think – public health was with us then, and I think it was with them. So probably someone like John Ashton would be able to describe better, but, I'm sorry, I don't know.

MR BROOKES: Okay. So you don't recall discussions at PEC, for example, around midwifery services, any changes to commissioning models, things like that?

DR JOLLIFFE: I don't recall anything – were there any alerts or any worries?

MR BROOKES: No, I'm not thinking about alerts as such.

DR JOLLIFFE: Just if we were changing things?

MR BROOKES: Yes, the – Sue, for example, when she was talking to us, was talking about, you know looking at wider plans in terms of thinking about maternity services across Cumbria and, you know, were they sustainable in their current forms etc. Is that something that came through the PEC that you're aware of?

DR JOLLIFFE: Well, of course we're doing it now. I don't remember any specifics of that to be honest, no.

MR BROOKES: Okay.

DR JOLLIFFE: No, sorry.

MR BROOKES: No, that's –

DR JOLLIFFE: It might have happened, but I just don't remember.

MR BROOKES: That's fine. It's a few years ago.

DR JOLLIFFE: It wasn't a priority. The priorities were massive overspend on the

budget generally. We were heading for a massive predicted budget overspend in the whole of Cumbria. The north Cumbria thing – and of course we had people marching on the streets in Kendal in the early days. There were changes to the hospital there, and again I wasn't involved in that, because I don't work in South Lakes, but that was a big issue. So there were some really hot issues, and there were hot issues in Barrow like we had major problems with outpatients, problems with cardiology, rheumatology, stuff like that in the hospital.

And nobody – one of my jobs was to go round and speak to all GPs, and the standard questions were, 'Have you got any concerns about the partnership trust' – that commissioned mental health at the time – 'about community services?' – which was the PCT then – 'Have you got any concerns about the hospital?' And we got a lot of soft intelligence and it was always the same things. It was always communication's poor, outpatients is atrocious in general, rheumatology and cardiology are the specialisms that are in trouble. Never once did anyone say, 'I'm concerned about maternity', which is why, as an individual, I was caught really hopping by this, knew nothing.

MR BROOKES: Okay. And that's really interesting. I just wanted you to pursue that a little bit. So from you as a practising clinician, GP in that area, you weren't hearing anything bad from your mums in terms of –

DR JOLLIFFE: No, in fact, and right through and up to now they keep reporting really good experiences. In fact, my wife had a baby there three months ago. It was fantastic.

MR BROOKES: Congratulations.

DR JOLLIFFE: It was, it was fantastic. I know I'm an old guy, but, you know, we had another baby. And none of my patients reported anything at all. I don't believe any of my patients are part of the families that have had problems, but I still get – know a lot of people in Barrow, and I know a lot of the GPs, and I've met with a lot of them formally, and nobody reported anything.

MR BROOKES: Okay. So when did you become aware of issues being raised and concerns being raised around maternity services at Barrow.

DR JOLLIFFE: I think it was when James Titcombe started to raise his – after his inquest with the coroner. And I know the coroner quite well.

MR BROOKES: Where were you in the system at that time, in terms of

commissioning roles or advisory roles?

DR JOLLIFFE: I was working as a GP three days a week. I was working in the locality lead for two days a week and I was – I'm not sure if it was still called the PEC at that point, because the body changed its name several times. I think it might have moved on, but it was at that time when James Titcombe had raised the issues. It had come up in the press. It had come up through the coroners' courts, and that's how I became aware of it, not from Morecambe Bay.

MR BROOKES: And what – were you aware of any discussions or were you involved in any discussions within the PCT at the time about all the issues that were being raised by James Titcombe?

DR JOLLIFFE: I was involved a little bit in the gold command. I stood – I think I was on one or two calls, right at the very beginning, but actually that was delegated to other people, and it – once it was set up it became too big and I think – I suspect Dr Boardman, I think, who's a GP from Barrow as well, who has special responsibility now around children and children's services in Cumbria. I think she was involved. And I think Mike Bewick ~~Buick~~ was involved, John Ashton, people like that. So I – but I was involved in one or two preliminary discussions in the gold command.

MR BROOKES: So once the information came in to – sort of, relatively well-known through the issues etc, did you talk with your colleagues locally about whether or not they were seeing issues now?

DR JOLLIFFE: I did.

MR BROOKES: And what was their view?

DR JOLLIFFE: No.

MR BROOKES: Okay.

DR JOLLIFFE: None of the GPs still reported any problems. None of the GPs had any experience of patients – you know, which is a bit shocking, but that's why we were – you know. There were lots of things that they were reporting, but that wasn't one of them.

MR BROOKES: Okay. So again, just for completeness in my mind, so the picture as being perceived from primary care was that it was a good service, it was meeting the needs of your patients.

DR JOLLIFFE: Yeah.

MR BROOKES: And there was no major concerns about it?

DR JOLLIFFE: No. No, there wasn't. And that's the worry, because how do I spot the next time something like this happens? You know, I'm really concerned. I mean, I want to see this inquiry come out with some good recommendations, but I'm really concerned how do I spot something that's hidden.

MR BROOKES: Yes.

DR JOLLIFFE: And I sense, and I don't know, and it's your job, not mine, but I sense that there was an element of this being hidden, and that's some of the innuendo, some of the conversations I have with people who are more closely associated, who have worked in the unit.

MR BROOKES: Okay. And as you're – with your medical advisory hat on, from a commissioners point of view, until later on when it was becoming widely known there were problems with maternity services, nothing came to you through the PCT saying, 'We've got concerns about...', or, 'We're beginning to hear concerns', or 'Evidence we're collecting in terms of' –

DR JOLLIFFE: I think the evidence, a lot of the time, showed that Furness was performing well. You know, I didn't make it a focus or a study, but I think actually Furness performed better than Lancaster, you know, if you looked at various statistics. Now, I may be wrong but I think I'm right. I say that because it wasn't my main business.

MR BROOKES: I understand.

DR JOLLIFFE: But I think things passed by me on the periphery and I guess public health were probably more in charge of that data then, but I think they were doing quite well overall mostly.

MR BROOKES: Did the PEC have any involvement in reviewing lessons learnt from serious untoward incidents?

DR JOLLIFFE: With regard to maternity?

MR BROOKES: Anything. No, I mean generally. So if there had been a serious untoward incident in one of the hospitals within your area, did that automatically or routinely go to the PEC?

DR JOLLIFFE: It wouldn't be a routine business matter, no, but I think there were things where lessons were learned, would come to the PEC. I'm trying to think of examples.

MR BROOKES: Okay. Did any of the maternity serious untoward incidents come to

the PEC that you're aware of?

DR JOLLIFFE: I didn't recall that. No, not at all.

MR BROOKES: Okay. Okay. I want to ask some questions about now. Is there anything – shall I stop now or do you –

DR KIRKUP: No, you carry on I think.

DR WALTERS: Yeah.

MR BROOKES: Okay, thank you. So we're now in a slightly different system. We have CCGs.

DR JOLLIFFE: Yeah.

MR BROOKES: Could you just explain your role now and also how CCGs are approaching maternity services.

DR JOLLIFFE: Okay. Well, we're obviously very concerned about maternity services and we're concerned to make sure things are put right. Several things are happening at the moment. You know, I think we recognised – you know, I think everyone has got a sense of, 'What could we have done that's better?' And I still don't have the answer to how I can pick up that soft intelligence. That's the one I'm stuck on, but in terms of doing things in a more systematic way, we now have a commissioning team dedicated to maternity, led by Eleanor Hodgson. We now have a maternity dashboard, which details most of the data which I think is relevant. I haven't seen maternity dashboards from other parts of the country, so I don't know how it compares, but that's not my special area of interest, but presumably they've done that. The only thing that I note that isn't on there, and it probably shouldn't be but it helped[?] elsewhere, are the neonatal problems, the data about neonatal problems and deaths, but that's held in separate database register, which I think public health lead on, which is now in the council of course. But I think they share that with us and we have a quality group that looks at that. So I think there's a more formal structure centrally.

Locally, in Barrow, we have formed a new maternity services liaison committee. It's called Maternity Matters. It's got parents on, it's got a councillor on who has an interest in this, Mandy Telford, and it's got a GP on from Barrow, Lauren Dixon[0:24:01.4?], who has special interest in paediatrics and maternity. So those are things that are very much better, I think, at the moment. At the moment I don't think it's showing any cause for concern

anywhere at the moment. I think the activity at the moment – unless I'm wrong, I think the activity at the moment is showing that things are within the normal range, you know, stillbirths etc.

MR BROOKES: So if I was to ask the same question I asked you before, so how would you deal with or become aware of serious untoward incidents?

DR JOLLIFFE: It would now go to the – well, I wouldn't necessarily become aware of every single one.

MR BROOKES: But as a CCG or as the commissioners –

DR JOLLIFFE: But as the CCG that would – we now have a medical director, Dave Rogers, who leads on quality and the quality group. He attends quality meetings for all the providers and they would be considered there and he would hold, you know, the ring on that really. He'd be in charge of that, and then I would become involved if I needed to be, from a Furness led committee perspective. From a maternity perspective, I wouldn't become involved particularly. It would become Dr Boardman, who I mentioned before. That would be her, I think.

MR BROOKES: So are you aware of any serious untoward incidents recently in the trust.

DR JOLLIFFE: There have been some. I can't report the details.

MR BROOKES: But you're aware of –

DR JOLLIFFE: Yes, I'm aware there have been some, yes.

MR BROOKES: Okay. So that is being fed routinely into you as a [inaudible]?

DR JOLLIFFE: Yeah. It's not my central business, maybe you'd say it should be or not, but it is being dealt with by somebody, and I'm aware there have been some. You know, there was a baby death the day my baby was born.

MR BROOKES: Yeah. Okay. So I just want to understand, as commissioners – so this is not you as an individual, this is collectively as commissioners – what your plans are for maternity services in Barrow and across Morecambe Bay.

DR JOLLIFFE: Well, of course it's a very emotional subject for all of us, and it's part of the Better Care Together review, which you will have heard of, and I'm sure you... Our view – in Furness to start with, and then I can extrapolate to Cumbria – our view in Furness is that a small unit can never be quite as safe as a big unit in a university hospital. We know that. The statistics – you know, and the Royal College says that. But, our view is when you factor in the

danger of the journey, and we're not necessarily talking of a journey just to Lancaster, we're probably talking about a journey to somewhere like Preston if you want to get somewhere particularly better, or – you know. Once you factor in the difficulty of the journey, that risk is mitigated.

So if you put our small unit right in the centre of Manchester or Liverpool, next to Liverpool Women's Hospital, for instance, I think with the same population we'd probably get slightly worse results. Not massively worse, but slightly worse results. But once you factor in that journey you don't. This is a road that takes well over an hour just to get to Lancaster, an hour and a half to Preston, a road that gets closed in Winter by bad weather, a road that gets closed with accidents at least once a month. When people die they just shut the road for hours on end. It's not safe. And indeed David Nicholson himself came to Barrow, and he drove from Lancaster, and he met me and he said, 'I wouldn't put my daughter in the back of an ambulance from Barrow to Lancaster, having done that journey', and he's right. I wouldn't. So our view as a commissioner is we have to accept that it's not a perfect solution, but it's not safe not to have a consultant led maternity unit in Barrow.

Subsequent to that, there have been issues in – exactly the same issues in Whitehaven. The issue in the South is easy, because the trust believe they can deliver a safe service, once they put in all the measures to correct the problems they've found, and I think they have taken a lot of actions. The trust in the North are not prepared to even go there, so at the moment there's a bit of a stand-off. So the trust in North Cumbria's saying, 'We're not going to deliver maternity'. The population's up in arms, and so we've commissioned an external review by Dr Faulkner ~~Forgma[?]~~, who was the leader of the Royal College of Obstetricians. He's currently just done the review. We've all met with him and he's going to go away and think about what recommendations he can make. So we're taking external advice on it, but our commissioning position is unless it's impossible to do at the moment we believe we should commission services in Whitehaven and in Barrow.

MR BROOKES: So that review, just to be clear, is about North Cumbria?

DR JOLLIFFE: No, it's about the whole of Cumbria. The reason it came in, you might argue, is because of North Cumbria, because in the South commissioner and provider are agreed: 'Let's sort the problems out, let's make

it better, let's continue to deliver service', and we're agreed on that. Because the North have not agreed with that we've had to bring in a review, but we've had to make it for the whole of Cumbria and [inaudible]

MR BROOKES: So, I'm putting my old hat on here, there is a willingness certainly within Morecambe Bay to invest in the service, in maternity service, to make it safe, as you say.

DR JOLLIFFE: Yes.

MR BROOKES: That comes at a cost.

DR JOLLIFFE: It does.

MR BROOKES: And as commissioners are you aware of that cost, and how is that cost going to be met?

DR JOLLIFFE: Well, it's never been costed other than on the back of a fag packet, as far as I know, but I think the costs aren't a million miles out, and I think we're looking at a few million pounds.

MR BROOKES: So if it's £23 million?

DR JOLLIFFE: Just for maternity?

MR BROOKES: Yeah.

DR JOLLIFFE: It won't be. I'm pretty sure – that goes right back to Tony Halsall's days, when we discussed this, and he would point out that it wasn't sustainable on PbR, and I think present management would agree it's somewhere in low millions. The money, to me, isn't the issue. I think what we have to do as commissioners is find that money, and we have to make the savings elsewhere. And I've been very clear on that in Better Care Together. I've been clear on that to the GPs and the clinicians in Lancaster, and to Barrow, and I'm supported on that by the CCG centrally in Barrow, who recognise there's a cost for that and we should meet that and we should make savings elsewhere. There's lots of savings to be made in the NHS, in my belief. There's massive waste, massive waste in prescribing

MR BROOKES: But there is always a tipping point between what is affordable as commissioners and what isn't affordable.

DR JOLLIFFE: Is there a point, you mean?

MR BROOKES: Yes. There always is.

DR JOLLIFFE: Well, yes, I'm sure if it was 20 million we couldn't do it, but I'm sure if it's 3 or 4 million I think we could, and that's where I believe the cost is.

MR BROOKES: But that is not something that you're aware of as being as an explicit discussion at the moment with the commissioners that you've been engaged with?

DR JOLLIFFE: I'm not aware of someone costing it out, and we haven't had a discussion about where the tipping point is, because at the moment we are – we start from the point of what is right for the population.

MR BROOKES: I understand.

DR JOLLIFFE: We're always starting from that and as GPs we're probably a pain in the arse because the managers probably want to say, well, 'Start from the point of what can we afford', and so that's where the balance is, but at the moment we start from the point of what is right for the population, what's safe. We're not going to commission something that's not safe, and I think the population of Barrow would be at risk if they didn't have a maternity service, you know.

MR BROOKES: Thank you.

DR JOLLIFFE: And there's other risks as well, which may not interest you. They're not clinical, but there's risk to the town and to the industry. You know, we have an industry of national strategic importance in building submarines for the nation. And we're world class at that and the population – that is the number one employer in Barrow, and they have trouble recruiting people. And if they don't have a health service in Barrow they won't be able to recruit people. They're very clear on that. They have surveys of people who don't take jobs, turn down jobs, and health is one of the top three issues, and the current concern over maternity, you know, is in the national press, so it comes up. So we will have major problems, not just about recruiting consultants and making the governance right.

MR BROOKES: I understand. So, in summary for that, the commissioning position, see if I'm right, is the continuation of a safe maternity service at Barrow and –

DR JOLLIFFE: Yes. If we can't deliver a safe service then that opens a new question. If the ~~-~~Faulkner ~~Forgma~~ review said, 'You cannot do it under any circumstances' then we have to revisit that, but our position at the moment is we believe we can and the trust believe they can and I think a lot of it is about getting the governance right, getting attitudes and behaviours right, getting training right, and them we've got the big issue of recruitment and retention.

And I think the money, to me, is the least of the problems.

MR BROOKES: Okay. And just one final question from me, again your soft intelligence in terms of what GPs are telling you and we'll come – it's actually two questions. I'll come back to what you mentioned before.

DR JOLLIFFE: Okay.

MR BROOKES: Is that – what is that telling you about the service at the moment?

DR JOLLIFFE: At the moment? We've still got major problems, but we're not quite where we were before. I think we've got – we've still got problems around the hospital is jammed. It's over – it's not a local story this, is it? It's a national story, but the hospital is too full of people that shouldn't be in there. They're in for too long and they're getting things done to them that they shouldn't get done to, you know, and acquiring problems because they're in hospital when they shouldn't be. So, you know, it's in the Five Year Forward View isn't it, and it's probably in every CCGs plan to reduce hospital activity, and that's a major problem.

We still have problems with individual departments. Paediatrics isn't strong in Barrow. Rheumatology isn't strong still, so that's 25 years now with Rheumatology. We still have too many locums filling posts, still can't recruit, so we've got locums in respiratory and cardiology and the like. Actually recruitment to obstetrics is actually quite strong in comparison. We've got real – I think the SCBU and the maternity unit are at the moment running a little bit on a knife edge, because you probably know at one point, post all this, the SCBU nearly closed down and was transferred to... And then, you know, there was... And I think that was bad planning by Morecambe Bay because they just planned to do it and there wasn't much discussion with commissioners. And basically what they were doing was protecting their organisation, reducing their risk, and transferring the risk to population and the ambulance service.

Having managed to rescue that, and that was a – I don't know if that was a gold command or what you call a silver command or whatever, but there was a fairly major involvement of the area team and the regions and the like and that was rescued. So, you know, recruitment to SCBU is really a bit on a knife edge. You know, recruitment and morale, I think, in midwives is still not good in Furness, so there are risks bubbling under the surface.

MR BROOKES: Okay. And really final question, in terms of the old system as it was when these incidents were happening, you've described a relationship around commissioning with the Strategic Health Authority.

DR JOLLIFFE: Yeah.

MR BROOKES: What was the role around – or what were your discussions about, where there were clinical concerns about services, was that a proactive discussion?

DR JOLLIFFE: With the SHA?

MR BROOKES: Yes.

DR JOLLIFFE: Well, I wasn't particularly involved in that. The meetings I went to were specifically around the funding of North Cumbria and how it was robbing Barrow. That was the main one. I think if anything you could say, as an individual, I probably would now do things quite differently and I would escalate things a lot quicker. I've learnt that.

MR BROOKES: Okay. Thank you.

DR KIRKUP: Thanks. Geraldine?

DR WALTERS: I'm probably repeating some of the questions here.

DR JOLLIFFE: That's okay.

DR WALTERS: But let's just stay on commissioning for a bit. So what in your view, and I'm sorry if you feel you've answered this before, perhaps I'm just asking it in a different way, what in your view is required to make the unit safe? So you've sort of alluded to cost, and...

DR JOLLIFFE: I think you've got to look at the whole system. I don't think this problem has emerged in isolation of everything in the system being right. I think this problem – I don't understand the problem completely, and you have a lot more insight into that, but I believe that this problem is like a pressure cooker blowing at some point. It's blown in maternity. It could equally blow somewhere else in the system, and that could have been the major focus of an investigation. And there have been other problems. You know, I've mentioned cardiology before, you know, and the outpatients. So I think the problem has emerged over several years.

I think some of the determinants of it are the fact that you've got a system of PbR that isn't fit for purpose. I can't – you know, you wonder where the money's coming from, the 4 million that I say we might need. The PbR

supports this population which elsewhere would have one district general hospital, but because of our geography we have three. We've got a trust that provides – I do feel sorry for them, you know. I don't blame the trust in this respect. I think they're fighting impossible odds. They're trying to run three services in three towns which are needed. You can't run a district general hospital in Lancaster and expect the whole population of Barrow to travel. That's just not reasonable or safe. So they've got an impossible job, PbR's difficult I think. I think commissioners have got a difficult job because we've then got that budget and how do we make the priorities, and then we're in a system where an SHA was controlling us, not allowing us to actually make our own decisions. So I think you had that boiling.

You've then got the second problem, which is not money but is actually recruitment and retention to Cumbria. It's difficult in the health service generally, it's difficult in general practice, it's difficult in the hospital service. It's difficult to industry. I don't understand this, other than I think there's a natural change in – you know, when I was a kid I grew up and I wanted to get out to Scotland and be a GP, a rural GP. No one wants to do that now. I could pick up a rural GP's job in Scotland tomorrow, which I know isn't going to interest you, but the young GPs are different. They don't want to work full time; they don't want a partnership job. They want a salaried job. They want to live in the suburbs. They want to be near to Manchester or Liverpool or London, so – and the same is true for hospital consultants.

So once you've got that you've got a bit of a melting pot, because you need – you know, for obstetrics you need your midwives and your obs consultants and your anaesthetists and your, you know, intensive care occasionally. So you need all these other facilities, so it's part of that whole system that is failing, and it's – some of it is borne outside of Morecambe Bay.

DR WALTERS: But then you – but you've talked about this, what you think is a moderate 4 million which would put it right, so what would you spend that on to put it right? What is going to make –

DR JOLLIFFE: Well, you need more manpower for a sustainable rota, don't you? You can't run a rota on three or four consultants.

DR WALTERS: So how are you going to – so that 4 million is about just having more posts, is it?

DR JOLLIFFE: I think a lot of it is, yeah.

DR WALTERS: So what else –

DR JOLLIFFE: I don't think the facilities are dire at Furness General. I think they could be modernised, and there have been plans, and there have been plans to modernise that right back to 2006. I was involved in discussions with somebody called [Steve Vaughan ~~Vaughn?~~], who was director of ops I think, and he showed me plans right back in 2006 about moving the labour ward, moving a theatre close to the labour ward, because you know that's one of the things that came out of various reports. So they – even before this blew they had plans and we shared plans. They said, 'What do you think about that', and some of them suited me because actually I was trying to modernise the front door of A&E. I wasn't interested in maternity, but moving a bit of maternity I got more space for GPs at the front door. So it all – so we had those discussions quite a while ago, so there's a bit of modernising the estate, but that's a one off capital cost. But the long term costs would be – I think would be in manpower.

DR WALTERS: But if you can't recruit them?

DR JOLLIFFE: If we can't recruit them we've got a problem about fulfilling our commissioning intentions.

DR WALTERS: So then what do you do?

DR JOLLIFFE: Don't know yet.

DR WALTERS: Because that's likely, isn't it, because –

DR JOLLIFFE: Well, I think there are ways round this, and, you know there's an N in the National Health Service. And I think part of the solution is I think people right in the centre need to have the balls to actually say, 'We need to support remote communities and rural communities'. So, you know, it's a National Health Service, there should be regional powers developing the manpower and redistributing the manpower, you know. I'm quite a fan of a franchise model.

Now, I know Morecambe Bay have gone part of the way and they're working with a partner, want to work with partners. I actually think the big university centres should actually partner up with us and support us. It should be part of job rotations that people work in places like Barrow, and if they don't like it, tough. That should be the new contract. And it shouldn't be just about

what suits doctors. It's about – it should be about what suits the population of this country. That's what we're here to serve. They're the people that pay for us. That's what we should be doing.

DR WALTERS: What can GPs do to manage the risk better?

DR JOLLIFFE: GPs as in their surgeries or GPs as commissioners?

DR WALTERS: In their role – both.

DR JOLLIFFE: To manage the risk.

DR WALTERS: Because you said – so we've heard in the past some interviewees saying, you know, 'We knew that actually the rotas weren't good enough for neonatologists or obstetricians, not quite enough midwives, but there had to be service in Barrow'. The previous chief executive wrote to say, 'Actually the tariff doesn't cover the service' So we have to cross-subsidise it'.

DR JOLLIFFE: It doesn't, no. Yeah.

DR WALTERS: But there seems to have been then this collusion about 'But there's got to be a service in Barrow', even though we're not acknowledging that we actually haven't sorted out or are managing the risk. What would be your view of that?

DR JOLLIFFE: No, I don't think we want to commission a service that's not safe in the future. I think we desperately want to find a solution that is safe but is a service that's commissioned in Barrow. And I think franchise is one possibility and, you know, there are 40, I think, hospitals of similar size to Barrow providing consultant led maternity services in the UK. A lot of them are in Scotland, Wales and in other rural places, but there's about 40. We've identified that in our Better Care Together programme.

And so it's not about finding a solution for Barrow; it's about finding a solution for the whole of England and Wales and Scotland, and that requires some central action. It doesn't – I can't solve that on my own as commissioner, but I'm going to try and do my bit. I think what we won't do is commission something that isn't safe, but we will campaign and promote trying to get a safe service. I mean, we did know that paediatrics in those days wasn't as strong as it should be, not so much around neonatology, just about – just around the consultant workforce generally, and there have been changes.

As an individual GP in my practice, I'm not sure what I can do, other than I do think all GPs have a duty, and I think it's clearly defined by the GMC

actually, to take part in commissioning. And I take that to mean for them to pass information on to me if they know something's going on that's wrong. And they – some of them do.

DR WALTERS: Do you think GPs have got a good understanding of what a high risk pregnancy is?

DR JOLLIFFE: I think we've got much less contact with maternity services now, and I regret that because I love that part of my job, but it was clearly removed from us. And you might say for good reason, I don't know, but I enjoyed it, but now we have – you know, we see the pregnant lady, you know, when she first presents mostly and we refer that patient on. We take action over things like management of medication and management of chronic diseases associated with that, and that's part of the high risk, you know, so the diabetics, the ladies with significant mental health problems. So we deal with that and we refer that, but then we don't see much of the patient until they've had the baby.

DR WALTERS: So those –

DR JOLLIFFE: So the answer is we're not –

DR WALTERS: Would you refer those somewhere else, not to Barrow?

DR JOLLIFFE: What we would normally do is refer to Barrow and expect Barrow to refer on.

DR WALTERS: Would you notice if they hadn't done that? Would you think 'Mmm, there's somebody there' –

DR JOLLIFFE: Would I question what a consultant does? I certainly would, and I think that's one of the ways that I think that, sort of, I've grown up and both in the job as a commissioner and as a GP. And we get rubbish from consultants sometimes. I have to say, not noticeably from obstetricians, which I know is your concern, but we get absolute rubbish from consultants, mostly the locums, but sometimes – we used to get rubbish from the paediatricians. There's a strong band of us now who would not take notice necessarily. We wouldn't prescribe just because we were told, we wouldn't – you know, we wouldn't accept what they were doing and we would question it. And certainly in other specialties there's a lot of referral outside the area.

DR WALTERS: So in your role as commissioners now, are you doing any work to look at how high risk pregnancies might be identified and dealt with?

DR JOLLIFFE: The central team might be. I'm not doing it.

DR WALTERS: Right.

DR JOLLIFFE: So I couldn't answer that, yeah.

DR WALTERS: Right.

DR JOLLIFFE: I think there is a concept in my head, which I would accept, and this goes for high risk babies and high risk pregnancies, whether the risk is to mother or child in other words, and I think if we commission a service in Barrow – I mean, we've often looked at the model in Scotland. And women get flown in from the Shetlands and the Orkneys to Aberdeen, and from Oban to Inverness, and then sometimes on from Inverness on to Aberdeen. And I think you have to – I think the population has to accept, and I think they will accept and do accept, that when you've got a high risk situation, you know, they may need to be transferred out while they're still pregnant, you know.

And I think that's accepted, and I don't think that goes against our general commissioning intention, but if you transfer everybody out you'd be looking at at least one whole new ambulance constantly. We've only got two ambulances in Barrow, which are all fully occupied for the 100,000 population in the peninsula, you know. If we were trying to do the maternity as well we'd have to have at least a whole new ambulance, possibly two, you know.

DR WALTERS: So if you had to sum up to somebody who didn't know about this whole incident at all in two or three minutes, what would you say? What's your take on the natural history of how it has happened?

DR JOLLIFFE: I think it has been borne out of problems in the system, some of them nationally defined, like the tariff, and the pressure, and it's been borne out – the pressure to become an FT. I think that was overwhelming the whole relationship between us as commissioners and the trust. Once they got the nod that they were going to become an FT things got demonstrably worse in terms of relations and contact. And then I think something happened, and I don't know what that is, but I think there were individuals where things were going wrong and it was kept quiet. It was kept quiet from people in the hospital, it was kept quiet from us commissioners. I'm not clear that senior management knew about it.

DR WALTERS: So you say – you alluded to this innuendo.

DR JOLLIFFE: Yes.

DR WALTERS: Obviously you don't want to betray any confidences, but can you

give us some insight into that?

DR JOLLIFFE: Well, there are several people who I know as patients who have worked in the unit, and the innuendo is that there was a – something going on there, that people knew about it but it was being contained. And that's not what I've read in the press or anything else, that's what I've heard from these people.

DR WALTERS: And how long ago does that go back?

DR JOLLIFFE: I think it goes back probably for when – as long as I was a commissioner, yeah, because there are people who've retired from the unit before this happened who say there were problems in the unit, so it was probably brewing for, I think, some time.

DR KIRKUP: Can you put a year on that? Just roughly.

DR JOLLIFFE: Probably 2007 I think, 2006, 2007, yeah.

DR KIRKUP: 2006, 2007.

DR JOLLIFFE: Yeah, I think. Yeah.

DR WALTERS: So you said you weren't very involved in the gold command.

DR JOLLIFFE: Not very, no. I was aware of it. I got the minutes. I was aware it was going on. I was at at least one of them. There was – I'm just trying to be technical here. There was a couple of teleconferences when it actually was called a gold command, when it was, sort of, like, when the people get together, formally declared a gold command by not sure who, but usually medical officer I suppose. Not sure who that was. It'll come back to me. But there were a couple of teleconferences which I think I was involved in.

DR WALTERS: Why were you involved in just two?

DR JOLLIFFE: I think because there were lots of people from the CCG involved, so, you know – I know I'm from Barrow so you might think I'd be involved, but there's another doctor from Barrow involved, Dr Boardman, I think.

DR WALTERS: So you were just standing in for him on a couple of occasions when he was wasn't there?

MR JOLLIFFE: No, I think what started was there were a lot of people involved, and then I thought, 'This has got to be slimmed down to a reasonable number'. I think that's how – why it happened.

DR WALTERS: So did you –

DR JOLLIFFE: I wasn't barred from going to them. I just – I've got a lot to do and

there was someone else attending and it was being covered by the CCG both centrally and locally.

DR WALTERS: So it was a sort of 'Join in if you can' sort of thing, was it?

DR JOLLIFFE: I think the invitation was open if I wanted to go. I wasn't barred from going to it. I didn't see the point in duplicating.

DR WALTERS: No. Did you know what it was for?

DR JOLLIFFE: The gold command? Not sure exactly what you mean, but –

DR WALTERS: Why was it set up? What was it trying to achieve? Was that clear?

DR JOLLIFFE: I think it was set up because of the crisis in the SCBU.

DR WALTERS: Right. And when you joined in on the teleconferences, did you think, 'Yeah, this is really achieving something'? Was it, sort of, energising –

DR JOLLIFFE: Well, I think it stopped Morecambe Bay closing the SCBU.

DR WALTERS: Right.

DR JOLLIFFE: They planned to close it, I think, on a – I think it was a Monday or a Tuesday, but I – there was literally days, and I think we got told – I was there, I was at a meeting with Hugh Reeve, who was our chair, and the medical director pulls him to one side at the end of the meeting and said, 'By the way, next week we're closing the SCBU'. It was a few days. And we were sort of – we were a bit stunned and we didn't say much at the meeting. Then we sort of came out of the meeting and thought, 'Hang on'. And then we talked to a few people and we thought, 'Hang on, you can't do this', and the whole enormity of it all dawned on us. And this was this business of transferring risk to the ambulance and... There wasn't an extra ambulance, so if you take an ambulance – basically if you take an ambulance out for maternity, you know, full time, what happens? You've got one less ambulance for all the medical patients in Barrow. People will die in Barrow, not of obstetric problems but of medical problems.

DR WALTERS: So did they – were they – was your perception that they were suggesting closing it because it wasn't safe?

DR JOLLIFFE: No, it was because they couldn't staff it. So, yes, it's the same. And what they were going to do is transfer – the problem wasn't just in Barrow. The problem was in Lancaster. They has problems staffing the Lancaster SCBU and they were going to transfer the Barrow staff to Lancaster. So this was part of the culture where Lancaster was always more important than

Barrow, whereas our view was transfer all the Lancaster staff to Barrow, close Lancaster because you're close to Preston, and actually that would have been safe for people in Lancaster.

DR KIRKUP: Just to clarify, the gold command was already in existence when they took that decision wasn't it? It was something that was taken up through the gold command, but gold command wasn't set up in response to that.

DR JOLLIFFE: You're probably talking about different bits of the gold command I wasn't involved in then.

DR KIRKUP: Right, yeah. Okay.

DR JOLLIFFE: Yeah.

DR KIRKUP: Okay.

DR WALTERS: So were you aware why it all closed down, the gold command closed down? Was it because all its tasks had been done were you just not that close to it?

DR JOLLIFFE: Gold command was closed down when it was felt that the commissioners and the trust were working – and the other parties were working well together and could solve the problem. That's what I believe.

DR WALTERS: Okay.

DR KIRKUP: Okay. Just one thing I wanted to pick up with you.

DR JOLLIFFE: Yeah.

DR KIRKUP: I want to go back to this point where you said that there were no warning signs at the time coming out of the unit about maternity, and you were asking yourself –

DR JOLLIFFE: Well, there might have been and maybe I didn't see them.

DR KIRKUP: Yeah. There were none coming to you, to be clear, and you were asking yourself what you might have been able to spot. What kind of thing might you have been able to see that would have said to you, 'Hang on, there might be a problem in maternity services here'?

DR JOLLIFFE: Well, one of the things we've done and we're trying to encourage for the GPs to do is – because I think the GPs see the patients who have the problems because of the system, so the intelligence must have been there, but it's so dispersed that it's not accumulated and forms a pattern. So one of the things we've done is set up a quality reporting system in Cumbria, and every GP has on their desk – I don't know what the computer service is like –

well, it's an icon. So it's a link to a programme that links in, so if you – so if a patient comes in you can in 10 seconds type in 'Joe Bloggs, got a problem with maternity'. That's all you need to do, because they'll come back for the information, carry on with your consultation, because that's all GPs can do at the time, in the time they've got. So they can quickly signal it and that accumulated up by our quality team, so Dave Rogers, the medical director, will be in charge of that.

So if there were problems GPs are encouraged – in anywhere, encouraged to report that in. Now, if it's an isolated problem it's an isolated problem and it probably might be looked at but it might not be escalated. If 10 GPs send a message in one week that there's something dire going on in the obstetrics unit then someone would urgently investigate it.

DR KIRKUP: Right. It may not be 10 GPs in a week.

DR JOLLIFFE: Well, it may not.

DR KIRKUP: In 2008, for example, there would have been a practice somewhere that said, 'There's a maternal death in one month' and then there's another practice that said a couple of months later, 'There's another maternal death', and then there's another practice somewhere else that says 'And here's an intra-partum stillbirth that looks as if it shouldn't have happened', and then there's a fourth practice that says 'Oh, and here's a baby that's died of sepsis and it all seems a bit weird'.

DR JOLLIFFE: Yeah.

DR KIRKUP: That's over the course of, what, eight months.

DR JOLLIFFE: Yeah.

DR KIRKUP: Would your system pick that up.

DR JOLLIFFE: Yeah, they would. Yeah. And I think a lot of that would – I think a lot of that really hard stuff would go through other reporting systems as well, so it would be on the maternity dashboard.

DR KIRKUP: It would go through other systems if each of those was reported as an incident.

DR JOLLIFFE: Yeah.

DR KIRKUP: But what I'm trying to get at here is what would happen if the trust itself didn't report those as incidents at the time.

DR JOLLIFFE: Well, the – that's a really good point and that came up really recently,

because I think Dave Rogers picked up in the quality group for Morecambe Bay that the incident reporting, not to do with obstetrics but just generally, had gone right down a certain month. So he then went to them and said, 'This can't be right'. So the lack of incident reporting itself is watched.

We also have another way of picking up stuff, and that is that patients can report issues directly, and we purchased the system 'I Want Great Care', which again is a sort of computer – you know about it. It's a computer based tool and it's advertised widely in all the providers and GP surgeries, so patients have got access to report that. And that again is monitored by the quality team. So I think we've put some measures in. I think GPs are better at understanding their responsibilities about reporting things. I still don't think they're perfect. I think there's a way to go.

DR KIRKUP: Sure.

DR JOLLIFFE: What I'm really concerned to do is to pick it up before it becomes a stillbirth or a – I'm concerned to pick up the gossip that someone says, 'It's not good work in the maternity at the moment'. Why? That's what I'm concerned about picking up.

MR BROOKES: Do commissioners do visits to the different services? Do they assess them?

DR JOLLIFFE: Yeah. I've been round the new SCBU. The new SCBU was set up in Barrow last year I think it was and I went to see it. We've had a series of visits to clinical services and to clinicians, which hasn't in the last – it hasn't happened actually since we've been a formal CCG over this last year, for various reasons, basically because Better Care Together's taken over. So we meet with clinicians a lot, but what I did between 2006 and 2012 was I went to – at least once a year I went to the surgical directorate, the medical directorate, the families directorate and I said – we talked to all the clinicians, we invited them in and said, 'What are your problems? What do you want to know about us?' So we tried to open up those channels of communication.

As I said at the very beginning, relationships weren't brilliant and one of the things I think we should just go and meet the people and get them to know us and get them to understand where we're at. I think when GP commissioning first came out people were suspicious that, a, we were out to just bully people into doing things, which we weren't, or, b, we didn't matter.

And I think the opinion has slowly changed in clinicians' minds from we didn't matter to we did matter but it wouldn't make a difference, to we did matter and we could make a difference. And I think now we've actually got to collaborative working. I think Better Care Together is probably the best process I've been in in commissioning over that very long time I've been involved in one way or another.

MR BROOKES: Did you meet with midwives?

DR JOLLIFFE: We've met with midwives, yes. Yeah, yeah, yeah. And, again, I'm not trying to duck the question but Mandy Boardman, who I keep referring to, that would be her lead role, so she'd be doing it more often and meeting with the paediatric leads.

Mr BROOKES: So are you aware of what kind of quality measures you build into your contracting for services generally and for maternity services?

DR JOLLIFFE: I am aware of them but I can't quote them to you, but I am aware of that and of the sequence that we do. We're involved in that every year, yes.

DR WALTERS: Just going back to the innuendo again, was it about what it was like working there?

DR JOLLIFFE: It was.

DR WALTERS: Right.

DR JOLLIFFE: And about an oppressive management culture, difficult to move and breathe and do your job properly.

DR WALTERS: From other clinical staff?

DR JOLLIFFE: Yes.

DR WALTERS: Clinical managers or...?

DR JOLLIFFE: I think it seems to be about the middle management, yeah. And I'm not sure – you see, we had lots of conversations with very senior management, medical director, chief executive, operating – the chief operating officer, and I got – not in 2006. I think by 2008, 2009 I felt we had quite a good relationship and actually told us a lot of stuff, and they took some actions, you know. I saw doctors – and I've never seen this before. I've seen useless doctors in the system and no one do anything about them. I actually saw a system where they were sacking doctors for various things, which are probably confidential, so I – you know, about the individual, so I probably shouldn't say, but serious, significant things that I've seen brushed under the

carpet before. And they were dealing with stuff more appropriately. So I'm not sure, either they weren't telling me at all, but they weren't reflecting back that they had any concerns or there was anything going on in the maternity unit. So my concern is either they knew and they didn't tell anybody or it was kept secret at that level, and that's some of the innuendo.

DR WALTERS: But not about clinical risk?

DR JOLLIFFE: I think clinical risk must have been known about, must have been known. From what's happened it must have been known in the unit, so that must have been kept contained. And I just – I'm bewildered how you can do that, you know, in the system, absolutely bewildered how it can do, but it seems to me that must because it kept going on. It wasn't about one month or three months in the life of a unit, was it? So it must have been known and it must have – but I don't have any evidence of that. I'm not saying I know something I'm not telling you. I don't have any evidence but it just – I'm bewildered.

DR KIRKUP: Okay. Thank you. Is there anything else you want to tell us? You don't have to, but if you –

DR JOLLIFFE: No. Sorry, talked too much.

DR KIRKUP: No, no.

DR JOLLIFFE: I think I've, you know, covered the main things. You know, I just hope you can give us some guidance as to how to make things better and some insights.

DR KIRKUP: Okay. We'll do our best.

DR JOLLIFFE: Yeah. Thank you.

DR KIRKUP: Alright. Thank you very much for your time.

(The meeting concluded at 11.15 a.m.)