**Context**

In October 2011, NHS East Midlands, NHS East of England and NHS West Midlands merged to form the NHS Midlands and East SHA Cluster. As the successor body, NHS Midlands and East is submitting this memorandum on behalf of NHS East Midlands. This document is designed to inform the deliberations of Committee members in advance of Gary Walker’s evidence session on Tuesday 19 March 2013.

The content of this document is based on records and reports available to NHS Midlands and East, and on the recollections of individuals directly involved in the local health system at the time of Gary Walker’s tenure as Chief Executive of United Lincolnshire Hospitals NHS Trust.

**Summary**

NHS East Midlands challenges Gary Walker’s contention that he is a whistleblower because he raised concerns about patient safety. NHS East Midlands is clear that there has never been any finding that Gary Walker had raised genuine concerns that would constitute his designation as a whistleblower.

Contrary to Gary Walker’s allegations, NHS East Midlands is adamant that it acted on its own concerns about patient safety and quality at the Trust where Gary Walker was Accountable Officer. These concerns were about a range of management failures identified by NHS East Midlands during Gary Walker’s tenure.

As a result of these failures, NHS East Midlands lost confidence in the Trust’s ability to provide assurance that patients were safe. NHS East Midlands subsequently sent a team of senior doctors and nurses to the Trust to assess the quality of care patients were receiving. They found that patients were receiving a good standard of care from front line staff but that the leadership team did not display effective oversight.

In the light of these concerns (and others that are detailed below), NHS East Midlands presented the evidence to the Appointments Commission who decided to suspend the then Chairman of the Trust, David Bowles. Since then, David Bowles and Gary Walker have made numerous allegations in the media about NHS East Midlands and other parties – which NHS East Midlands vehemently contests.

**Detailed Memorandum**

1. NHS East Midlands refutes the allegations against them made by Gary Walker in his Employment Tribunal claim of 2011, and in the media in recent weeks.

2. The primary focus of NHS East Midlands was the safety and quality of patient care commissioned or provided by the 23 NHS organisations which it oversaw. The effective management of these organisations was the way in which NHS East Midlands identified that safety and quality of patient care could be delivered to a high standard. Annually, the Chair of NHS East Midlands would appraise the Chairs of each NHS organisation in the region, with the delivery of patient quality and safety the top objective for each Chair. In the spring of 2009, the Chair of NHS East Midlands wrote to all Chairs within the region and specifically stated that quality and safety must be at the top of their agendas.

3. As Chief Executive and the Accountable Officer of the Trust, Gary Walker was personally responsible for patient safety and quality. Gary Walker’s principal role was to ensure that national standards of care were met through the effective management of the Trust and its Executive Team.

4. In his interaction with the media, Gary Walker claims that NHS East Midlands placed greater emphasis on achieving standards rather than safety and quality of patient care. National standards are designed to improve patient safety and to enhance the patient experience as a whole. There is no contradiction between achieving these standards and improving the safety and quality of care. To imply otherwise would be to suggest that somehow making people wait in A&E; wait for operations they need; continuing to have high numbers of hospital acquired infections and not diagnosing and
treating people with cancer quickly are not fundamental quality and safety issue for patients. This is clearly not the case.

5. NHS East Midlands contends that it focussed not just upon national operational standards but also on a range of other patient experience, safety and quality issues. For example, the quarterly performance review meeting between Lincolnshire Teaching Primary Care Trust and NHS East Midlands in July 2009 focussed upon the performance of all the Lincolnshire providers for safety alert compliance, mortality rates, serious untoward incidents, children’s safeguarding, patient surveys and compliance with healthcare standards set by the Care Quality Commission.

6. NHS East Midlands is clear that it raised concerns about Gary Walker’s ability to build a sustainable framework in which to perform his role as early as November 2008. These concerns focussed on Gary Walker’s and the Trust’s inability to establish effective systems and processes for the delivery of safe patient care, and their inability to recruit and retain high quality staff. NHS East Midlands raised these concerns with Gary Walker and David Bowles and was assured that the Trust performance issues at that time would be rectified.

7. NHS East Midlands notes that the position at the Trust deteriorated significantly in early 2009, especially its ability to meet the 18 week patient referral to treatment standard and the maximum four hour standard for patients waiting in A&E. NHS East Midlands confirms that it had no confidence at that time that the Trust had a credible plan for delivering on either of those standards.

8. NHS East Midlands highlights that at no point throughout this period did Gary Walker raise any concerns about patient safety. On 8 April 2009, some five months after NHS East Midlands had raised concerns about the Trust and Gary Walker (see above), he emailed Dame Barbara Hakin (then Chief Executive of NHS East Midlands) to raise a concern about safety in the light of high demand.

9. NHS Midlands and East confirms that Dame Barbara Hakin met Gary Walker the next day. Dame Barbara Hakin contends that Gary Walker assured her that the issue was short-term in nature and that he had a number of processes in place across the Trust to assure himself and his Board about patient safety in general.

10. However, by late April 2009 NHS East Midlands reports that due to the continuing deterioration of performance, it decided that a review of the Trust was necessary in order to be assured about patient safety and quality, and that appropriate leadership and governance processes were in place to maintain patient safety and quality. During this period the Trust was identified as having a higher than expected Hospital Standardised Mortality Ratio and NHS East Midlands confirms that it was in regular dialogue with the Care Quality Commission about the Trust.

11. The review was led by Professor Dame Catherine Elcoat (the then Director of Nursing at NHS East Midlands) and Dr Kathy McLean (the then Medical Director at NHS East Midlands) with the aim of establishing whether the Trust was providing services that were safe for patients and to check whether patients were being treated appropriately on a day-to-day basis. To ensure that the review was objective and had opinion from a broad range of experts, a number of senior doctors and nurses from other parts of the region carried out the review.

12. ‘The Elcoat Report’ concluded in June 2009 and found that front-line patient care was of a good standard, but highlighted that ‘making the governance links from ‘Board to Ward’ in a robust way was difficult’. Gary Walker was interviewed as part of the review and NHS East Midlands confirms that he did not raise any concerns from front line staff about patient safety.

13. NHS East Midlands affirms that it had a number of on-going concerns about the Trust at the time of the ‘Elcoat Report’, most notably:

   a. The continued failure of the Trust to meet national standards for A&E and the requirement for patients to commence treatment within 18 weeks of referral from their GP

   b. The excess number of C. Difficile infections at the Trust
c. The underperformance of the Trust against two key national cancer standards (two week waits and 62 days)

14. NHS East Midlands confirms that at this time, the Trust was the only one in the country that was failing to meet four key national standards.

15. Given these concerns, NHS East Midlands therefore took action to address what it observed to be systemic problems at the Trust. NHS East Midlands commissioned two further independent reviews – ‘the Garland review’ and a finance review carried out by Deloitte.

16. In June 2009, the Garland Report noted that ‘despite the seriousness of the performance failures, there is very little evidence from Trust Board papers or Board minutes of extended debate about performance or serious challenge of the executive team’ and that ‘the paper trail does not provide evidence of robust, corporate decision making and action by the Board’. NHS East Midlands confirms that at no point during the review did Gary Walker raise any concerns with Peter Garland about patient safety.

17. In late June 2009, the Deloitte review of the Trust raised issues relating to proper governance, noting that it found ‘no evidence of active involvement of Non-Executive Directors in the Foundation Trust process’.

18. Taking into account all of the evidence referred to above, and after discussion involving the SHA Board, the Chair of NHS East Midlands asked the Appointments Commission to suspend the Chair of the Trust, David Bowles. NHS East Midlands is clear that this action was taken with the best interests of patients in mind – as they could no longer accept the levels of Trust performance, which by the accounts of three independent reports, were principally caused by the lack of appropriate governance at the Trust.

19. The Trust appointed a new Chair, Paul Richardson, in July 2009. NHS East Midlands confirms that Dame Barbara Hakin met Paul Richardson with Gary Walker and emphasised that patient safety and quality was the primary concern of the SHA, and highlighted the SHA’s concerns about the poor performance of the Trust.

20. NHS East Midlands emphasises that it was only after the suspension of David Bowles in July 2009 that David Bowles and Gary Walker complained to Sir David Nicholson of bullying and harassment by Dame Barbara Hakin and NHS East Midlands. Allegations that Dame Barbara Hakin and NHS East Midlands vehemently deny. NHS East Midlands contends that the continued investigations of the Trust were prompted by performance and governance failures that the SHA had a duty to manage.

21. On receipt of the allegations of bullying and harassment, Sir David Nicholson commissioned an independent review, led jointly by a senior Non-Executive Director and NHS Manager – ‘the Goodwin/Pyper review’. The review considered pertinent correspondence and interviewed the relevant parties (as well as Chairs and Chief Executives from 21 organisations across the region). In October 2009, the Goodwin/Pyper report found that the approach taken by NHS East Midlands was ‘fair, consistent with its own procedures, equitable and patient’.

22. In March 2010, Gary Walker was dismissed for gross professional misconduct from his role as Chief Executive by the Trust. The subsequent Employment Tribunal claim, alleging an unfair dismissal, contained claims (amongst others) that Gary Walker had been dismissed because of making protected disclosures. NHS Midlands and East understands that both NHS East Midlands and the Trust dispute this allegation.

23. NHS East Midlands confirms that it was not a party to the content of the compromise agreement and that it has never attempted to prevent genuine concerns about patient safety being raised. NHS East Midlands reiterates that Gary Walker has been, and continues to be, free to raise specific concerns about patient safety, if he has any.

24. NHS Midlands and East has access to numerous documents which can be made available to the Health Select Committee, including:
a. file notes of meetings between Gary Walker and Dame Barbara Hakin;
b. correspondence between Gary Walker and Dame Barbara Hakin;
c. the Elcoat, Garland, Deloitte and Goodwin/Pyper reports;
d. NHS East Midlands Board minutes and internal documents; and,
e. a summary chronology of key events

12 March 2013