Health Committee – Written Evidence

Care Quality Commission

Written submissions received and accepted by the Committee as evidence for its inquiry into the Care Quality Commission.

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Written evidence from Jill Finney (CQC 01)

I am writing to you in the hope that you, of all people, might enquire into the facts surrounding the media frenzy that erupted over the past week about allegations that senior members of CQC tried to conceal or delete a critical report. This came about from the publication of the Grant Thornton review published by CQC on Wednesday 19 June, but actually leaked to the press on Tuesday 18 June, before anyone against which allegations were to be made was shown a copy, or could get hold of a copy.

It is essential that as the regulator CQC can demonstrate the highest standards of fairness and balanced process, resulting in judgements based on thorough evidence.

For the sake of brevity in this note to you, I believe there are three key issues that need to be considered regarding the Grant Thornton report and the failure of CQC interviews to put the misconceptions right, are:

1. What was the report about that Grant Thornton alleges was instructed to be deleted?
2. Were Grant Thornton reporting fact or just their view of allegations?
3. Was the process fair to the people accused and found guilty by Grant Thornton and CQC, or has there been a miscarriage of justice?

What was the Report?

The report about which the allegation to delete was made, the Louise Dineley report (which was put up on the CQC web site some time after the Grant Thornton report was leaked and then published, thus enabling all reading the Grant Thornton report to assume this was about an allegation to cover up an investigation into the tragedies at UHMB) was a report about how the CQC had handled the registration process in 2010 of UHMB in the context of the 400 other health and 24,000 social care providers done that year; and most importantly about the regulation activity undertaken since then.

It made a number of helpful remarks about lessons to learn, but concluded that CQC had made the right decision to register UHMB in 2010. By the March 2012, when the discussion about the Dineley report took place, it was clear that the CQC leadership did not feel that Louise Dineley's conclusion was the right one and indeed the report painted a far too favourable picture of CQC. So, far from being critical and damaging to CQC, this report was in fact far too favourable and the only damage to CQC would have been that it was not credible.

It is alleged within much of the press reporting that followed the leaking / publishing of the Grant Thornton report and indeed neither made clear by Grant Thornton nor CQC in any subsequent statements, that this report was related to an investigation into the maternity services in UHMB. It was not a review about the maternity services and any tragic events that occurred at UHMB.

Fact or Allegation

The relevant section in the Grant Thornton review is section 6, which is actually titled the same as the Dineley report and again shows that this was about looking for lessons learned in registration and regulation, not the investigation of maternity services.

It is worth reading all of section 6 of the Grant Thornton report as this deals with the "delete" allegation and in paras 6.166 onwards, Grant Thornton go on to give their view of the evidence and to conclude regarding the allegation that a delete instruction was given for this report, in para 6.232, "… of the four accounts we were given during the course of our enquiries, we find Mr J's version the most reliable". They use a number of adjectives in the preceding paragraphs that are entirely subjective in describing their view of the interviewees reactions to questions on which much of this judgement in para 6.232 is based.

I have continually denied instructing the deletion of this report and two of the other three in the meeting also separately confirmed this, but this evidence was judged by Grant Thornton to be wrong.

The Dineley Report was provided to Grant Thornton (on their own chronology) on 18 September 2012, two days before they were instructed to undertake the review and, approximately, two weeks before their first Terms of Engagement were signed off by both Grant Thornton and Serco.

The Grant Thornton report therefore goes onto make a judgement as to which set of answers they chose to believe and thus turned an allegation by one person and denied by three into an accusation against one individual, me, that they determined to be true. Yet, they failed to juxtapose in the section where they determine my 'guilt' about instructing the report to be deleted, the unchallenged fact that I (Jill Finney), Mr G in the redacted report, told Grant Thornton of the Dineley Report and provided them with a copy prior to the commencement of their review (so clearly not trying to hide it) and I arranged for them to have a copy of the report within days of them starting (so clearly not deleted) [para 6.4, Grant Thornton states that, "On 18 September 2012, Mr G (Jill Finney) emailed us a copy of a report entitled: "*Summary of the internal review of the regulatory decisions and activity at UHMB*" …"].

The acknowledgement of my giving Grant Thornton the Dineley report at the beginning of their work is separated by approximately 228 paragraphs from their assessment I was guilty of a "delete" instruction.

Fair Process or Not?
I signed off the original terms of reference for the Grant Thornton review on behalf of the CEO and there was no reason at the time for me or anyone else to believe that their discussions with the review team would be judged by Grant Thornton in terms of Grant Thornton's view of people's perceived behaviours, their level of immediate recollection as well as their answers; nor that they would choose to then make public accusations in their report.

If that was expected to have been the case, then the interviews that took place would have needed to be carried out under either a disciplinary process, allowing people many safeguards such as allowing an independent witness and a verbatim transcript of the interviews; or under PACE conditions, where interviewees would have been cautioned and allowed representation. None of this happened. We have never seen transcripts of our interviews, I for one have had a partial set of notes which I have given Grant Thornton many corrections, to no avail.

There was a circumstance which I had to intervene, in the strongest possible terms, to the CEO about Grant Thornton insisting they interview a member of my staff who was on maternity leave only weeks after giving birth and where the Grant Thornton representatives said they should visit her at home. After my intervention, this interview was eventually postponed to allow her to attend the CQC office and also she was allowed an independent witness. I can furnish the Clerk with detailed emails on this subject if this would be helpful; including exchanges with David Behan and Grant Thornton over the weekend of 15/16 June asking them to ensure the appropriate juxtapositioning of the crucial evidence in support of my denial of the "delete" instruction, that I had told Grant Thornton of the Dineley report on the commencement of their work and provided them with a copy very soon after.

There are very many aspects about the process instituted by David Behan which are flawed, which I and others wrote to him about on a number of occasions, hoping he might act to make the process be fair; yet the Grant Thornton report and CQC's approach to this have resulted in myself and others to be judged and stated to be publicly guilty by Grant Thornton and CQC with allegations dressed up as fact and an incomplete representation of the evidence.

In several exchanges with myself and others, Grant Thornton also made clear that they would determine what information they would use from our evidence and replies to their allegations. Most recently was in a letter received by my Lawyers on Friday 14 June at 17.42 when Grant Thornton stated, "*It is also important to note that we made it clear in our 12 April 2013 letter to Ms Finney that we did not undertake to include all or any representations in our report*."

The way in which the report was released and the redaction of names resulted in aggressive media attention. This has resulted in destroying 35 years of unblemished reputation, it has had devastating consequences for myself and my family. Also, let me be clear, CQC only notified me that I was to be named and the redactions removed on the morning after they had already done so.

I was offered a new post in the private sector after being approached by a Headhunter, in December 2012 which I accepted and which I have now been dismissed from as a direct result of these accusations and determination of guilt by Grant Thornton and CQC. My children have been hounded

by the media, my house and others in my family laid siege to and my husband also accused of wrongdoing. The Secretary of State is to try to take my small pension (I was only at CQC for four years) away from me, without any means by which I can appeal.

Let me finish by saying that I would welcome a Police investigation or further parliamentary scrutiny into these matters.

24 June 2013

Written evidence from Louise Guss (CQC 02)

I understand from your statements reported in the press, that Mr David Behan, the Chief Executive Officer and Mr David Prior, Chair of the Care Quality Commission (CQC) have been called to give evidence before the Health Select Committee – possibly on the 25th of June 2013.

It is with regret that I write this letter to be placed (with your permission) before the Committee as evidence regarding the engagement by CQC of Grant Thornton to produce a report entitled '*The Care Quality Commission re: Project Ambrose dated 14 June 2013*' and their subsequent delivery of this report which is flawed and in my view a waste of public money.

I assure you that in writing this letter, I do not intend in any way to be, or appear to be defensive, or indeed to support any version of a closed culture – hence my decision to openly write to you.
In the interests of clarity, I should also point out that I have not been involved in any regulatory decision making in relation to University Hospitals Morecambe Bay, nor have I been 'implicated' in the recent issues presently being covered by the media.

Background

Until the 31st May 2013, I was the CQC's Director of Governance and Legal Services. The decision to leave CQC was mine, and completely unconnected to the production of the Grant Thornton report.

Prior to leaving CQC, I had been employed as a Director from July 2010 to 31st May 2013, and had worked for 2 predecessor organisations leading the in-house legal provision. I have been a solicitor for 20 years, working in both the private and public sectors.

I write this letter with sadness, having enjoyed the challenge of working in a national regulator and having the opportunity to make a difference to the quality of health and social care services and in the way in which they are provided. I have never before found myself in a position where I feel that there has been such a distortion of facts, to the detriment of the public. I am committed to the public sector and have chosen to work on behalf of the public for the majority of my career – I am also committed to transparency of decision making by those paid out of the public purse, where such openness is permitted by law and not misleading.

The recent publication of the CQC/GT report referenced above has, in my view been extremely poorly handled, creating circumstances where inaccurate information and flawed judgements have been placed into the public domain resulting in damage to both those who have an interest in the regulation of the Foundation Trust in question (for example parents of children treated in the Trust), and individuals who have found themselves at the centre of a press frenzy and public humiliation without any support from their (ex)employer.

This letter contains information only from my own perspective. I hope that it is ultimately helpful to the Committee.

Commissioning the report

In July 2012 it was considered appropriate to instigate a review – led by a senior individual with experience in the regulation of health and social care – to undertake an overview of the regulation of University Hospitals Morecambe Bay (UHMB), and within that, consider issues raised by Ms Kay Sheldon, Board member regarding the handling of UHMB.

There was considerable debate regarding who would be responsible for the review, and who should be approached with a view to engagement to undertake the work.
It was clear to all involved at that time that the timescale for completion of the work would be no more than 6 weeks. Consequently, the review was to be completed by September 2012.

At the time, reviews were also being undertaken by Professor Kieran Walshe, upon evaluation, and Steve Bundred and Deloittes on the use of the CQC's powers under section 48 of the Health and Social Care Act 2008 of 'special review and investigations'.

All of these pieces of review activity were intended to consider how CQC had approached it's work in the time it had been functioning, in order to identify what had gone well, and what could be improved. The UHMB review was also intended to fit into this direction of travel. As you are aware, due to the timescales on set-up of the CQC, learning was effectively 'on the job', and reviews such as those described above were a critical part of the development and evolution of the organisation.

The UHMB review was to be largely paper based (with some interviews of staff where necessary to supplement data held in the system). I drafted a very early 'starter for 10' terms of reference which broadly required a review of what evidence was taken into account, decision making, the questions identified by Ms Sheldon and to make any recommendations regarding lessons to be learned, or positive issues to be enhanced in the developing regulatory system.

Initially, the (then) Commissioner and Chair of the Audit and Risk Assurance Committee, Professor Deirdre Kelly was to 'own' the review – as she did the review into the use of section 48 powers. Another possibility was that Amanda Sherlock as Director of Operations would take ownership as the purpose of the work was largely to identify improvements required in Operational activity.

A number of names were mentioned regarding a suitably experienced individual to undertake the review – it was agreed that someone with experience of health or social care and regulation would bring added value to the process bringing with them an understanding of the sector.

These discussions took place precisely at the time of the change over in the role of CEO from Cynthia Bower to David Behan.
When David Behan (DB) became aware of the proposals he immediately took charge of the considerations and the proposals – I had no further involvement. I later learned that he was to be the owner of the work, and that a professional services company would undertake the work.
I did not consider his ownership of the work unusual at that point – he is after all the CEO of the organisation, and clearly was very interested in progressing the matter in his way. I *did* however find it unusual that the plan to use an individual with knowledge and experience in the sector had been abandoned. However, my view at that stage was that so long as the individual(s) involved were sufficiently knowledgeable, and had experience in the sector, they should be able to undertake the work to an acceptable standard (although it could potentially take longer as they 'got to grips with' the system and regulatory activities).

I was later advised that the firm Grant Thornton (GT) had been engaged to undertake the UHMB review.

We were advised that GT would make contact with us if any issues arose that required our input. I was not anticipating that I would be providing legal advice to the firm, but would need to advise DB on any issues he raised with me in connection with the GT work.

The GT processes

As the GT work progressed, and individuals were starting to be interviewed, I became aware of concerns that some individuals had about the manner of interview used by GT.
I was advised by 2 individuals directly that they were astounded by the way in which the interviews were conducted – the following was reported to me;

- that the interviews were very aggressive and bullying in tone
- that the interviewer brought documents (which the interviewees had *not* seen beforehand) and demanded that comments be made upon them
- that they were treated like 'criminals', but without the courtesy of representation or support
- that GT used a junior member of staff to 'record' in writing what was said, but that the record (when eventually provided) was sloppy and inaccurate and did not represent the content of the interviews
- that when individuals stated that the notes were not representative of the discussion, and provided amendments, these were largely not accepted by GT
- that due to the nature and tone of the interviews, some members of staff were driven to tears

Due to the aggressive nature of the questioning, I am also aware that some individuals asked that they be accompanied by a colleague – I know this because a line report of mine checked with me that I was happy for him to act in this role – which of course I agreed.

I mentioned this to DB, to which he replied that he wanted to completely 'keep out of' the GT work. He stated that this was because he did not want it to be said that he had interfered. I absolutely understood this standpoint – but advised him that ultimately he would need to be assured that the process itself was robust so that he could accept the report in the knowledge that it had been fairly produced. I also reminded him that he would need to recommend the report to the CQC Board of Commissioners. He reiterated that he wanted to keep completely away from the process.

I am aware that DB agreed to add elements to the original terms of reference for the review. I became aware of this purely because DB advised the Board of Commissioners in a meeting which I attended in my role. DB stated that he had met with Mr James Titcombe, the father of baby Joshua Titcombe who had sadly died in one of the UHMB locations, and had agreed to roll into the review complaints that Mr Titcombe had about CQC activity.

I am also aware that the terms of reference of the work changed on a number of occasions – 4 sets of agreed terms were eventually signed between CQC and GT, each building upon and extending the one before, and at least 2 of the sets drafted by GT themselves.

Throughout this time, I was not consulted by either DB or the Chair David Prior regarding the review. I had no involvement at all (beyond me raising concerns with DB myself with the intention of alerting him to possible problems in GT process) in any exchanges, or discussions about the GT work.

I am aware that others in the Executive Team raised their concerns regarding the conduct of GT and their processes direct with DB in and around November 2012. They advised me that they had raised their concerns regarding how they had personally been treated, and how their staff had been treated. It was their view that DB was not intending to do anything about this as he wanted to 'keep away from' the process. This was consistent with his response direct to me.

Separate changes to the CQC structure

After DB had been with the CQC for a short time, he advised the Executive Team of Directors that he wanted to make some changes – this was no surprise, as it is entirely usual for new CEOs to wish to re-structure directorates and have their 'own people' around them. I was personally anticipating this to occur and was completely content.
In my discussions with DB from the start I was very clear indeed that I wished to leave the organisation if changes to my role meant that it would be redundant, and no suitable alternative was available. DB stated that he was disappointed by this, but accepted my personal reasons for taking this position.

When the new structure became clear, and it was evident that my role would be redundant, DB stated that he would be happy with me naming the date on which I would go. I chose the 31st May 2013.
I, along with other Executive Team members who had also decided to leave the organisation as an outcome of the re-structure, made our announcements to our teams, and the dates of our leaving were made public.

There was no suggestion what-so-ever that my departure was linked in any way to anything other than the re-structure and my own choice to leave. I discussed with DB future references, and he confirmed that I would get nothing less than an excellent reference reflecting his opinion of my work, integrity and professionalism.

The draft GT report appears

After some 8 months following GT's engagement, and having had no contact with them, on the 11th April 2013 I received by email correspondence from GT advising me that there was a risk that I was to be criticised in their report, and attaching a 'schedule' of the potential criticism (which contained 1 item). No evidence was provided nor any indication of why potential criticism may arise – in short, I had no idea what the claims were against me in order that I could respond.

I replied by return – astounded and amazed that any professional firm could consider it in any way appropriate to entertain the thought of criticising an individual without having previously spoken to or interviewed that individual in order to seek their views on issues where their name may have been raised.

My letter in reply (consisting of 7 pages) covered 3 specific areas;

Part 1 – flaws in procedure resulting in absence of natural justice
Part 2 – comments regarding 'publication'
Part 3 – Schedule 1 (the criticisms)

My comments regarding the process followed by GT were;

'Part 1 – flaws in procedure resulting in absence of natural justice

The following matters are of fundamental importance;

1. *You state in the first sentence of your letter that 'You will be aware of Grant Thornton UK LLP's investigation into specific matters concerning CQC's regulation of UHMB'. I am not so aware. I am only aware that your firm has been engaged to undertake some work in relation to CQC's handling of UHMB in regulatory terms – nothing more, nothing less. I have not had sight of your firm's Terms of Reference (ToR), or any other such detail. I am therefore not aware of the context of your work or how and why any of my email correspondence may factor in that. I cannot make full and appropriately informed comments until I am aware of the full remit of your role.*
2. *Moving on, in the second line of your letter you state, 'We are grateful for your co-operation with regard to this investigation.' I have had no involvement – it therefore stands to reason that you cannot be grateful for my co-operation. This is not intended to be a trite comment – the substantial point here is that I have had no involvement, have not been spoken to or interviewed in any way, or given any opportunity to understand the context of terms of the work. Your letter (under cover of a one-line email from your colleague) is the first and only contact I have had in this matter. I make the assumption that this is a standard letter, forwarded to those who are being contacted for this purpose. I also assume that those others have been afforded the opportunity to be interviewed or in some way input to the process of discussion and sharing of information (hence being thanked for their co-operation thus far). The fact that I have not been afforded this opportunity is a serious flaw in your process which has deprived me of steps that amount to natural justice i.e. a code of fair procedure or 'the natural sense of what is right or wrong'. For the sake of clarity and completeness, I do not consider the receipt of your letter with attached 'Schedule 1' with an invitation to respond 'before 6pm on 18th April 2012' (my italics) as a replacement for the due process that should have been followed in order to afford me the opportunity to understand the context in which you are working (i.e. your ToR), the allegations made against me, and the overall context of the investigation.*
3. *Your 'Schedule 1' refers to evidence that I have not seen. I have not seen the email string itself, therefore gaining any context. My comments in point 2 above in relation to natural justice relate directly to this. I have not seen the string, not had an opportunity to discuss this and have been placed in the position of having conclusions and judgements about me (albeit draft ones) put to me without context or meaning.*

Part 1 - Summary

So, in summary (in relation to these fundamental matters set out above), to enable any response to be meaningful, it would be necessary for me to be aware of and view;

1. *The full purpose of your work (which would enable me to understand how your work came to draw the erroneous conclusions that you have regarding my attitude and activity on the wholly inadequate 'evidence' to which you refer).* ***Please therefore provide a copy of your Terms of Reference for the work that you are undertaking and any underpinning documentation, for example (but not limited to) any allegations regarding my conduct***

2. Please provide copies of the 'evidence' upon which you seek to rely
***In short, the principles of natural justice have not been followed – this fundamentally undermines your process thus far, and the judgements that you have chosen to make which, I submit are flawed and 'unreasonable' in a strict legal sense. Throwing me an opportunity at this extremely belated stage in your work to 'make representations' does not rectify this flaw or make unreasonable judgements reasonable. I reiterate that it will not be possible for me to make any attempt at full and fair comments upon 'Schedule 1' until I am clear about the full context of your work and the entirety of any 'evidence' used to question my work and integrity.*'**

I was subsequently provided with one email string, from which GT proposed to make very incorrect, sweeping, derogatory assumptions regarding my thoughts and opinions.
I made detailed representations regarding both those incorrect assumptions and the completely inadequate process that led to such assumptions being made without affording me any opportunity to discuss and challenge prior to them being formulated in the draft GT report.

I made further representations regarding statements in the GT correspondence that their final report was to be published containing the names of those connected.
It was at this point that I became seriously concerned – it was now clear to me that the flawed process could result in a report which contained completely unfounded and weak conclusions, that had not been robust in its processes, and could put CQC at risk of both severe criticism and place into the public domain what was effectively defamatory material.

My representations regarding publication were thus;

'Part 2 – comments regarding 'publication'

Your letter (second paragraph) refers to an intention to 'publish' your report. I do not know who made this decision and when – I presume the CQC Chair, Mr Prior or CEO Mr Behan have singularly or jointly decided this. I therefore intend to raise this issue with them by providing them with a copy of this correspondence, and recognise that the decision on whether to publish and in what form does not sit with you. I am however raising the issue in principle here for completeness.

The Commission is a public body and is therefore bound by public law. Further, and specifically, it is bound by laws relating to the handling of personal data. Its statutory role is (broadly) to fulfil the functions of registration of specific defined services, review and investigation in the context of regulatory duties, specific activities under the Mental Health Act and the Deprivation of Liberties Safeguards, functions under the auspices of Healthwatch England and monitoring information governance compliance of providers.
It is at liberty to run its business largely as it wishes, subject to government mandatory controls, and so long as it fulfils the duty of carrying out its functions effectively, efficiently and economically. It is however subject to legislation regarding the handling of personal data (in this case, that belonging to its employees) and legislation protecting employees in the context of an employee/employer relationship.

While therefore the Commission is at liberty to (and indeed has a duty to) put information regarding its regulatory work into the public domain, it is not similarly at liberty to do so regarding information comprising personal data of its employees without the consent of those affected. Publication of personal data (which would be by its very nature sensitive) without either consent or any legal standing to do so would be a serious breach of several principles of the Data Protection Act 1998.

Part 2 – Summary

The Commission has specific powers and duties regarding the publication of certain classes of information connected to its regulatory activities and other statutory functions – it does not however have the power to circumvent its responsibilities under other legislation which is key to its duties as a public body and an employer.

Additionally, should incorrect sensitive information be placed into the public domain, or indeed circulated by the Commission in any way, it will be liable/responsible for the damage caused by that action. This is a particular risk if the fundamental rules of natural justice have not been followed, resulting in flawed judgements.'

As the decision to publish did not lie with GT, but with CQC, I wrote to DB and David Prior on the 12th of April 2013, providing them with a copy of my correspondence to GT and expressing my concerns and explaining why publication with the names of individuals would leave the CQC very vulnerable indeed. I also stated that as I had now been involved in the GT matter personally, this created a potential conflict for me in the provision of advice, and that they should make arrangements to seek independent legal advice urgently from the CQC external panel.
DB later advised me that he had sought advice from a panel firm who had confirmed my advice.

So – the advice was categorically not 'you can't do this because of the Data Protection Act' but was far more detailed and nuanced.

I understand that on the back of the external legal advice, DB advised GT that he wanted them to produce a report for him without naming individuals

It was my view that simply removing the names from the report *did not* rectify the fundamental issues regarding the flawed process – but did, from CQC's point of view, mitigate to a small extent the potential for legal proceedings based upon defamation.

Publication of the final report and its impact

I was given no further opportunity to comment upon or see the GT report before it was placed upon the CQC website in its final version on the 19th June 2013 at 9.30am. It had apparently been 'leaked' to the press before that.

During the 19th June I was contacted by the press 4 times on my home telephone and personal mobile number. I was also emailed.
The press made the erroneous connection between me leaving CQC and the GT report. This connection was supported by comments made by both David Prior and DB during the day.
Their comments generally stated that the Executive Team and Board prior to their arrival at CQC had been dysfunctional, but that those people had been cleared out.
On the Today programme on Radio 4 on the morning of the 19th June, David Prior stated the following;

'*There's an old saying – 'the fish always rots from the head' – the Board and the Executive were totally dysfunctional. The senior leadership team failed at the CQC and they've all gone. There were no pay-offs or anything like that.*'

This is a clear inference that firstly, individuals were 'rotten' i.e. lacked integrity, and second that those who left CQC did so *due to* the GT report.

This quote, and several others from both DB and David Prior were used in on-line news and subsequently in TV news reports and then in the print press.

Towards the end of the day, I received abusive emails and viewed aggressive 'tweets' directed at me personally and at those of the Executive Team who had left CQC.

At 17.25 I emailed DB personally stating that I was being contacted by the press, and had started to receive abusive emails – and that I believed that CQC could help by making it clear that my leaving CQC was not in any way linked to the GT report. I asked that this be made clear in any other CQC contact with the press.

DB replied;

'*Other staff members have also contacted me about the same issue and have informed me that they*

have responded in a way that they have felt most appropriate.
David'

A most unhelpful reply and clearly reflecting the intention to afford me no support what-so-ever in seeking to reflect the truth.
It is my view that CQC was more interested at that point in demonstrating incorrectly that everything before was 'bad' and that everything now was 'good' – regardless of the truth of this or the cost to individuals.

On the 20th of July, I was 'doorstepped' by journalists and photographers, and could not answer either my home or mobile telephone as I was bombarded by calls from the press. I have been contacted by the Mail, the Times, the Mirror and the BBC.
My 12-year-old daughter was left upset and bewildered by the barrage of journalists and photographers ringing the doorbell and blocking our drive.

Conclusion

In my view, the GT report is fatally flawed as it was produced on the back of a process of evidence gathering and judgement formulation that fell well short of any acceptable standards. Those who were interviewed were refused sight of the terms of reference for the work, were treated aggressively, and were ignored when they pointed out the inaccuracy of the notes of interviews produced by GT. I was not interviewed at all, and yet GT felt it appropriate to make assumptions about me, my opinions and my work.
The report should not have been published in any form – DB went so far to ensure that he was not accused of tampering with the report, that he exercised or put in place no assurance process over the process or report. He did not therefore recognise that the report, when delivered to him, was inadequate and not fit for any publication. Even when warned of the failings in the GT processes and judgements, DB preferred to ignore those warnings in favour of the assumption that GT's work was sound. This assumption led to CQC publishing a flawed report.
In my view, it is essential that as the regulator CQC can show that it demonstrates the highest standards of fairness and balanced process resulting in evidenced judgements – how can it validly demand that of others when the CEO has so patently failed in its own handling of this matter?

When there was a general clamour for disclosure of the names of individuals mentioned in the report after it was put into the public domain on the 19th June, I believe that this was partially due to the fact that both DB and David Prior claimed that they 'could not' disclose the names 'due to data protection law' – this was a lazy interpretation, which led to calls from those external to the process that the Data Protection Act should not be use to 'protect the guilty'.

In actual fact, the removal of names was protecting individuals from incorrect and defamatory information about them going into the public domain, and protecting CQC from compounding an already poor situation.
When the names were disclosed on the afternoon of the 20th June, the appalling damage to individuals, their reputations, careers and private lives was compounded.

I sincerely hope that this information is of use to the Committee. I am happy to provide any further detail required, or answer any questions linked to this matter.

23 June 2013

Written evidence from Anna Jefferson (CQC 03)

1. I understand that the Select Committee is hearing evidence from Grant Thornton. Whilst I understand that the Committee's emphasis will be, quite rightly, on the Care Quality Commission itself, I suspect there will also be evidence in respect of the 'cover-up' alleged by Grant Thornton in which I am implicated. I am extremely concerned that the Grant Thornton report appears to be being treated as definitive. In so far as it relates to the March 2012 meeting and the internal CQC report, Grant Thornton's work is riddled with errors and comes to conclusions that are unjustified and not borne out by evidence. Clearly, it is not the Select Committee's remit to assess and analyse that work but I would be grateful if it could be kept in mind that the Grant Thornton allegations remain just that – allegations – which I dispute vigorously.

2. I have been employed by CQC since February 2011, initially as a Media Manager and later as Head of Media. I have been on maternity leave since October 2012.

3. I was required to attend an interview with Les Dobie from Grant Thornton in February 2013 while on maternity leave. I was accompanied at this meeting by my line manger, and also by my three month old baby.

4. Mr Dobie asked about my recollections of a meeting on 12 March 2012 during which discussion of an internal report (the 'Dineley Report') into regulatory activity at UHMB took place. I told Mr Dobie that while I did not recall the detail of the meeting, I did recall the internal report, which I had considered to be lacking in objectivity and rigour.

5. I had hoped that this internal report would ask some tough questions about whether CQC's regulatory action at UHMB had been appropriate (the answer to my mind was clearly 'no') and provide real learning for the future, allowing us to be open about historic failings and then to move forward. Instead, the 'Dineley Report' blamed the Trust's 'secretive culture', rather than examining CQC's own regulatory failures, and concluded that CQC would take the same regulatory action again. I thought this sounded at best deeply complacent and at worst like a whitewash – it failed to address serious issues about whether CQC could have acted more swiftly and effectively to protect patients. The weakness of this internal scrutiny led me to propose an independent review. [See paragraph 8 below].

6. The very specific quote allegedly attributed to me by Jill Finney in the report *("This can never be in the public domain or subject to FoI")* was not put to me during the interview with Mr Dobie. My line manager was also present at this interview and confirms that this is the case. During the interview, I was told that it had been alleged that I said that the report could not be subject to FoI as it was a reputation risk. I thought that this emphasis on FoI was odd (my concern was whether the report did the job it needed to, i.e. provided a robust analysis of whether CQC could have exercised its oversight of UHMB more effectively), but I said that I certainly did not think the report was fit for publication or wider circulation. I felt it was a wholly unsatisfactory piece of work and I would not have wanted it to go further that the limited audience it was intended for. There is a difference between voicing an opinion that a piece of work is not fit for purpose and advising that a more rigorous and objective approach is needed – as I did – and actively advocating suppression on the grounds that it might be to subject to FoI requests.

7. I was asked about a 'delete' instruction – I said I could not remember Jill Finney asking for the report to be deleted, although I did remember a conversation which concluded that the report was not a good piece of work. I made the point that the report had not in fact been deleted, as I myself kept a copy of it – the same copy which was sent to Grant Thornton.

8. I also made it clear to Mr Dobie that I had pushed for independent external scrutiny of this Trust once it became apparent that the internal report was inadequate. Despite being the most junior person involved in these discussions by some considerable distance (at the time of the March 2012 meeting I was a Media Manager, not a 'senior official' as stated in the report), I raised the need for this several times, the last of which was at a meeting with David Behan in attendance on 17 July 2012 [extract from minutes below].

"AJ [Anna Jefferson] suggested we subject our historic regulatory activity about MB [Morecambe Bay] to external independent scrutiny. The group agreed. DB [David Behan] suggested this work should be completed before he officially starts on 28 July. AJ suggested using PWC (or similar credible consultancy firm) rather than a clinician as this should be a scrutiny of our regulatory processes, not clinical outcomes, and DB agreed."

9. I sent these minutes to Mr Dobie on two occasions so was astonished to see no reference to them in the final Grant Thornton report. These minutes do not support the thesis that I was complicit in covering up a critical report which would damage the reputation of the CQC; rather, they confirm that my concerns were about the rigour and objectivity of Louise Dineley's report. I can see no reason why Grant Thornton would not include this highly relevant documentary evidence from a meeting at which seven people including the current Chief Executive were in attendance, and which directly contradicts the allegations made about my actions and motivations.

10. The first time I saw the quote "*This can never be in the public domain or subject to FoI*" was in a 'Schedule of Criticisms' sent by Grant Thornton on 11 April. I was horrified and wrote immediately to Mr Dobie making it very clear that I had not said this, and that this quote had not been put to me during our interview. I was so distressed that I also called Mr Dobie to say that this quote was completely untrue and I could not believe that Jill Finney would have put those words in my mouth.

11. Given that this quote is not only false but uncorroborated – no one else, including Louise Dineley, the author of the internal report, makes any reference to me making any comment of this kind – I assumed, perhaps naively, that it would not appear in any final report. I am appalled that it has done so. Jill Finney has since said on national television [Sky News, 24 June http://news.sky.com/story/1107552/cqc-cover-up-jill-finney-denies-hiding-report] that she did not in fact attribute this quote to me. I am at a loss, therefore, to know where it has come from and why it was included in the Grant Thornton report.

12. I was also surprised to read Grant Thornton's claim that this quotation was put to me during our interview. It most emphatically was not. Both my line manager and I are clear the quotation was not provided and the notes of this interview do not bear out Grant Thornton's assertion that it was. The relevant section of the interview notes read*: "It is alleged that you [Anna Jefferson] said that this report could not be subject to FoI, because of reputation management."* Deprived of the context of this very specific quote, I understood this to mean that someone at the meeting had said that I would have had concerns about this report being published, which indeed I would have done, as it was a poor piece of work which read like the product of an organisation wholly lacking in insight.

13. The first time I saw the final Grant Thornton report was on Wednesday 19 June, when it was published on the CQC website. The report at that stage was anonymised. I did not at any point support the decision regarding anonymisation – either a report is robust and those that have commissioned it and authored it should stand behind the conclusions, or it is not robust and requires further work. Anonymisation was a very poor compromise which did not serve the public interest and in fact created a far heightened degree of media attention than would otherwise have been the case.

14. When I read the sections of the final report which related to me, I was physically sick. My first instinct was to waive my anonymity in order to publicly state that the allegations made were completely false. I was advised by David Behan via my line manager that I should not do this and should 'follow due process', i.e. wait until the discussions about the legal status of the report that were at that point ongoing had been concluded. While I can see that this was sensible advice, I hope that my desire to waive my anonymity demonstrates a least a small degree of my distress and outrage about the allegations which have been made against me.

15. My primary concern was to get some real answers about what had gone wrong at this Trust and to ensure we could do better for patients in the future; through the inclusion of this fabricated quote, along with failure to include documentary evidence that I pushed for proper external scrutiny; my reputation and my career have been destroyed.

16. It is alleged: that I conspired to delete a report – of which I kept a copy; that I conspired to conceal poor care – when there is documentary evidence that I pushed for more scrutiny; and that I made a

comment which even the person who allegedly attributed it to me agrees that I did not. I still find it difficult to understand the sequence of events which has resulted in my vilification in the national press, death threats against me and my baby, and no prospect of future employment.

17. The thought of what the families who have lost babies at this hospital have gone through is heartbreaking. I would never have conspired to cover up anything which could have led to a better understanding of what went wrong in the regulation of this hospital and I am absolutely devastated that I have been implicated in this way.

27 June 2013

Written evidence from Kay Sheldon (CQC 04)

Introduction

This statement is provided as evidence for the Health Select Committee hearing on 3rd July 2013 set up to hear evidence on the Grant Thornton (GT) report. I would suggest that my evidence submitted in August 2012 to the Committee's accountability hearing on the Care Quality Commission (CQC) is also relevant. I am happy to provide any further information to or answer any questions from the Committee if considered necessary.

Background

The independent review by Grant Thornton was originally commissioned by David Behan when he took up post as CEO of the CQC to look into the issues I raised about the regulation of University of Morecambe Bay Hospitals NHS Trust (UHMBT). As the Committee will be aware, in November 2011 I made the difficult decision of approaching the Mid Staffordshire Public Inquiry with serious concerns about the leadership, culture and regulatory approach of CQC. This was met with further denial e.g. the rest of the board at the time – Deirdre Kelly, Martin Marshall and John Harwood – publicly dismissing my evidence via a statement on the CQC website. Therefore I felt I had to further demonstrate why I was so concerned.

In the February 2012 CQC board meeting I asked the Director of Operations, Amanda Sherlock (AS), whether we would have picked up the issues at Morecambe Bay earlier if we had been fully functional. The response was that we had been fully functional and that it had been a robust piece of work by CQC. It was difficult to see how this could have been the case. As a consequence I looked at various CQC inspection reports as well as reports from other organisations and media reports. I identified numerous concerning omissions, inconsistencies and questions. I therefore put together a paper (which subsequently formed the basis for the Grant Thornton review) in an attempt to either get some answers and/or demonstrate that there had been weaknesses in CQC's approach. I sent this paper to Amanda Sherlock and Cynthia Bower (CB) copied to the chair, Jo Williams (JW) and the rest of the board on March 19th 2012. I did not receive a reply from AS and CB, only a cursory reply from JW and nothing from the rest of the board.

Due to the level of my concerns I sent the paper to senior officials at the DH on 22nd March 2012 but I was unable to secure an appropriate response. At this point I decided to speak to the Daily Telegraph and an article was published on 30.3.12. My personal data from the DoH shows that my questions regarding UHMBT caused concern and that (unknown to me) they considered suspending me. A decision was taken not to suspend me as it was deemed more risky to suspend me than to keep me in post. However the balance eventually tipped the other way on March 31st 2012 and I was sent a letter by Andrew Lansley saying he was considering removing me.

As part of my response to the attempt to remove me, I sent Andrew Lansley a detailed document on 4th May 2012 outlining my concerns about CQC, and specifically including the issues relating to Morecambe Bay. The response once again was to simply refute the concerns I had raised. I had previously met with Andrew Lansley on February 8th 2012 outlining my concerns about CQC and subsequently provided further evidence in corroboration. No response had been forthcoming.

Grant Thornton report

The review was initially commissioned in August 2012 and was intended as a desk top exercise to address the concerns I'd raised. This resulted in more questions and as such the terms of reference were amended. In fact the focus of Grant Thornton review went through various iterations with changes to the terms of reference, scope and methodology due, in part, to the nature of the evidence that was emerging. Whilst the review was thorough and meticulous there are substantial limitations – as outlined by the authors of the report. As such, the report raises as many questions as answers it provides. I do not believe this was due to any omission on Grant Thornton's part but rather it reflects the changing and complex nature of the review as well as its limitations particularly the fact that the role of other organisations could not be explored in any depth.

Although the review was conducted independently there was frequent contact with the current CQC CEO who, in turn, was in contact with the DoH (I derived this information through another request

under the Data Protection Act). Thus the emergent findings from the review were shared with CQC and most likely the DoH. In December 2012 the CQC board was told that it was likely disciplinary action would be taken against members of the executive team but no further information was given. Since then most of the board and executive team have moved on.

My interview with Grant Thornton took place on 1st October 2012. It was not until this day that I found out that the review was looking at the concerns I'd raised. After the interview, I put together a submission outlining key events which I sent to GT on 21st October 2012. The first time I saw the report (or had any indication of the findings) was on June 17th 2013 just two days before the report was published. There was no opportunity for me to comment on any drafts or emergent findings.

I am concerned that the report states that CQC could only provide paper copies of emails to GT and that emails are only kept for 12 months. This does not accord with my understanding. I wrote to David Behan on June 27th 2013 asking for clarification but, at the time of writing, I have yet to receive a response.

My understanding is that those criticised in the report were written to ahead of the publication as part of a fair process. I don't know who was written to or the details of any replies. I believe there was a threat of legal action under the Data Protection Act and possibly defamation but I have not seen or heard the details of this. I believe the threat of litigation and resultant legal advice led to the report being anonymised. This was probably an error of judgement but was quickly rectified (following advice from the ICO) and acknowledged as such by CQC – which I view positively.

My paper on Morecambe Bay: the 11 questions

The specific '11 questions' in Chapter 4 of the GT report are those posed in my paper of March 2012. Grant Thornton has investigated each question and provided detailed answers. The findings demonstrate that the regulation of Morecambe Bay was woefully inadequate. At the present time I am confident that limitations of the current regulatory approach have now been acknowledged and that actions are being taken to establish a more robust approach. A major transformation is required and there is a long way to go as we are in effect 'starting over'. I am more optimistic about the future of CQC and more confident in the current leadership to deliver the required changes. This optimism is shared internally and by many external stakeholders.

However I remain concerned about what could be termed the cover up issues.

Cover up

There are two main issues relating to cover ups in the report which are inextricably linked. One relates to the much publicised suppression of a critical report and the other relates to actions taken to hide or disguise regulatory – and organisational – failings. In my view the former stems from the latter. In turn the latter is indicative of the culture of the organisation (and indeed more widely in the health environment).

I have no specific knowledge of the suppressed report or the meeting where its alleged deletion was ordered. It is significant that I was not made aware of the report by anyone in CQC given the concerns I raised. It is my opinion that the incident could easily have taken place given the culture of the organisation (described further below). It is noteworthy that the report by Louise Dinely (Mr J) was initially discovered by GT via an internal 'source' and not from senior managers (page 230). It is also significant that the report 'disappeared' within the organisation in that it did not reach the front line team or the Risk and Escalation Committee both of which would be clearly indicated. The GT report details various responses within CQC as the problems at UHMBT re-surfaced which appear to support the assertion that CQC sought to minimise negative publicity about the regulatory omissions (pages 237 – 244 are pertinent).

The responses I faced when attempting to raise concerns about the regulation of Morecambe Bay hospitals are indicative of the prevalent culture of secrecy and self-protection in, at least some parts, of the wider health environment. The CQC chair, board, executive directors, senior Department of Health officials, the Permanent Secretary and the (previous) Secretary of State all refused to respond to my concerns. They did this in the knowledge that there were other concerns being raised about failings in relation to UHMBT.

It is very apparent that the omissions at UHMBT are widespread and not confined to CQC. In fact to lay the blame solely at CQC's door would be inaccurate, unfair and could hamper securing the truth of what did, and didn't, happen. It is evident from the GT report that there were frequent communications with other stakeholders including UHMBT, the SHA, the Department of Health, Ministers, Monitor and the PHSO. The nature of these interactions suggests an ethos of minimising concerns and an approach overly focussed on media and reputation management.

Culture

In the report, Grant Thornton has, quite rightly, adopted a technical and methodical approach in establishing whether there was a cover up. However I would distinguish between a culture of suppression – and oppression – and the technical definition of a cover up. It would seem reasonable to conclude that where such a culture exits, explicit acts of covering up are more likely. The culture of CQC, at least until 2012, was one that was characterised by minimising 'bad news' and putting reputation above all else. The culture was also one within which bullying could – and did – flourish.

After I raised concerns more assertively, from the summer of 2011, attitudes and behaviours towards me became problematic. These increased further after my appearance at the Mid Staffs Public Inquiry. I have detailed these in my evidence to the HSC from August 2012. In short there were repeated, concerted attempts by CQC and the DoH to undermine, discredit and remove me. I asked for facilitated mediation in December 2011 but this was refused. After the Compromise Agreement with Andrew Lansley mediation was agreed. The aim of this was to improve the working relationships of the board but this did not happen. Neither the chair nor the board sought to engage appropriately with me on the issues I raised. On the contrary they sought to discredit and exclude me. In my view this is unacceptable behaviour from public appointees in responsible positions.

One of the main issues I have been concerned about has been bullying within the organisation. I was very concerned about some of the things CQC staff were saying to me. I raised this in September 2011, at the Public Inquiry and several times after this. This was refuted and I was told to provide evidence. To which I replied I could not give staff names as this would run the very real risk of repercussions for those staff (which I advised the board of). I requested an independent investigation several times but this was refused. My personal data shows that the Director of Human Resources dissuaded the chair from taking concerted action including setting up an independent investigation.

When David Behan came into post he commissioned an independent investigation into bullying and harassment. The board is due to receive the report at it extraordinary meeting on July 2nd 2013. The findings of the investigation are stark reporting "worrying levels of perceived bullying at all levels in the culture". It also states that staff that were interviewed (236) wanted strict anonymity. Informal feedback I have received from staff is relief that the investigation was commissioned and a belief that this indicates determination to create a more open and supportive culture.

My situation

Up until the publication of the Grant Thornton report, there was a plan to manage me until the end of my current appointment even though I made it clear I wanted to continue and that I was eligible to be re-appointed. My personal data from the DoH talks of a 'long term view on [my] dismissal' after the move to remove was aborted following the notice to instigate legal proceedings against the Secretary of State. Since the publication of the GT report, there has been a dramatic turnaround in attitudes towards me. This would not have happened if the Grant Thornton review had not been undertaken. David Behan deserves credit for commissioning the review and committing to publishing the report. It is worth reflecting that many whistle blowers are not afforded the opportunity to have their concerns investigated in a thorough and open way.

Conclusion

I believe the publication of the Grant Thornton report can be seen as a seminal moment for CQC and potentially the wider health environment in challenging the culture that has dogged the NHS for some considerable time. We need to move towards openness, honesty and accountability. CQC needs to operate without fear or favour and be accountable to the public and not the DoH or the Minister.

It is important that CQC is allowed to move on but this must not be at the expense of accountability for past failings. Significant questions remain about what happened during 2010–12. These are not confined to the actions and omissions of CQC and, most likely, do not just relate to Morecambe Bay hospitals.

1 July 2013

Written evidence from James Titcombe (CQC 05)

Background

In November 2008, my baby son Joshua died due to failures in his care at Furness General Hospital (FGH). Subsequent to his death, I have been through the entire NHS complaints process to try and ensure that the truth regarding what happened to Joshua was established and ensure that lessons were learned so that the same mistakes were not repeated.

This process started with the Trust's internal complaints procedure, which I felt was inadequate. Then, in early 2009, I referred my complaint to the Parliamentary and Health Service Ombudsman (PHSO) and the Care Quality Commission (CQC).

In February 2010, PHSO refused to investigate, citing that the CQC were the organisation best placed to deal with the issues involved. In May 2010, the CQC registered University Hospitals of Morecambe Bay Trust (UHMBT) without conditions. In June 2010, the CQC carried out an inspection of maternity services at FGH, which found the unit fully compliant and meeting all essential standards of care. Later in 2010, Monitor awarded UHMBT Foundation Trust status.

The Fielding Report

Unknown to me at the time, there were other Serious Untoward Incidents (SUIs) involving maternity services at FGH in 2008. I now know that this led to the Trust commissioning an external expert, Dame Pauline Fielding, to carry out a full review of the Trust's maternity services. This report (now referred to as the 'Fielding Report') was completed in March 2010. I have included a copy of the Fielding Report with this submission. This described FGH as a 'problem unit' and detailed numerous significant concerns about patient safety.

In May 2010, several weeks after the Trust received the Fielding Report, I met with the former UHMBT Chief Executive, Tony Halsall. During this meeting (which I recorded), I was told that, "CQC had crawled all over the maternity services" at FGH and that, "there was nothing this organisation knows about its maternity services that it hasn't shared fully and openly with CQC".

The truth was that the Fielding Report was not shared with the CQC or any other regulatory body. However, the Grant Thornton Review states that CQC were informed of its existence on 'at least two occasions' but did not follow up to request a copy until several months later.

Joshua's Inquest and subsequent regulatory action

Following the PHSO's decision not to investigate, I wrote to the Coroner in Newcastle, where Joshua died 9 days after his birth, requesting him to open an Inquest. The Newcastle Coroner was initially reluctant to do so, but following the exchange of several letters, an Inquest was eventually opened with jurisdiction transferred to the Coroner in Barrow-in-Furness.

It was during the course of the Inquest preparations that I became aware of Fielding Report, which in January 2011, was sent to me by my solicitors. The significance of the Fielding Report was immediately apparent to me, so on the same day that I received it, I forwarded a copy to regional director of the CQC. It was later confirmed that this was the first the time that the CQC had seen the report.

In January 2011 Cumbria Police informed me that they were investigating the circumstances of Joshua's death. This was not made public at the time.

In June 2011 the Inquest into Joshua's death was held. The Inquest revealed significant failures in Joshua's care. The Coroner wrote a rule 43 letter. Cumbria Police formally announced an investigation that was later widened to include a number of mother and baby deaths. Various other regulatory activities were then triggered.

This regulatory activity initially involved a CQC response review and inspection at FGH which found significant problems. This triggered Monitor to commission a 'diagnostic review' of the Trust's

maternity services, which was published in February 2012. This concluded that mothers and babies at FGH remained at 'significant risk'. A subsequent 'lessons learned' report (KPMG) commissioned by Monitor and published in July 2012 stated the following.

"It would be hard to conclude anything other than that most of the underlying issues in maternity were present throughout the period of assessment and up to the current time."

http://www.morecambebayinquiry.co.uk/images/pdfs/Monktor%20lessons%20learned%20report%2012%20July%202012_1.pdf

It is in this context, and the certainty that lives were lost due to failures in maternity services at FGH subsequent to false assurances provided by CQC, that I am now making this submission to the Health Select Committee.

Grant Thornton Report – process and delays

The background to how and why the Grant Thornton report was commissioned is detailed in the report itself and I will not repeat the detail here. It is however necessary to highlight that during the course of the Grant Thornton review I expressed concerns to the CQC on a number of occasions. I felt that the issues being considered were extremely serious and I was concerned about the robustness and independence of the process. I was also concerned that during the course of the review the expected completion date was extended time and time again. In response to these concerns I received numerous reassurances from the CQC.

After more delays David Behan advised me in March 2013 that the Grant Thornton report would be completed and handed to CQC on 19th April 2013 and would be presented to the CQC Board on 25April. However, on 19April (at 16.42) I received an email from David Behan informing me that the report was not complete and that the planned Board meeting for 25th April had been cancelled.

Just a week later (26th April), I noticed an 'exclusive' article in the Health Service Journal (HSJ) detailing how CQC had overhauled the entire CQC Board.

http://www.hsj.co.uk/news/workforce/exclusivecqcoverhaulsboardandbringsindwpchangedirector/5057957.article

This sequence of these events seemed odd and I raised my concerns with David Behan. I was told that the changes to the Board had nothing to do with the Grant Thornton report and that the decision to remove senior CQC executives was part of CQC's wider strategy development.

I am aware that a short while later, the Daily Telegraph reported this story in the context of the anticipated release of the Grant Thornton Review. However, the day after, the Telegraph story was taken off-line and I was informed that CQC had threatened legal action against the Daily Telegraph. The Daily Telegraph confirmed this in an article dated 20th June 2013 (link below).

http://www.telegraph.co.uk/health/healthnews/10133561/New-CQC-chief-threatened-to-sue-after-we-exposed-failings.html

According to this article, Mr Behan lavished praise on the directors, who he said had "given a tremendous amount to the CQC over the past four years". Mr Behan is quoted as saying "Their guidance and leadership has been crucial in setting our new strategy".

I struggle to reconcile this with the recent CQC analogy of a "fish rotting from the head down".

My specific concerns with the Grant Thornton Report

I wish to draw to the attention of the Health Select Committee to the following issues:

Non availability of CQC emails

Page 31 paragraph 2.31

"While we have seen a number of paper copy historical emails, we understand from CQC that it does not retain historical electronic emails older than a year. This has therefore had a limiting effect on our email review process."

Given that the Grant Thornton Review was intended to be a forensic review of the circumstances leading up to registration of Morecambe Bay (which occurred in late 2009/early 2010), this statement is deeply concerning.

David Behan has since stated, "I would like to confirm that Grant Thornton were given full access to CQC information" and that "...emails are stored on a shared electronic storage area, they, along with all other records, are kept in line with our records management policy. CQC's records management policy allows for records to be retained for usually between three and seven years, depending on the content."

I am confused as to why Grant Thornton have stated that CQC "does not retain historical electronic emails older than a year", in view of David Behan's comments.

I hope this is something the Health Select Committee can clarify.

Independence of CQC/PHSO decisions

Pages 70–91 of the Grant Thornton Review deal with a specific concern I raised in relation to the interactions between the PHSO and the CQC surrounding the decision by both organisations not to formally investigate Joshua's death and the connected subsequent decision by CQC to register UHMBT without conditions.

The Grant Thornton Review details clearly the sequence of events and the interactions between the two organisations. I am not questioning the sequence of events described in the report. However, I feel that these events do not lead to the conclusions reached by Grant Thornton.

My concerns were sparked in 2012 when I received information under the Data Protection Act (DPA) from both PSHO and the CQC. This information contained a memo written by the former deputy Ombudsman (Kathryn Hudson) to the former Ombudsman (Ann Abraham). The memo states:

"In your conversation with Cynthia Bower shortly before your leave, the suggestion arose that if we could assure Mr and Mrs Titcombe that as a result of their experiences CQC are now taking robust action to ensure improvements in the maternity services at the Trust, you might decide not to investigate".

Another note of this meeting (which was provided to me by the CQC under DPA but not the PHSO), was a reference in an email from Kathryn Hudson to Amanda Sherlock (former CQC Director of Operations) written on 4th September 2009. This is stated that during the meeting, Cynthia Bower had:

"...suggested there might be a better way to deal with the issues involved through other assessments of the quality of the Trust and the future of midwifery services in the North West"

When interviewed about the memo and this email, the Grant Thornton Review states (Page 81 paragraph 3.186) that Kathryn Hudson "told us that what she had written was an accurate reflection of her conversation with [Ann Abraham] after the [Abraham/Bower] meeting on 12 August 2009." Further, Kathryn Hudson told the Grant Thornton team that, "this was supported by [Ann Abraham's] response to hers, in which [Ann Abraham] concurred with her assessment."

This section of the report describes how under interview, Ann Abraham and Cynthia Bower both deny having had such a conversation. Page 87 paragraph 3.228 states that Ann Abraham had stated that,

"she would not have had an unminuted discussion with Cynthia Bower on such a serious matter along the lines suggested by [Kathryn Hudson]".

Despite the denials of Cynthia Bower and Ann Abraham that such a discussion took place, Page 88 paragraph 3.231 of the Grant Thornton Review concludes that:

".... more likely than not... a discussion concerning which organisation was best suited to deal with the issues arising from the complaint occurred at that meeting".
If this conclusion is accepted, it infers that either the recollections of Cynthia Bower and Ann Abraham are not accurate or that their statements are inconsistent.

If Cynthia Bower and Ann Abraham had an undocumented discussion about my son's death on 12 August 2009 (as the Grant Thornton Review concludes more likely than not did occur), it suggests other unminuted discussions between Ann Abraham and Cynthia Bower may have taken place.

Concerns about the relationship between CQC and UHMBT

In an email from Tony Halsall (former Chief Executive UHMBT) to Eddie Kane (the former UHMBT Chair) of 2nd June 2009 (before the conversation between Cynthia Bower and Ann Abraham about 'which organisation was best suited to deal with the issues' took place), Tony Halsall wrote:

"If I'm correct then the CQC can cover off the Ombudsman in their response if they are prepared to have that conversation with them which they didn't indicate they were not."

This suggests a degree of collusion between UHMBT, the CQC and the PHSO.

Grant Thornton's analysis of these events

The Grant Thornton Review dismisses my concerns The report concludes (Page 91 paragraph 3.248):

"on the basis of the information presented and the evidence gathered, it would seem that there is no basis to any suggestion that there was anything improper about the CQC's contact with the PHSO, or that the CQC's former CEO sought to influence PHSO not to investigate the complaint."

The report concludes that that the decision's taken by both CQC and PHSO were independently made and there was nothing improper about the contact between the two organisations.

The report also states that my concerns in relation to the email from Tony Halsall to Eddie Kane (Page 90 para 3.241) are 'groundless'.

This does not seem to me to be a reasonable conclusion based on the evidence.

For example, page 89 paragraph 3.236 states:

"The facts are that CQC had made a decision not to investigate the Baby T case on 27th May 2009, almost a week before [Tony Halsall's] email mentioned above."

This is simply not the case as evidence earlier in the Grant Thornton Review (page 49 paragraph 3.54) refers to a letter from Cynthia Bower to the Executive Chair of Monitor dated 12June 2009 (after 27May 2009). This states that the final decision on whether to investigate was "pending the outcome of the PHSO review".

This is further supported by the interview with the regional director of the CQC on 7th February 2013. Page 76 paragraph 3.161 confirms that "a final decision on whether to investigate was, in effect, stayed until the PHSO had concluded their work".

The facts are, that the CQC had not made a final decision not to investigate UHMBT in May 2009. The Grant Thornton review itself is clear that any such decision had been stayed pending the outcome of the PHSO review.

This is completely consistent with Tony Halsall's email to Eddie Kane on 2nd June 2009, in which he states his confidence that the CQC would "cover off the Ombudsman" if "they were prepared to have that conversation". Despite the denials from Cynthia Bower and Ann Abraham, the Grant Thornton Review confirms that the CQC were indeed prepared to have such a conversation.

Page 89 paragraph 3.239 states "No evidence has been found to suggest the former CQC CEO [Cynthia Bower] communicated or even knew the UHMB Chief Executive [Tony Halsall] at the time". The implication in the Grant Thornton Review is that this is somehow proof that nothing untoward or inappropriate has occurred between the two organisations. This does not follow. There are considerable avenues of networks and relationships between the two organisations that could have led to communications about such intentions being exchanged. The report offers no innocent explanation for how Tony Halsall could have been given the impression that a conversation between CQC and PHSO would happen, something which subsequent events demonstrate he was correct about. I find it hard to accept that his email to Eddie Kane was merely a lucky guess, plucked from thin air.

Grant Thornton's analysis of these events is therefore fundamentally wrong and does not follow from their own evidence.

The Grant Thornton analysis continues, it is argued that Cynthia Bower could not have unduly influenced the Ombudsman's decision not to investigate as "the CPHSO [Ann Abraham], independent of any influence from CQC, was already minded not to investigate the complaint prior to her meeting with the CQC's CEO [Cynthia Bower] on 12th August 2009."

Again, this is extremely misleading. In fact, the earlier panel meeting on that same day to discuss Joshua's case is referred to on page 72, paragraph 3.144. This states "...the CPHSO [Ann Abraham] expressed a view that in light of a number of SUI's at UHMB, CQC should be persuaded to take 'relevant action' and that if such an undertaking could be secured the PHSO should discuss this with the Complainant'. The report goes on to say 'The note concludes by recording the CPHSO deferring any decision concerning the complaint until after the CQC meeting".

Whatever happened before the panel meeting is irrelevant. The fact is that on 12th August 2009, Ann Abraham had clearly not made a final decision on whether or not to investigate Joshua's death and stated herself that such at decision would be deferred pending a planned meeting with Cynthia Bower later that day. The subsequent conversation with Cynthia Bower is clearly absolutely critical to the decision Ann Abraham later took not to investigate.

In terms of the independence of the PHSO process, page 91 paragraph 3.246 concludes that the CQC had "on more than one occasion" assured the PHSO that "something was being done". The report goes on to say "These assurances, which came from CQC's North West Region and not the CQC's then CEO, appear to have persuaded PHSO not to investigate the complaint.'

Grant Thornton therefore tries to separate the reassurances given by CQC's regional team with any involvement of Cynthia Bower. This ignores the evidence from Kathryn Hudson (which she firmly stands by), in which she wrote that during the August meeting, Cynthia Bower had "...suggested there might be a better way to deal with the issues involved". In any case, Grant Thornton confirm that 'more likely than not' the discussion that took place at the meeting between Ann Abraham and Cynthia Bower involved 'which organisation was best suited to deal with the issues arising from the complaint'. Therefore, it can reasonably be concluded that that discussion must have involved some reassurance from Cynthia Bower that CQC would take action, otherwise the PHSO's decision not to investigate would surely have been different.

Grant Thornton concludes that CQC:

"apparently misinterpreted the reasons for the PHSO's decision not to investigate the Baby T case" (see table on page 300). Page 103, paragraph 3.287 states "the exact cause of the misinterpretation is unknown to us."

Grant Thornton's conclusion that the decisions take by CQC and the PHSO were independent and

proper, does not stand up.

The current CQC leadership claim to be making a fresh start on the task of making the organisation fit for purpose. How can this be the case if they are still unwilling to recognise what really happened under the previous regime?

In my opinion, the Grant Thornton review failed to help the CQC in this area.

I hope this issue can be taken up by the Health Select Committee.

The 'alleged' cover up

I feel that there is far too much emphasis on what specifically was said at the much talked about meeting of 12th March 2012. In this meeting, it is alleged that an instruction was given to a senior member of CQC to 'delete' a critical internal review of CQC's regulatory activity at UHMB.

These events have been much debated in the media over the last few weeks and there has been strong denial from the people involved. Despite this, for me the wider picture is clear. As well as the alleged 'delete' instruction, Page 251 paragraph 6.104 states that Mr J was also asked:

"to provide a summary chronology of CQC's regulation of UHMB, free of references critical of CQC".

The report goes on to say:

"In effect, he had been asked to omit anything that could be considered damaging for CQC."

I am familiar with this chronology as I received a copy of what I assume must have been this document when I requested all information under the DPA.

In my opinion, the instruction to rewrite the report removing any criticisms of CQC's actions, can only be considered as a deliberate act to hide its regulatory failures at UHMBT.

Furthermore, just weeks after the alleged 'delete' instruction was given, CQC Board Member Kay Sheldon, raised her own concerns about CQC's regulation of UHMBT. Ms Sheldon was informed that CQC's actions were consistent with 'a robust piece of enforcement work'. (Page 211, paragraph 5.11).

I am further convinced that CQC deliberately suppressed known concerns about its regulatory actions at UHMBT from other facts I am aware of. For example, in May 2012, Tim Farron MP wrote to Andrew Lansley specifically to ask why earlier CQC inspections at FGH had failed to uncover problems which the Monitor 'lessons learned' report had confirmed were "present throughout the period of assessment and up to the current time."

The internal CQC report which was allegedly deleted has been published on the CQC website. In relation to CQC's inspections at FGH, the internal reports referred to:

"..the limited scope of the inspection along with the evolving understanding and experience of the regional team in its application."

It also concluded that:

"...the limited scope of the regulatory activity was insufficient to provide firstly an overall judgement on the Trust in terms of the safety and quality of systems and secondly to describe the limitations and context of any regulatory judgements at the time."

Despite these serious issues which clearly CQC were aware of; on 6th June 2012, the then Chair Jo Williams responded to Tim Farron's letter by defending CQC's regulatory activity at UHMBT. Her letter contained no reference to the acknowledged failings detailed in the hidden internal review. I have included this letter with this submission.

Whilst the specific issues surrounding the 'delete' instruction may be disputed, there is no doubt that CQC's own concerns about its own regulatory failures at UHMBT were suppressed by themselves.

The Grant Thornton review confirmed that these concerns were first raised internally within CQC in October 2011 (Page 239, paragraph 6.46).

The real cover up

In all of this, I am increasing saddened that the focus has moved away from what the Grant Thornton Review is really about. This is the regulatory activity undertaken by CQC leading up the registration of UHMBT without conditions, and the subsequent false assurances given regarding the safety of maternity services at FGH. These events led to the lives of mothers and babies being put under 'significant risk' for a number of years. I personally know families who lost babies due to failures in care at FGH or in some cases, are bringing up children with significant brain injuries, which occurred after CQC gave these false assurances.

As recently as the 30th June 2013, the family of Eloise Hutchinson spoke for the first regarding the unnecessary death of Eloise at FGH on 25th December 2010.

In the Sunday Express newspaper, Eloise's mother said:

"I only discovered well after Eloise's birth about problems at the hospital maternity unit. If I'd known how bad it was I would never have agreed to have my baby there."

"I am appalled at what the regulator did. How could they give the maternity unit the green light? It's a disgrace."

"The Care Quality Commission is meant to be there to make sure hospitals are safe. And if they are not safe they should do something about it."

http://www.express.co.uk/news/uk/411362/Motherspeaksoutatscandalhithospitalwherehernewbornbabydied

I believe that the sequence of events described in the Grant Thornton Review, considered in isolation of wider context is simply inexplicable.

When I met with Les Dobie of Grant Thornton in the early stages of the review, I pointed out there were wider issues at the time these events occurred that needed to be considered. I have raised these issues in my blog on 22nd June 2013, which I have included with this submission. The Grant Thornton Review unfortunately, has in many respects failed to fully address these concerns.

I hope that the committee can challenge the incredible sequence of mistake after mistake and bring out just how appalling the actions of CQC were. In doing so, please reflect on the fact that in December 2009, the CQC regional director in the North West warned of 'future tragedies' unless standards of maternity care at UHMBT improved. How can the subsequent actions of CQC be described as anything other than grossly negligent given such a clear acknowledgement that the lives of mothers and babies were at risk.

The Grant Thornton review repeatedly states that these events happened with no external pressure, despite elsewhere in the report questioning the credibility of the evidence senior CQC executive gave.

Despite the very important exposure of major failure of the CQC in its regulation of UHMBT, it seems clear that a full understanding of what happened and why is yet to emerge.

If confidence in the regulation of the NHS is to be restored, it is vital that a further and wider investigation into these issues is urgently undertaken.

30 June 2013

Morecambe Bay Inquiry Action Blog
http://www.morecambebayinquiry.co.uk/index.php/blog

Grant Thornton Investigation – 22nd June 2013

On Monday last week, I travelled along with my MP John Woodcock to meet with David Behan at a Holiday Inn conference room in Lancaster. I recall feeling very nervous. David Behan had previously expressed his opinion that Morecambe Bay should not have been registered in 2010 'without compliance conditions'. I was expecting the report to be critical of CQC's regulatory actions at the Trust. However, the concerns I had asked David Behan to ensure were considered went much further than this.
I was concerned that the regulator may not just have catastrophically failed in its regulatory responsibility, but may have deliberately done so in order to protect the reputation of the DoH and Ministers at the time, in the aftermath of the Mid Staffs scandal and assurances given that events there were 'isolated' rather than representative of more systemic failures across the NHS.

At first glance, such concerns may seem far-fetched, but other evidence needs to be carefully considered.

For example, evidence submitted to the Francis Inquiry by Roger Davidson, who had a senior communications role at the CQC during this time period.

Mr Davidson describes the relationship between the CQC and Ministers: he says 'The government's focus would be on minimising political fallout'.

Davidson describes how he was removed from post shortly before the May 2010 General Election after a piece appeared in the Guardian newspaper which highlighted work done by CQC into healthcare associated infection (HCAI). The report included examples of appalling practice regarding infection control across the NHS.

Davidson writes 'Other than the fact that the article appeared on page 1 rather than page 6, I do not know why the CQC were so upset. I know that a General Election was due to take place the following month, and, although I cannot prove this, I suspect there were conversations between the CQC and Ministers to the effect that the CQC would not cause any trouble in the run up to purdah.'

Davidson is not the only former CQC employee to have expressed similar concerns. The former senior CQC inspector who played a major part in uncovering the scandal at Mid Staffs, Heather Woods has been outspoken in recent days about what was going on at the time. She has stated 'CQC were dancing to the tune of the DoH... they were in the business of suppressing bad news'.

Today, David Morris MP has written to Andy Burnham stating

....the Chair of the CQC at the time, Baroness Young, later said you, who she specifically named when giving evidence to Mid Staffs – had put the regulator under 'pressure' to 'tone down' criticism of hospitals around that period.

The concerns go on and on, MP and Health Select Committee member Charlotte Leslie states

What worries me about this saga is that the Morecambe Bay horrors...are actually the symptoms of a far deeper and more sinister mafia-like network at the centre of the NHS.

In Parliament this week, Dr Sarah Wollaston stated

The public will be horrified, but not probably be surprised, to hear that Ministers were leaning on the CQC not to criticise NHS hospitals.

In the same Parliamentary session, Health Select Committee Chair Stephen Dorrell described the 'long litany...of events' detailed in the Grant Thornton report as 'inexplicable'. Considered in the absence of wider context, I agree. The report details pages and pages of events that simply defy any kind of

reasonable explanation. However, considered in the wider context of the concerns repeatedly talked about in recent days, things start to make more sense.

Serious systemic concerns about maternity services and wider governance at Morecambe Bay were passed off from the Parliamentary and Health Service Ombudsman (PHSO) to the CQC with promises of 'robust action' that failed to materialise. Even now, there are unresolved discrepancies regarding the nature of discussions between the two organisations.

There were warnings of 'future tragedies' from the regional team unless improvements were made, yet there was not even a basic pre¬inspection before registering services as fully safe just months later.

The report states that the PHSO were 'actively pushing for CQC to confirm it would launch its own investigation into the Trust..' and goes on to say that 'CQC appears to have duly acquiesced to PHSO's representation and offered it assurance on more than one occasion that something was being or would be done'. The report states that 'these assurances...appear to have persuaded PHSO not to investigate'. (Page 91 para 3.246).

Despite this, CQC were told on at least two occasions about an external review of maternity services at the Trust (the Fielding review), yet made no attempt whatsoever to request a copy.

Mortality alerts from Dr Foster were not acted on and the report states "We have also seen that CQC staff were in possession of adverse evidence which does not appear to have been considered or taken into account prior to registration". (Page 132, para 3.405)

Detailed 'safety concerns' were sent to the CQC by the Primary Care Trust (PCT) on 8th June 2010, yet the report confirms that these 'did not appear to have been followed up'. (Page 152, para 4.36)

In what is perhaps the most appalling revelation in the report, despite the assurances CQC gave regarding 'robust action', the inspection CQC eventually carried out (June 2010) 'lasted only one day and was conducted by inexperienced inspectors lacking maternity experience and, in the lead inspector's case, a lack of confidence in her own ability'. The report states that the 'second inspector had no NHS experience at the time and participated in the inspection as part of her learning objectives'.

Here is the killer line (page 151 para 4.31), we are told the lead inspector was

...aware of the inadequacy of her experience and, prior to the inspection, sought from within CQC specialist clinical input without success.

From whom did she seek help – the same central CQC team who 'acquiesced to PHSO's representation and offered it assurance on more than one occasion that something was being or would be done'?

The report quotes the inspection team as saying

...applying conditions was not encouraged

Careful consideration must be given as to the wider context of what was going on during this period and ask the question; could these events have happened due to entirely innocent mistakes and genuine oversight (as Mr Behan and Mr Prior would have us all believe) or is it more likely that what happened, as Charlotte Leslie puts it, was a 'symptom of a far deeper and more sinister mafia-like network at the centre of the NHS'?

The net result of these appalling circumstances was that a small maternity unit in Cumbria continued to place the lives of mothers and babies under 'significant risk'. Devastating failures that families who lost children and loved ones in 2008, fought so hard to ensure were not repeated, were instead suppressed and more lives were lost as a result. Further, issues regarding poor clinical leadership at the Trust were also ignored, mortality rates rocketed Trust wide and the full toll of subsequent failures is still unknown.

For obvious reasons, the media attention this week has focused on the shocking allegations that senior staff within CQC conspired to ensure a critical internal review was deliberately hidden from the public and not acted on appropriately. The report concludes that an instruction to 'delete' this internal review 'more likely than not' did occur, and that such an act could reasonably be described as a 'cover up'.

There has to be a real and justified concern that the potential cover-up goes far wider and is far more serious than this. How can any of us have confidence in the regulation and wider governance structure of the NHS (including the DoH), until these concerns are properly ruled out through a forensic and independent investigative process?

The apologies this week to families affected by events at Morecambe Bay are hollow and meaningless unless such a process is now urgently established.

Before finishing this blog, on behalf of all members of Morecambe Bay Inquiry Action, I would like to express sincere thanks to Kay Sheldon for all that she has done. If it was not for Kay's courage and bravery, the full extent of this week's revelations would not now be known. The treatment Kay has endured at the hands of CQC is nothing short of disgraceful. The fact that David Prior and David Behan have so far made no public apology or confirmed her reinstatement on the Board, is nothing short of shameful.

James Titcombe
Morecambe Bay Inquiry Action (MBIA) spokesperson
22 June 2013

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Tim Farron MP
House of Commons
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6 June 2012

Your Ref: MSTR031

Dear Mr Farron

Re: Inspection's undertaken at the University Hospitals of Morecambe Bay NHS FT, in particular the Furness General Hospital

Your letter to Rt Hon. Andrew Lansley has been passed to the Care Quality Commission (CQC) so that I can respond to your questions in relation to the methods of inspection used by CQC at the University Hospitals of Morecambe Bay NHS Foundation Trust (the trust) and in particular the Furness General Hospital.

I would like to thank you for raising your concerns and providing me with the opportunity to outline some of CQC's work within your constituency. I will provide you with an overview of the work we have completed in respect of the trust and hope to assure you that our inspection programme has been delivered appropriately and in accordance with statutory responsibilities.

As you are aware, In April 2010 the trust was registered as required by the Health and Social Care Act (2008) (HSCA). In assessing the trusts application we determined that there was a minor concern in relation to regulation 22 (outcome 13 - Staffing). The concern was identified in response to the matters raised following the death of baby Joshua Titcombe. We issued the trust with an improvement letter and asked the trust to make specific improvements to the identification of risk for mothers and babies at Furness General Hospital.

We followed this up in June 2010 and CQC carried out an unannounced inspection of the Furness General Hospital. Using all the information and intelligence we held about the trust, we checked whether Furness General Hospital had made these specific improvements, CQC's inspection found that the specified improvements had been made. This was also corroborated with the Strategic Health Authority (SHA) who indicated that they were satisfied with the Trust's progress and in particular, the response made as a result of Joshua Titcombe's death.

In April 2011, around the time that we carried out a full inspection at the UHMB's Royal Lancaster Infirmary site, CQC started to receive new information, including the Fielding Report the Coroner's inquest into Joshua Titcombe's death at the Furness General Hospital; the Ombudsman's findings; and concerns raised by the Nursing and Midwifery Council (NMC). CQC acted immediately and carried out a planned inspection of maternity services in July 2011, jointly with the NMC. The Fielding report was not shared with the CQC at the time of the 2010 inspection.

The unannounced inspection covered all three hospital sites and indentified a number of major concerns with maternity services. In September 2011, we issued a formal warning notice demanding immediate improvements in relation to regulation 10 (outcome 16 – Monitoring Quality) at Furness General and Royal Lancaster Infirmary sites.

In October 2011 CQC held several risk summit meetings to ensure that key agencies collectively shared information and concerns. These meetings included Monitor, service commissioners and the SHA.

As a consequence of the Maternity Review and a number of emerging concerns the SHA established GOLD command, a strategic coordinating team that is mobilised in response to patient safety issues. Monitor also undertook a formal review of the trust and found them to be in significant breech of their authorisation. Monitor commissioned several pieces of work including a diagnostic review of maternity services (published in December 2011). We are working closely with Monitor, GOLD Command and all local agencies to actively ensure the delivery of care at this Trust.

In January 2012 CQC launched a full-scale investigation, using our powers under section 48 of the HSCA (2008), into the trust's emergency care pathway. The report is due to be published in early June. We would be very happy to meet with you then to discuss our findings. We have also indicated to the Minister of State for Health that we would also be happy to participate in another meeting with all the local MPs on the investigation findings as we did at the start of the investigation.

I would also like to take this opportunity to reassure you that CQC are working closely with the University Hospitals of Morecambe Bay NHS Foundation Trust, Monitor and the SHA to ensure that the quality of care provided to your constituents meets their needs, the Government's standards and protects their rights.

I trust that this information is helpful to you and would like to thank you again for raising your concerns.

Yours sincerely

Dame Jo Williams
Chair
Care Quality Commission