Written evidence submitted by David Bowles – Former Chairman, United Lincolnshire Hospitals NHS Trust (FRA 02)

My Background

I provide this evidence in my capacity as a Chairman of United Lincolnshire Hospitals NHS Trust from June 2006 until July 2009. I am a highly experienced manager, particular in the public sector where I have had four Chief Executive roles, a number also as a ‘trouble-shooter’ where governance issues had emerged. I am a member of the Council for Public Concern at Work, the whistleblowing charity, and a supporter of Patients First.

Summary

In my evidence I intended to demonstrate that

- the overarching management culture of the NHS is inconsistent with delivering safe care to patients;
- this management culture has been known about for some time by senior officials and there seems to be little recognition of its damaging impact upon the organisation;
- the NHS has not learnt the lessons of Mid-Staffordshire in that as Chairman of ULHT, in spite of hospitals being overfull, and the need to build additional wards to meet the demands placed upon them, the Trust was nevertheless pressurised to meet targets;
- this pressure to put targets before safety came from senior people at the East Midlands Strategic Health Authority;
- I was forced out of my position as Chairman with the threat of suspension based upon these overfull hospitals not meeting targets in 2008/9 and due to my refusal to agree to meet waiting time targets in 2009/10 until new wards had been built;
- senior officials in the NHS condoned or encouraged this conduct and behaviour and did so in breach of the NHS Code of Conduct which requires them to put the safety of patients first and in breach of a Code of Conduct dealing with Capacity Reviews for overfull hospitals;
- the complaint I made to David Nicholson received such a wholly inadequate response to the safety concerns that I had raised that it could be regarded as little more than a ‘cover up’;
- there were attempts to gag me as a result of the Compromise Agreement entered into by Gary Walker the former Chief Executive of the Trust;
- significant sums of public money appear to have been expended to protect personal reputations;
- in spite of repeated formal complaints against the activities of senior officials within the NHS, these complaints remain to be investigated; and finally
- I have little confidence that the changes necessary to deliver an NHS focussed on safety will be made.

1 Introduction

a) In the wake of the Mid Staffordshire Inquiry the issue of culture change has been highlighted. There has been significant political and media interest in the treatment of whistle-blowers within the NHS. The fact that we currently need to protect whistle-blowers is merely a symptom of a much more significant problem.

b) The NHS faces two big challenges. The first is to change frontline culture where professional staff have tolerated or been implicated in such shocking levels of care. The second is the overarching management culture of the NHS itself set by its leaders, including its Chief Executive.

c) There has been considerable discussion about the first of these challenges, with suggestions of referrals to professional organisations and even police action. There has not been as much debate about the latter issue of the management culture which either led to or contributed directly towards the widespread problems the NHS has experienced, with new allegations about care and manipulation of data emerging on almost a daily basis. It is a management culture which as
d) No doubt senior officials would rather concentrate upon the former issue as that is a way of ‘pushing the blame’ back down the system to individuals or to Trusts rather than recognising that those officials who manage, run and control the NHS and its systems have significant responsibility for the NHS and its failings.

e) It is the overarching management culture which creates the ‘need’ to fiddle waiting lists and mortality data or manipulate financial information; a culture which gaggs whistle-blowers and a culture where staff in Mid Staffordshire thought they would lose their jobs if they did not meet targets. Simply outlawing the manipulation of data and banning gagging will not solve the problem; it will merely result in those responsible finding new ways of hiding them. Gagging clauses have been banned on several occasions in the past.

f) One of the most significant ways patient care and safety can be improved is by a change to the overarching management culture of NHS.

g) In my experience and in discussion with many others it is a management culture obsessed with looking good rather than being good. Much of what happens is not ‘management’ and the culture can be as damaging to patient care and safety as failing front-line staff.

h) Roy Lilley, the well known NHS commentator, summed it up:

*History tells us; whistleblowers get punished, people who speak-up get thrown out. Mortgages have to be paid, families fed, careers protected, organisations and politicians sheltered from ‘bad press’. There are reputations, status and standings at stake. Everything matters more than what really matters.*

i) There is real opportunity to change the NHS for the better. There is, I have to say, little sign that the opportunity will be seized. This is not Labour bad, Conservatives good or vice versa. Both political parties need to realise that an NHS culture designed to shelter them from ‘bad press’ has not served either of them well and even worse is a danger to patients.

2 Recent reports on culture of the NHS

a) The overarching management culture referred to above has been known about for quite some time; indeed in 2008 the IHI and JCI reports made scathing comments about NHS culture, summarising the prevailing views in the following terms:

*The risk of consequences to managers is much greater for not meeting expectations from above than for not meeting expectations of patients and families;*

*If something goes wrong or a newspaper gets on the case find someone to blame and punish him or her;*

*A shame and blame culture of fear appears to pervade the NHS and at least certain elements of the DoH as well;*

*This culture generally stifles improvement and... behaviours that are necessary for creating organisational cultures of quality and safety*

*Humiliation and CEO fear of job loss are the system's major quality improvement drivers.*
b) These are absolutely damning comments about the overarching management culture and if such reports had been produced for an airline it would probably be grounded based on safety concerrrs.

c) Even though these reports were produced in 2008, the latest surveys carried out at the end of last year by HSJ still refer to a 'climate of fear'. It is difficult to see how such a culture can be consistent with safe care.

d) With all due respect to the Secretary of State, banning gagging clauses and criminalising the manipulation of performance or mortality data does not tackle the root cause of the difficulties that the NHS faces.

e) The NHS has a culture in which ministers come and go but the officials continue regardless. One of the most spectacular examples of the contempt shown for the political leaders of the NHS is that one week after Andrew Lansley stated that he was going to change the NHS constitution to protect whistle-blowers, Gary Walker was being forced to sign an agreement which not only sought to gag him but also his witnesses as well, with a so-called 'Supergag'. This was in a case where the ET Judge stated that Mr Walker had made protected disclosures to David Nicholson and Barbara Hakin, the two most senior officials in the NHS. The major beneficiaries of that Supergag are senior officials, not United Lincolnshire Hospitals NHS Trust (ULHT) and it is inconceivable that senior civil servants had no knowledge of the events leading up to the gagging clause being signed.

3 Impact of culture on ULHT and Mr Walker's appointment

a) In June 2006 I was appointed as Chairman of ULHT. It has a long history of poor performance and has struggled financially ever since its inception.

b) It is one of the worst funded Trusts in the country. On appointment it had a deficit on its balance sheet of over £20 million and there was a compulsory minimum 33 week wait. In other words if the Trust treated non urgent patients before 33 weeks the Trust would be penalised financially, by not get paid for that activity.

c) I was concerned at the underlying culture of the NHS and particularly the description of conversations and discussions with the East Midlands Strategic Health Authority (EMSHA) prior to my arrival. The allegations made against the then senior officials at EMSHA amounted to bullying the Trust to do work for which would not be paid in accordance with the tariffs. The result and intent was that the deficits within Lincolnshire reside in the acute sector, rather than with the PCT.

d) It was with these and other experiences in mind that Gary Walker was appointed as Chief Executive. Not only was he introduced by Barbara Hakin, by then the Chief Executive of the EMSHA, but it was clear from interview that he had significant integrity and a desire and willingness to seek to shield ULHT from the worst aspects of the NHS management culture referred to above. Barbara Hakin approved his appointment. Mr Walker's performance was such that the Board sought to extend his contract. Barbara Hakin's approval was needed for such an extension and this was readily agreed by her in July 2008.

e) Examples of the NHS management culture can be highlighted by Mr Walker's treatment on red and black alerts. Mr Walker deals with these in his statement but I can confirm that he complained to me at the time about these matters. He received my support in following the agreed escalation plans notwithstanding the criticisms from the EMSHA and the embarrassment that issuing such alerts may have caused them.

f) A further example of the culture can be highlighted by the treatment of ULHT over the resource accounting and budgeting issue. This is a complex matter but suffice to say that because of those complexities the Trust’s deficit had effectively been doubled. The government announced some changes to remedy the position but ULHT did not appear on the lists of Trusts to be recompensed.
The reason for that was, to quote from a report from the Trusts Director of Finance, "this Trust is not to receive a cash adjustment as the SHA did not wish to identify any Trusts in the East Midlands is being financially challenged". It is difficult to ascribe a proper motive to such a stance and it has all the appearance of EMSHA wanting to 'look good'.

g) Clearly from the above and other matters I had to deal with, a pattern was emerging of people being rather more concerned with how things (or they) may look rather than dealing with the reality. Conducts and behaviours as highlighted in the two 2008 reports above were evident.

4 Codes of conduct

a) The most worrying aspect of NHS management culture is the obsession with what ever the latest target may be at the expense of patient safety. In the case of the EMSHA they also disregarded key aspects of the governance arrangements of the NHS, so putting patients at risk. It was this particular issue which led to my resignation as Chairman in July 2009.

b) The National Code of Conduct for Managers says

‘make the care and safety of patients my first concern and act to protect them from risk’

c) In that context it is clearly illogical to expect that hospitals which are already overfull with emergency patients, should be mandated and required to still meet targets for non urgent patients. Common sense would tell you that. Overfull hospitals can be dangerous places evidenced, for example, by Maidstone where outbreaks of C Difficile occurred primarily due to the hospital being overfull. In addition patients can often be put on the wrong sort of ward for their care and complications not detected early enough by staff, inexperienced with dealing with that type of condition e.g. a surgical patient being on a medical ward. These are so-called ‘outliers’.

d) The NHS recognise this problem and the system is supposed to work on the basis that if a particular specialty or indeed the whole hospital cannot cope with the demand placed upon it then, subject to some constraints, under the Code of Conduct for Payment By Results a ‘Capacity Review’ should be carried out. During the period of the Capacity Review, the requirement to meet targets is temporarily suspended until a plan can be produced which both the PCT and the Trust sign up to get back to target.

e) The excess demand on ULHT was such that a Capacity Review should have been carried out and targets suspended. Whether capacity reviews existed or not, simple common sense should tell you that it is dangerous to force non urgent patients through overcrowded hospitals.

f) I set out more details of a Capacity Review under the Code of Conduct for Payment by Results in Annex A. Given that the PCT and the SHA refused to comply with this particular Code, I actually wrote the Department of Health for confirmation that the Code did result in targets being temporarily suspended during the review. Not only did they confirm this, but they also highlighted the wider role of the PCT in managing demand.

g) To understand the seriousness of this issue more fully is also necessary to describe the roles of the various layers of management within the NHS which I set out in Annex B. It is a fairly logical structure and approach but again was also not complied with by the EMSHA who when faced with the fact that ULHT may miss some national targets immediately resorted to 'blame the Trust' rather than to seek to analyse the problems or understand the role of others such as the PCT. This Annex makes it clear that there is a shared responsibility but much of the onus on effective planning is with the PCT with oversight by the SHA.
5 Targets before safety

a) The Lincolnshire PCT had carried out a major consultation and, in line with much of the rest of the NHS, stated that it would invest more in community and preventative care and reduce its demand on the acute sector. It therefore, in 2008/9, contracted for reduced use of ULHT’s facilities. We nevertheless less planned at a slightly higher level. In practice demand increased across all areas of service rather than reduce.

b) Annex C provides some of the data in terms of the degree to which the Trust was over performing its contract.

c) However, an admission that the PCT had under commissioned activity, in a county notorious for difficulties, would ultimately raise questions within the Department of Health as to the competence of the SHA in its performance management of the PCT and the performance of the PCT itself. Requesting a Capacity Review and temporarily accepting that targets would not be met would bring this issue to the attention of the Department of Health and be an admission of poor planning by the two organisations with the lead responsibility, the SHA and PCT.

d) Whether for self-preservation or otherwise the PCT and SHA sought to pass all the ‘blame’ onto ULHT. The SHA conformed to the descriptions in the 2008 reports referred to above:

   The risk of consequences to managers is much greater for not meeting expectations from above than for not meeting expectations of patients and families;

   If something goes wrong or a newspaper gets on the case find someone to blame and punish him or her

   A shame and blame culture of fear appears to pervade the NHS and at least certain elements of the DoH as well.

   This culture generally stifles improvement and... behaviours that are necessary for creating organisational cultures of quality and safety

   Humiliation and CEO fear of job loss are the system's major quality improvement drivers

a) At no stage was there ever any proper analysis of the problems within the healthcare system. The mantra from both the SHA and PCT was ‘everybody else is coping’ (even though they were not) and so by implication ULHT were failing.

b) The PCT, by failing to plan properly and then failing to stand up to the SHA and agree a Capacity Review and remove some of the pressure on non-urgent targets, contributed significantly to the subsequent problems for ULHT and patients. It was clear that many Non-Executive members of the PCT Board had been ‘badly’ briefed, were unaware for example that ULHT had served performance notices on the PCT for their contractual and other failures and were even unaware that ULHT was over performing its contract in terms of volume of activity.

c) The scale of the increase in emergency admissions particularly on the Lincoln County Hospital site was very significant. From December 2008 onwards Executives such as the Chief Operating Officer, Director of Performance, Director of Medicine and Director of Nursing were complaining about the response from the SHA. They confirmed what Gary Walker had been informing me - that staff were exhausted, there was an increased risk of cross-infection and that if the system was pushed any harder patient safety was at serious risk. The message was consistent from all four - patient safety was in danger of being jeopardised by the pressure to meet the “18 week target” for non-urgent patients. It was clear to us all that ULHT could not yield to the external pressures to meet the “18 week target”. For the period November to March emergency
admissions were running at 22% above contract. The hospitals were described as like a ‘battlefield’.

d) Mr Walker made it clear that the pressures from above on the Trust would increase significantly. He was concerned that such pressures could result in staff taking steps that they should not. There were ways the Trust could improve its performance against targets such as putting additional beds in places where there were not proper services, ‘manipulating’ waiting lists, discharging patients prematurely and not admitting patients via A&E and that all of these were detrimental to patient care. Mr Walker made it clear to me that he was not prepared to countenance any such steps. I had made it clear to the Executive Directors of the Trust Board that they must not allow themselves to pass the SHA pressure down the line and push front line staff into meeting targets at the risk of safety. I appreciated that this may make them feel exposed in terms of defying the demands of the SHA to meet the “18 week target”. Therefore at the Trust Board meeting of ULHT on 29 January 2009 I made it clear that they would have support for pushing back on the SHA and refusing to comply with its demands. The minutes state:

‘The Chairman stated that the organisation had in the past been described as operating in a climate of fear and he wished to confirm that the Trust would not tolerate this in any circumstances and would support any executive members under pressure’

e) I had a telephone conversation with John Brigstocke the EMSHA Chairman, on 18 February 2009. I made the file note immediately after the telephone call because of the concerns I had regarding his comments. (see 260a in Mr Walker’s pack).

f) Throughout the call, John Brigstocke was very assertive and pressured me to give assurances regarding the “18 week target”’ being met. I was very direct to him about the SHA needing to do its job and manage the PCT to ensure that such under commissioning of services were prevented from occurring. He was concerned with how the SHA would look if NHS Trusts in its region did not meet the “18 week target” and that as a result Ministers could not make a statement to the House of Commons that the “18 week target” had been met. He said that it would be a disaster for the SHA if it was due to the East Midland that the target was not met. There were a number of occasions where he referred to Ministers and what they wanted. I have to say given my experience it was difficult to conclude other than that this was more about making others and particularly the EMSHA look good. I do not believe for one moment, given the facts, ministers would wish to compromise safety in the pursuit of targets.

g) Specifically he asserted that ULHT had to meet targets regardless of demand. I refused to give him assurances that targets would be met saying that safety comes first. At no time did he wish to discuss the fact that ULHT’s concern as to patient safety and the detrimental impact on emergency admissions was the reason for ULHT’s failure to deliver on the “18 week target”. I was very honest with him that I could not guarantee that ULHT could meet its targets. I further took a line which Gary Walker had been taking and advised me to take and told him that I was not prepared to put pressure on staff to do so, given the issues of patient safety.

h) I had a number of subsequent conversations and meetings about performance against targets with John Brigstocke. The SHA’s grasp of the situation can be highlighted that he told me on 30th April that we ‘must open extra wards’ and we ‘you have to be able to cope’ and repeated his ‘no let out clause for demand’ comment. I told him that every single ward had been opened for a long while and told him yet again about Capacity Reviews.

i) Barbara Hakim had told me that ‘everybody else was coping’, there was nothing unusual about ULHT and therefore we should be able to cope in meeting targets. These comments were also made by the PCT Chairman and by John Brigstocke. I found these comments extraordinary in that their own staff had expressed concerns that ULHT’s hospitals were overfull and this posed a risk to patients (see Annex D). This Annex, produced by EMSHA analysts clearly shows ULHT’s hospitals under pressure and raises concerns about the implications of such pressure; regardless John Brigstocke continued to press for targets to be met. The SHA analysts were critical of the high
percentage bed occupancy at ULHT and the implications of medical outliers (patients on the wrong type of ward). It said bed occupancy should be kept below 85% to keep a grip on Healthcare Associated Infections and that the number of outlier should be as low as possible. The reasons for this is that as hospitals become full the risk of Hospital Acquired Infectons increases so putting patients at risk. Maidstone experienced 269 deaths in 2005–6 through C-Difficile infections when managers crowded in patients in order to meet waiting time targets. In addition due to the pressures on beds some patients will be put in the wrong type of ward risking the quality of their care and treatment.

j) Cursory examination of the data would show that ULHT had for some time been running at relatively high utilisation levels in comparison with other Trusts and the chart produced by Sir Brian Jarman at Annex E confirms this; ULHT was not like ‘everybody else’ and would be more likely to run out of capacity earlier. In other words that was not just an issue of demand but also of capacity. I was staggered that in a health economy, spending some £1.1bn, the assessment of ULHT’s performance by the PCT was being based on ‘everybody else is coping’ and not a more rigorous analysis as would be required under a Capacity Review.

k) I expressed concerns to John Brigstocke that putting further pressure on staff to meet targets would compromise patient safety and made it abundantly clear that I was not prepared to do so.

l) I raised with John Brigstocke the issues of Capacity Reviews on a number of occasions, a process which he denied all knowledge of. I even provided him, via e-mail, the references to the document so that he could read them himself.

m) In setting my targets for 2009/10 I made it clear to him that I was not prepared to guarantee meeting targets regardless of demand. At a meeting in April I had told him that given that the increase in demand did not seem to be abating it would be necessary to build new wards at Lincoln. I told him that I thought this a potential waste of public money if it was due to a dysfunctional health system and that he needed to look at the PCT in detail. Surveys had shown that around 17% of those being admitted to hospital would not need to be if other parts of the health a social care system working properly. In the light of no support from the SHA or PCT for a more radical review I made meeting the key national targets subject to a number of caveats:

- that there was effective demand management (a responsibility of the PCT)
- that there was agreement to building new wards at Lincoln. Given the scale of demand, the level of investment would need SHA approval and flew in the face of national policy to reduce acute beds;
- that the new emergency assessment beds in A&E were opened which was a key part of the plan to achieve A&E targets and avoid admissions;
- that the escalation plans in event of excess demand were revised which was again a PCT responsibility and the lack of an effective plan had inhibited performance in 2008/9.

n) John Brigstocke emailed me (see Annex F) saying ‘18 weeks as you know is a National Target which has no let out clause against ‘demand’; all hospitals are expected to cope...this is particularly important in the lead up to FT....’. This comment is shocking as it is an echo of the Mid Staffordshire situation where it is alleged that chasing targets in pursuit of Foundation Trust status was a cause of their problems. Such a statement is also at complete variance with the governance and performance management framework in Annex B and continued to ignore the Code of Conduct and Capacity Reviews. The email was copied to Barbara Hakin. Subsequently he was more explicit and rejected any caveats referring to Barack Obama and called for a ‘yes we can’ attitude.

o) Worse still it was clear that this line was supported by Barbara Hakin who on being consulted on my targets by John Brigstocke made it clear that targets had to be met ‘whatever demand’. See Annex G.

p) John Brigstocke made it clear in a meeting on the 8th June, in front of Barbara Hakin, that he wanted the caveats removed from the proposed objectives relating to meeting the 18 weeks
targets and he did so without being prepared to entertain any discussion as to why they were there. Prior to the meeting he had asserted that ‘the difficulties you face are no more challenging that those of other trusts’. These caveats were designed to get others to play their role in a ‘whole systems problem’ and were safeguards for the purpose of safety. It included the building of new wards. Although this meeting had been convened to discuss targets he wished to raise a large number of alleged failures by the Trust which frankly were a farce. For example he alleged that we had received a Health and Safety notice and that this was serious and unheard of event, only ever happened twice in the whole of the NHS and that it was appalling that the SHA had not been informed. I pointed out to him that the NHS gets around 50 of these notices a year and told him of 2 others in the region that year of which he was unaware. The conduct of the meeting was a disgrace. I was accompanied by my Finance Director who emailed me after the meeting saying ‘I am not sure that I really want to work in this type of environment anymore’.

q) I had previously told John Brickstocke that if he wanted a Chairman who would guarantee meeting targets then he would have to get himself a new Chairman. It clear from that meeting that was what he had decided to do, though not via a direct conversation.

r) The Mid Staffs problems were in the public domain at this time. I was in effect being pressured by the SHA Chair and the SHA Chief Executive to take my Trust down a course taken by Maidstone and Mid Staffordshire with such disastrous consequences.

s) I reiterate that at no time was he contradicted by Barbara Hakin, indeed the reverse as he was clearly taking his lead from her.

t) As part of the review process I was subject to objective setting and annual review via a 1:1 meeting with the Chair of the SHA. My first two years had been good. It works on a process of a self assessment and proposed targets which are sent to the SHA Chair in advance and then discussed in the 1:1 meeting with the SHA Chair. The first two years appraisal results have various comments such as ‘most impressive progress’ stating that my performance was ‘well above average’ and that I had the potential to be Box 1 which is ‘outstanding performance’.

u) At the end of the meeting on the 8th June with Barbara Hakin, John Brigstocke and I were then due to have our appraisal meeting. I told him at the outset that I would be resigning which he welcomed. I was then told by John Brigstocke that this year the appraisal would refer to his ‘loss of confidence due to [my] unwillingness to commit to clear and unequivocal objectives’ a reference to the caveats I had placed on the targets. This was confirmed in a less than flattering note he handed to me which he had already prepared on the outcome of my appraisal, notwithstanding that we had not even had an appraisal discussion.

v) My view was that as they had effectively removed me they would now seek to remove Gary Walker.

w) The ULHT Board agreed to continue not giving assurance on the 18 week target as set out in the extract from the June Board minutes which state:

ULHT Board formally supported the Chairman’s position in not giving an unequivocal assurance or guarantee to the SHA with respect to achieving the 18 week performance targets and in so doing also noted the SHA’s position in this respect. At the same time note was taken of the nature and tone of the meeting attended by the Chairman and the Director of Finance.

x) After this Board meeting Gary Walker raised more concerns with me about the SHA. He used words like he would now be ‘dead meat’ for being the most senior executive to support the Board resolution in defiance of the SHA. Mr Walker is a voting member of the Board and supported the above resolution.

y) Subsequent events were somewhat complex as I prevaricated on the date of my resignation in part because I was exploring what action I could take against the SHA and John Brigstocke. I
spoke to local MP's and researched the criteria for suspending SHA Chairs as I was concerned that John Brgstocke's cavalier attitude was a risk to patients. Bizarrely I was offered a more positive appraisal by John Brgstocke if I resigned by a set date referring to 'impressive progress on key relationships' and FT status feasible by 2011. Clearly both appraisals cannot be true.

z) I was preparing a formal complaint about John Brgstocke seeking his removal and the Tribunal Judge was probably correct in saying that John Brgstocke ‘got in first’ asking the Appointments Commission for my immediate suspension on grounds which were frankly absurd but included my ‘refusal to agree objectives without caveats’ in one document and in another submission to them because I ‘repeatedly refused to accept any specific targets without caveats’. In spite of ‘my impressive progress on key relationships’ he now described ‘an inability or unwillingness to work effectively’ with others. My caveats were designed to protect safety. He also stated that I should be suspended as my overfull hospitals (where senior clinical staff warned against seeking to meet targets on ground of safety) did not meet the 18 week target in 2008/9.

aa) Clearly had I adopted the approach of Mid Staffordshire and pursued targets to achieve FT status, I would not have been forced out. You will note the similarity with one of the observations in the 2008 reports that ‘the risk of consequences to managers is much greater for not meeting expectations from above than not meeting expectations of patients and families’. I resigned before I could be suspended. I would welcome taking apart line by line his absurd assertions in his letter tc the Appointments Commission. Subsequently he received a warning letter from my Solicitors about defamation.

bb) Following my resignation the SHA Chair in his BBC Radio Lincolnshire interview referred to serious problems ..in the Trust ..that if not rectified very quickly then that is what would affect patient care’. A report by his own Director of Patient Care, Catherine Elcoat however said ‘The review team concluded that there was no cause for concern. The individual care delivered by individual staff members was good and in some instances exemplary. ... Those we spoke to acknowledged that the Trust places high priority on patient safety’

6 Goodwin Review

a) I had sent a formal complaint to David Nicholson (see Annex H) just before I resigned. I was seriously concerned that had ULHT not sought to withstand the pressure it would have slid into a Mid Staffordshire position given the disregard for the PBR Code and the contractual provisions designed to ensure patient safety. It was subsequently announced by David Nicholson that Neil Goodwin was being appointed to look into allegations of bullying and harassment. I was concerned about the exact terms of reference (see 412d) as they did not seem to tie in with my letter of 20th July to David Nicholson and the complaints therein. For example there is no reference to a refusal to carry out a Capacity Review in either the terms of reference or the report itself, which formed a large element of my complaint.

b) I was even more concerned when it became apparent that Neil Goodwin was a former SHA Chief Executive himself and therefore potentially immersed in or part of the management culture of the NHS so roundly criticised in the 2008 reports. Furthermore he had the East Midlands SHA on his client list and staff expressed no confidence in the confidentiality of the review process led by him. Staff told me that their careers would be seriously damaged if they spoke out. He did not meet some of those I suggested.

c) I asked David Nicholson if I could see a draft of the report to check it for accuracy etc. This was denied by way of an email dated 14th October (see 636a) on the basis that there was substantial documentary evidence upon which they were relying.

d) The report when it was released was shocking. At paragraph 15 it stated ‘we frequently encountered differing accounts of the nature [of meetings and telephone conversations]’ in the face of conflicting evidence about what happened in meetings and in phone calls they decided to ‘principally use extracts from relevant correspondence and
reports as a more reliable account of the tone and style of communications and therefore relationships...’.

e) I considered this an absolutely extraordinary approach when dealing with allegations about bullying and amounted to suggesting that bullying must be in writing either for it to count or for it to be investigated. It is extraordinary to suggest that correspondence and reports would be a ‘more reliable’ account of relationships. If, as a former Chief Executive of a local authority employing 20,000 staff, I had allowed such a criteria to be used in such an investigation I would expect to be strongly ridiculed. If I had been David Nicholson I would have binned the report as soon as I got to that paragraph.

f) Last year I was asked to conduct a review of the culture of NHS Lothian, one of the largest health organisations in the UK, after the manipulation of waiting lists. I was commissioned to submit a confidential report to Nicola Sturgeon, Deputy First Minister and to produce a public report. We conducted around 60 one to one confidential interviews and were informed of numerous incidents where staff were either told or witnessed others being told that they would ‘get their P45’ or be ‘parted from their livelihood’ if they did not meet targets. These threats were never in writing. If my review of NHS Lothian had been based on the Goodwin criteria as set out in paragraph 15, its conclusions would have been very different and completely inaccurate.

g) I remain appalled at the quality of the report and it is difficult to conclude other than the results were a foregone conclusion and just part of the culture of cover up evident elsewhere in other parts of the NHS. I referred to it as whitewash.

h) However the position is even worse than that in that David Nicholson ignored limitations of paragraph 15 and added further whitewash. In spite of the report making it clear that there were conflicting accounts of meetings and phone conversations, David Nicholson issued a statement saying that there was no bullying ‘whatevsoever’. The word whatsoever does not appear in the report.

i) Above all David Nicholson was formally put on notice in stark terms about safety concerns along the lines of a Mid Staffordshire should pressure continue to be put on staff to meet targets. There is nothing in this report and the way it was conducted which should give confidence to him that those concerns were not genuine or indeed that such pressure would not continue. It will be clear from Mr Walker’s statement that there are allegations that patients came to harm as a result of continued pressure after he was forced out of his post. The Trust is now one of 14 subject to a special safety review. If these safety concerns are valid, David Nicholson will at best have missed an opportunity for effective intervention in the interests of patient safety and at worst be complicit in an investigation which was, to be charitable, ‘deeply flawed’.

j) The degree to which it was flawed can be demonstrated by the fact that I had put in a data protection request to the EMSHA. It was responded to a few days after the issuing of the Goodwin report. I do not think that was a co-incidence. It contained three key documents which I had not seen before (and which presumably Goodwin did not see). These were:

- The handwritten note by Barbara Hakin saying that targets must be met whatever demand (Annex G);
- The report from the EMSHA’s own analysts expressing concerns about ULHT’s hospitals being overfull (Annex D);
- The email to me from John Brigstocke saying there was no let out for demand as far as targets are concerned. The email had been incorrectly addressed which is why I had not seen it before (Annex F);
7 Subsequent events

7.1 Hospital capacity

a) Prior to me leaving ULHT had put in a bid to build new wards at Lincoln. The Executive Directors genuinely feared that it would not be approved by the EMSHA as it would amount to an admission that their mantra ‘everybody else is coping’ would be wrong.

b) Could we have commissioned new wards earlier? The problem is that when your purchaser launches a major consultation on reducing demand and contracts for a lower level of service it would have been difficult to build a business case on ‘we think they are wrong’. It would also have been difficult given that it was national policy to reduce demand for acute beds. Were new wards really needed and would it have been better to invest in community and other services? In spite of requesting such widespread reviews on alternatives such a review was not carried out.

c) The EMSHA finally agreed that ULHT was not like ‘everybody else’ and the capacity on the Lincoln site was insufficient and approved a capital building programme which would take around 12 months or so to complete. Regardless of that belated acceptance of insufficient capacity they allegedly continued to put pressure on targets and Mr Walker’s statement refers to concerns about the shift in focus toward targets and away from safety. A number of specific safety concerns have been raised with me by local residents.

d) Again I would reiterate that all of these events are post Mid Staffordshire and I repeat comments I have made before; if as a result of ignoring my concerns and those of Mr Walker, pressure continued to be put on staff which has resulted in harm to patients, criminal sanctions should be considered against those who created such a climate.

7.2 Supergag

a) Mr Walker will deal with his ET and his compromise agreement. I can confirm that I was written to in an effort to gag me as well, which is virtually unheard of. It is clear that given the sums of money involved and the extent of the gagging provisions that there has been a very extensive effort to prevent the sort of information that Mr Walker and I have revealed, ever getting into the public domain. Even though ULHT led on the negotiation of the compromise agreement with Mr Walker they will have consulted extensively with the SHA and the main beneficiaries of the gagging clauses are senior health officials, not ULHT.

b) Mr Walker was allegedly sacked for swearing. He states and I believe him that he was sacked because he was prepared to challenge the powerful and put patients first. The Department of Health will no doubt claim that the settlement was reached on a commercial basis. Their own internal assessment therefore was that Mr Walker had a good chance of winning and achieving an ET finding that he was sacked for blowing the whistle, which would result in a substantial uncapped award. In the wake of Mid Staffordshire such a finding in an open Tribunal would be damaging to put it mildly. I am mindful of Jeremy Hunt’s comments about gagging being to protect ‘institutional’ reputations. Questions need to asked whether this is more a case of protecting ‘personal’ reputations which, if it is, would have serious implications for those involved.

7.3 Formal complaints

a) I have taken these governance failures within the NHS very seriously and it is important that those responsible be held to account.

b) A formal complaint was submitted to Bob Kerslake, Head of the Civil Service in July 2012 in relation to Barbara Hakin and David Nicholson. It was not even acknowledged.

c) The Prime Minister was written to on behalf of Patients First on 14th February 2013 drawing his attention to the fact that this complaint had not been acknowledged, let alone investigated. That letter to the Prime Minister was simply acknowledged.
d) The Prime Minister was also written to jointly by Patients First and Cure the NHS seeking action on the culture of the NHS and specifically the removal of David Nicholson. See Annex I.

e) In the light of what would appear to be ‘political support’ for David Nicholson the Prime Minister was written to again jointly by Patients First and Cure the NHS on 23rd February (Annex J) and advised that ‘we are truly horrified by media reports which suggestion that Sir David is not to be exposed to the same system of personal accountability you are proposing for the rest of the staff of the NHS, allegedly due to his close relationship with Ministers and the ‘debt’ owed to him by your party’. It was made clear that a more extensive complaint would be sent to the Head of the Civil Service and it was expected that there would be no political interference in its treatment.

f) The Head of the Civil Service was written to on 26th February 2013 jointly by Patients First and Cure the NHS with a much more extensive complaint about David Nicholson making it clear that it was expected that the complaint would be considered carefully. The covering letter is shown at Annex K.

8 Anticipated future events

a) I believe that Ministers and others continue to misanalyse the problems within the NHS probably in large part because some of those who are advising them have either helped create the overarching management culture or at least learnt to work within it. In some instances they may have come to accept that such a culture is normal; this is just the way we ‘fix’ things or people round here.

b) The task is even more difficult given some of the comments from David Nicholson who rejected the statements about the organisational culture made in 2008 and who regarded Mid Staffordshire as ‘singular’. It its leader does not recognise a problem then that problem will not be solved. Ministers set policy and strategy, the officials are responsible for the managerial culture and the operational processes used to implement those policies.

c) There is every likelihood that as a result there will be no change in the management culture, even if there are changes in its current leadership team.

d) I blew the whistle on the NHS when I resigned in 2009; it was a most unpleasant experience and I had to tolerate smear, half truth and downright lies. Mr Walker has already experienced some of this. I anticipate that he will experience more. In the run up the ET even though Mr Walker was sacked for swearing the SHA Tribunal statements seemed designed to undermine his track record. I therefore attach as Annex L a copy of my statement in anticipation that such assertions about him will be repeated.

19 March 2013
"Capacity Review"

A document called the National Model Contract ("NMC") exists which is the contract between the PCT’s and acute Trusts such as ULHT. It contains all the provisions that you would expect to see in a contract for hospital services ranging from standards of service thought to payment terms etc.

At Schedule 3 of the NMC it states that when GP referrals to the provider have exceeded the (seasonally adjusted) Activity Plan for the preceding three month period by more than 5% at treatment level or more than 3% at whole provider level’ and the provider cannot meet the 18 week target there shall be a ‘Capacity Review’. As a result of the PCT agreeing to a Capacity Review the requirement to meet targets is temporarily suspended and an action plan produced to get back to a position where the targets can again be met safely.

Essentially this is the safety valve. Trusts like ULHT are expected to meet reasonable increases in demand (up to 5% at treatment level or 3% at whole provider level) over the levels in the contract but if beyond that it can no longer meet the targets there is a Capacity Review.

ULHT had agreed the contracts for 2008/2009 and 2009/2010 with the PCT in accordance with the national framework and in the contract undertook to still meet targets up to the tolerance levels (the so called ‘trigger points’ in the PBR Code) of 3% overall and 5% at function level.

The increase in demand for all services above the contracted levels were at such levels that if ULHT could not meet targets there should have been a Capacity Review and the requirement to meet targets suspended until the action plan from the Capacity Review was implemented. As already mentioned, if a NHS Trust is under pressure to meet non-urgent patient targets then the safety of urgent patients, and others, may be put at risk – as demonstrated in the Mid Staffordshire example.

If a Capacity Review were carried out, the outcome would have been a joint action plan between ULHT and the PCT ‘to enable the provider [ULHT] to comply with the 18 week …target…as soon as is reasonably practicable’. In other words, in the interest of patient safety, the need to meet the targets is temporarily suspended until the plan (perhaps build more wards, increase diagnostic facilities etc) is implemented.
Annex B

Governance and performance management frameworks

There is no one document which defines the governance and the performance management arrangements to make sure that the 18 week targets are not pursued to the detriment of emergency patients.

At the highest level the “National Code of Conduct for Managers” issued in 2002 (the “National Code”) sets out requirements. It states as its first guiding principle that the duty of a Managers is to (see page 051):

“make the care and safety of patients my first concern and act to protect them from risk;”

The next document is the “Code of Accountability for NHS Boards” issued in 2004 (“Code of Accountability”) (see page 64a).

This states at page 64f that the role of the SHA is:

“To consider the overall needs of the health economy across primary, community, secondary and tertiary care, and working with primary care Trusts and NHS Trusts to deliver a programme to meet these needs;”

and

“performance manage and ensure accountability of local primary care Trusts and NHS Trusts;”

This is important as the Code of Accountability states that a role of the SHA is to work with others to make sure that primary care (GP’s, community nursing, aspects of social services etc), acute care (largely hospital based) and tertiary care (complex care such as transplants) are in balance and can meet the needs of their local communities. If they are not then at its worst it can affect patient safety.

It also states that the role of the PCT is:

“to identify the health needs of the population...secure the provision of a full range of services... and lead local planning...”

The document shows although NHS Trusts like ULHT have a role in planning for services they are mainly contractors in the provision of health services.

Clearly, there needs to be a safety valve to prevent the safety of patients being jeopardised where there is excess demand. The PBR Code deal with this by including concepts such as “trigger points” and other complex arrangements and these were given practical effect by clauses in the National Model Contract.
The PCT under commissioning services from ULHT – 2008/2009

The PCT grossly under-commissioned services from ULHT in 2008/9. For example:

The PCT contracted for a 7% reduction in first outpatients. ULHT experienced an increase and over performed the contract by 14%;

PCT contracted for a 7.8% reduction in follow up outpatients. ULHT experienced an increase and over performed the contract by 11%;

PCT contracted for a 3.4% reduction in follow up planned care. ULHT experienced an increase and over performed the contract by 5.6%;

PCT contracted for a 1% reduction in non-elective care. ULHT experienced an increase of 3.1% over the contract for the year as a whole; and

PCT contracted for a 0.6% increase in A&E admissions. ULHT experienced an increase of 5%.

The above is the annual whole Trust data. When examined in detail there was a significant surge particularly at the Lincoln site from October 2008 onwards. It was running at circa 22% above contracted levels on emergency admissions. Given the geography of the County many patients exercised their choice not to go elsewhere such as Boston or Grantham. There was ample evidence that the Trust, particularly from January 2009 could justify a Capacity Review.

The PCT under commissioning services from ULHT – 2009/2010

In the first week in June 2009 a new record was achieved of 556 emergency admissions at Lincoln County Hospital.

The picture for 2009/10 was looking even worse as it had already get to a point where for ULHT: (see 570j).

"emergency admissions were running at 9.4% above contract with the position at Lincoln [County Hospital] even worse" and

"outpatients were running at 10% above contract".

There had already been 1010 additional emergency admissions above the contracted level.

The PCT had just entered into a new contract with ULHT for 2009/2010 in the full knowledge of its gross underestimation of demand for services in 2008/9. It seemed as if the outlook for 2009/2010 would be even worse as it seems it had not properly estimated its services for 2009/2010 either.
# Chairman’s Summary Sheet – PERFORMANCE REPORT

<table>
<thead>
<tr>
<th>Name of Chairman:</th>
<th>David Bowles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation:</td>
<td>United Lincolnshire Hospitals Trust</td>
</tr>
</tbody>
</table>

ULHT failed to **achieve 3 of the ‘top 3 national priorities (A&E / 18 Weeks/ MRSA) in 08/09**, failing both A&E and **18 weeks (Admitted) targets**, and have now failed delivery of 18 Weeks non-admitted target for both February and March 09.

**Performance Headlines**

**A&E** (98% National Operational Standard)

**2008/09 Year-end Performance**

- ULHT Network failed to meet the 98% target for 2008/09 with year-end position of 97.37%; Actual Trust 08/09 performance was only 96.96%.

- A&E attendances and Emergency Admissions via A&E at ULHT increased during the key winter months (Nov 08/ Dec 08/ Jan 09), but were actually lower than trusts such as KGH/ NUH/ Sherwood Forest FT/ and UHL which all still managed to achieve both 16weeks and A&E targets.

- **During the crucial winter months, ULHT had one of the worst bed occupancy percentages in the East Midlands**, with Bed Occupancy at Nov 08 (97.7%), Dec 08 (96.3%) and Jan 09 (97.7%) (Bed Occupancy is the percentage of patients occupying a bed to the number of beds available. Bed Occupancy should be kept below 85% to help keep a grip on Healthcare Associated Infections and ensure system efficiency)

- ULHT (up to Quarter 3 2008/9 – this covers crucial months Nov) had the **2nd worst number of medical outliers per bed in the East Midlands at 2.50**. For comparison University Hospitals of Leicester and Derby Hospitals are the lowest in the East Midlands at 0.00 and 0.37. (Medical outliers are a measure of the number of patients admitted to hospital under a medical specialty but are not treated in an environment specified for medical patient e.g. surgical ward. The number of medical outliers should be as low as possible)

- Delayed transfers of Care (Percentage of medically fit patients awaiting discharge from hospital. Should be low as possible). ULHT during the crucial winter months had the worst in the East Midlands with Delayed transfers of care as percentage of occupied acute beds of (Nov 08 - 4.36%); (Dec 08 4.33%); (Jan 09 4.38%); these figures were twice the East Midlands average. Currently week ending 23/5 ULHT is still the worst performing trust and is 2.3 times the East Midlands average. Currently best performer in East Midlands is Chesterfield Royal (0.15%)

- The above indicators are some of the key factors which are strongly associated with poor performing A&E department.

**2009/10 Current A&E Performance**

- 2009/10 ULHT Network YTD 97.58%; Rolling 4-week average 98.18%
- 2009/10 ULHT Network as only achieved 98% 4 out of last 8 weeks (Since 1st April 09)
- Daily and Weekly performance continues to fluctuate. Performance week-ending 24/05 - 97.2% (Worst in the East Midlands)
From: JOHN BRIGSTOCKE [mailto:johnbrigstocke@]
Sent: 20 April 2009 11:51
To: 'davis.bowles@ulh.nhs.uk'
Cc: 'Hakin Barbara (Q33) NHS East Midlands'
Subject: RE: David Bowles 2009/10 Objectives
Sensitivity: Personal

David

Thank you for you proposed Objectives.

I'm afraid I have difficulty with some of these. For example, 18 weeks is, as you know, a National Target which has no let out clause against "demand"; all hospitals are expected to cope under the "payment follow the patient" formula. This is particularly important in the lead up to FT and, as compliance with National Targets for a year is, effectively, a pre-requisite for consideration of FT status, the need for you to be well up to speed on all Targets is paramount. A & E, in particular, is an area where "money in the bank" in the Spring, Summer and Autumn months is essential to achieving the end year position.

We can talk this all through when we meet on 30th April, but I view this mtg to be essentially a debate about ULH, and not the PCT.

Best wishes

John
Vicky Beale

From: Hekin Barbara (Q33) NHS East Midlands [Barbara.Hekin@]
Sent: 20 April 2009 23:53
To: Harper Val (Q33) NHS East Midlands
Subject: Fw: David Bowles 2009/10 Objectives
Sensitivity: Personal

Sent from my BlackBerry Wireless Device

--- Original Message ---
From: John Avil (Q33) NHS East Midlands
To: 'JOHN BRIGSTOCKE' <johnbrigstocke@>
Cc: Kukucynska Stanisla (Q33) NHS East Midlands; Orchard Kevin (Q33) NHS East Midlands
Sent: Mon Apr 20 14:21:19 2009
Subject: RE: David Bowles 2009/10 Objectives

As requested separately I have given Margaret a few additional items for the discussion with DB on 30th. I would offer the following comments on his draft objectives.

1. 18 weeks delivery cannot be 'subject to effective demand management'. Most Trusts plot their own trends on referrals so that they can plan still to deliver even where ambitions to manage demand away by PCTs is not realised. The evidence for this is seen in a number of our FT applications where a convergence discussion with PCTs will frequently show that the PCT plans to buy less from the Trust than the Trust has modelled into its 18 WTPM. Monitor accept the differences in figures where the Trust is able to demonstrate both that it has based its numbers on historic trends and that the PCT were successful in managing the demand capacity can be taken out and costs reduced in the Trust.

2. A Trust does not need to get PCT agreement to increase its bed base. The provider decision about numbers of beds needs to be based on robust Trust predictions on future tariff income.

3. The FT section on finance is too weak. It needs to say that the Trust will ensure that the risk rating for each of the first 5 years in their LTFM does not drop below level d.

Hope this is useful.

Avril Avil
Director of System Development
East Midlands Health Authority
Octavie House
Interchange Business Park
Bostocks Lane
Sandiacre

21/04/2009
United Lincolnshire Hospitals

NHS Trust

DJB/CG

STRICTLY PRIVATE AND CONFIDENTIAL

Mr D Nicholson
Chief Executive
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

20 July 2009

Dear Mr Nicholson

My particular but by no means sole concern relates to actions which could be construed as seeking to bully me as a Trust Chair into meeting its non urgent targets in the face of one of the Mid Staffs recommendations that

*Trusts .... ensure that a focus on elective work and targets is not to the detriment of emergency admissions*

Given that ULHT have had unprecedented demand well above contracted levels such pressure from John Brigstocke is also inconsistent with the NHS Code which puts patient safety first.

Before setting out my complaint in detail I should acquaint you with the general background. When I was Chief Executive at Lincolnshire County
Council we met on a few occasions and you were open about the difficulties of providing acute care in Lincolnshire given its geography and other factors. I took over as Chair in 2006 and in the light of serious failings asked all the NED’s to stand down and suspended the then Chief Executive. Since then, whilst the turnaround of the Trust is by no means complete (we still have a £12m deficit on our balance sheet and some deep seated attitudes from staff to overcome as evidenced by the partial registration by the CQC) we are now meeting virtually all key national access targets, a considerable achievement considering that there was a minimum wait of 33 weeks imposed upon us by the PCT for non urgent care in 2007. We have relatively low HAI rates, have achieved financial balance and a recent SHA report found that we had achieved the maintenance of clinical standards.

The particular problems arose in December 2008 and have continued to the present time. The initial cause of the problem was that the PCT, following public consultation, planned to substantially reduce the need for acute care and for 2008/9 reduced its contract with ULHT. Although we did not reduce our capacity it became apparent that the PCT’s planned contractual reductions were not materialising. In fact quite the reverse, not only were we performing well above the contract levels we were also performing well above the levels of the previous year. The Trust then had from December 2008, and continues to have, exceptionally high emergency demand; the problems we experienced were that we did not simply have a peak followed by a trough as many other Trusts had, but demand has continued to rise through into the summer. The record for the weekly level of emergency admissions at Lincoln was broken in February, broken again in March, May and then again in June. The physical constraints of the Lincoln site are such that it requires new build to meet this excessive demand; experience has shown that the local population are not willing to travel to the Trusts other sites at Boston and Grantham where it would be easier to lay on the additional capacity; patients exercise their choice to wait for Lincoln. This has made consistent achievement of the 18 week target difficult. The scale of the emergency demand has been so pronounced and sustained that planned care wards in Lincoln have been converted to emergency care. There are now worrying signs that the problems are increasing. In the first week of July the Trust had the highest number of emergency admissions it has ever experienced across the entire Trust. For 2009/10 we are already out performing the contract substantially by around 10% in most key contractual areas.

The table below sets out some of the data:

<table>
<thead>
<tr>
<th>2008/9</th>
<th>% by which contract over performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Outpatients</td>
<td>14</td>
</tr>
<tr>
<td>Subsequent outpatients</td>
<td>11</td>
</tr>
<tr>
<td>Planned care</td>
<td>6</td>
</tr>
<tr>
<td>Emergency Adult Medicine Nov - Mar</td>
<td>21</td>
</tr>
</tbody>
</table>
Weekly Emergency admissions to Lincoln

<table>
<thead>
<tr>
<th>Week</th>
<th>% over 2007/8 average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 48 2008/9</td>
<td>12.4</td>
</tr>
<tr>
<td>Week 51 2008/9</td>
<td>13.4</td>
</tr>
<tr>
<td>Week 1 2009/10</td>
<td>16.4</td>
</tr>
<tr>
<td>Week 9 2009/10</td>
<td>16.9</td>
</tr>
<tr>
<td>Week 10 2009/10</td>
<td>18.8</td>
</tr>
<tr>
<td>Week 15 2009/10</td>
<td>18.8</td>
</tr>
</tbody>
</table>

2009/10

<table>
<thead>
<tr>
<th></th>
<th>% by which contract over performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency - acute</td>
<td>9.4</td>
</tr>
<tr>
<td>1st Outpatients - acute</td>
<td>10.0</td>
</tr>
<tr>
<td>2nd Outpatients - acute</td>
<td>10.0</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Given our geography to understand the problems properly one should not look at Trust wide data, it is necessary to look at it by site which is why the Lincoln site is shown above. There is also a lack of community and other services in Lincolnshire.

The Department has made it plain that one of the biggest risks to the 18 week target is under commissioning. It is clear from the table above that this has happened within Lincolnshire. Had there been effective commissioning we would have commenced our building programme for new capacity at Lincoln much earlier. It will not be until the end of this year that additional capacity will be available.

The Department had foreseen that problems could arise with 18 week targets due to lack of capacity and the national contract sets out the circumstances under which a 'capacity review' should be undertaken in Schedule 3 of the National Model Contract. We have exceeded those circumstances in both 2008/9 and 2009/10 and under the contract the requirement to meet the 18 weeks can effectively be temporarily suspended and no penalties imposed while an action plan is implemented.

My complaint stems from the above under commissioning and reaction to it. He has ignored and continues to ignore those mechanisms set out by the Department such as 'capacity reviews' but instead has put me under huge pressure to guarantee that the Trust would meet its 18 week targets regardless of demand or any other factors i.e. without caveat. Whilst assuring him that we were committed to meeting the targets I have made it clear that I can not give an unequivocal assurance or guarantee especially, as shown above, demand seems to be out of control and it will be many months before the new build is on stream to provide the capacity in Lincoln. As a result of this refusal over the past few months there have been
a whole series of sweeping and unsubstantiated allegations about the Trust
I take my personal responsibilities very seriously; the first principle of the NHS Code of Conduct for Managers is to make the care and safety of patients their first concern and act to protect them from risk. Thus, to the extent that there is a conflict between achieving national performance targets and ensuring patient safety, the latter must take precedence notwithstanding the strong views expressed by the SHA Chair. The importance of this approach was highlighted recently in the Healthcare Commission report on Mid Staffs NHS FT. I cannot and will not give the unequivocal assurance that John Brigstocke is seeking on non emergency targets especially at a time when the Lincolnshire health economy is out of control with the highest ever level of emergency admissions last week, when the Lincoln site has converted planned wards to emergency wards, when it will take 6 months for the new capacity to come on stream, when my frequent complaints about there being no overall plan for the balance between community, primary and secondary care in place or effective demand management arrangements continue to be ignored.

I would be grateful for a response to this letter as soon as possible. My Board whilst working hard to meet the targets have been briefed on this and support me in refusing to give an unequivocal assurance on meeting the 18 week target. This effectively pitches my entire Board against the Chair of the SHA.

I look forward to a speedy response.

Yours sincerely

[Signature]

David Bowles
Chairman
IN THE NOTTINGHAM EMPLOYMENT TRIBUNALS

Case no 3501140/10

BETWEEN

GARY WALKER

Claimant

and

UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

Respondent

SUPPLEMENTARY WITNESS STATEMENT OF DAVID BOWLES

I David Bowles of do say as follows.

1. I have considered the witness statements provided by the Respondent and would like to comment further in order to assist the employment tribunal.

2. All of my dealings with the SHA and PCT focused on their key concern which were two key targets the A&E target and the 18 week target but particularly the 18 week target. My focus and concern was on delivering them safely. This can be demonstrated by the following:

   - In my phone conversation with John Brigstocke on 18th February 2009, see document 260a, the sole issue discussed was targets for 18 weeks and A&E.

   - The SHA notes of my meeting with John Brigstocke on 30th April, see document 288, are overwhelmingly about targets and specifically the 18 week target.

   - The threat to my position and that of the Chair of the PCT in the letter following that meeting see document 296, arise solely as a result of problems with targets and specifically the A&E and 18 week targets. If the concerns had been on broader ULHT performance and not predominantly the 18 week target then the PCT Chairman would not have been threatened as well.
• My phone conversation with John Brigstocke on 29th May 2009, see document 316d, was predominantly about the 18 week targets.

• My conversation with John Brigstocke of 3rd June was solely about the 18 week target, see documents 320e.

3. It was only after I told John Brigstocke on 3rd June, see 320e, that if he wanted a cast iron assurance on targets he would need to get another Chairman that a significant range of other issues were raised for my meeting on 8th June. At that meeting I was given a document, prepared in advance of the meeting, saying that I had lost his confidence as I would not agree to meet the 18 week targets without caveats and that I had 36 hours to consider my position.

4. In the SHA statements there are references to data quality. This is a problem throughout the NHS. Two of the largest trusts adjacent to ULHT had ‘difficulties’ with data. In the case of Peterborough there was a substantial waiting list fiddle. In 2010 it became apparent that the way that Nottingham was recording performance against its A&E target was incorrect.

5. As part of the 2008/9 contract, ULHT was entitled to a performance payment of £0.5m from the PCT if it met the 18 week targets in the first quarter. The PCT initially refused to release the payment stating concerns about data quality but after a review were satisfied in the robustness of the ULHT data and released the payment.
8. When looking at the performance of a Trust as well as the issues above highlighted by Dale Bywater one would also need to look at other measures of safe care, are they meeting their financial targets and are they meeting their contracted activity.

**Healthcare acquired infections (HACI)**

9. Reducing HCAI's is a national priority.

10. The tables below, showing nationally available data from the Health Protection Agency show the two main HCAI’s being C-Difficile and MRSA and indicate that the rate of infection in ULHT declined markedly during Gary Walker’s period at the Trust.

### Performance on Healthcare Acquired Infections (source Health Protection Agency)

<table>
<thead>
<tr>
<th>Type</th>
<th>Period</th>
<th>Actual</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA (rate per 100,000 bed days)</td>
<td>2006/07</td>
<td>19.6</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>2007/08</td>
<td>12.0</td>
<td>11.9</td>
</tr>
<tr>
<td></td>
<td>2008/09</td>
<td>7.7</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td>2009/10</td>
<td>5.4</td>
<td>5.1</td>
</tr>
<tr>
<td>C.diff-patients 2yrs and older (rate per 100,000 bed days (includes all cases regardless of whether the Trust was the source))</td>
<td>2007/08</td>
<td>70.2</td>
<td>93.3</td>
</tr>
<tr>
<td></td>
<td>2008/09</td>
<td>52.4</td>
<td>54.9</td>
</tr>
<tr>
<td></td>
<td>2009/10</td>
<td>36.4</td>
<td>36.7</td>
</tr>
</tbody>
</table>

### Hospital Standardised Mortality Ratio (HSMR)

11. The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. Dr Foster, the research organisation which produces the data annually, does this by taking into account patients’ age, the severity of their illness and other factors, such as whether they live in a more or less deprived area. This allows them to work out how many patients they would expect to die at each hospital. I should declare that I have in the past worked as an adviser to Dr Foster.
12. Trusts position in the HSMR league tables can change simply as a result of refining the methodology. Using the methodology for 2009 the annual Dr Foster analysis showed that ULHT death rates looked abnormally high.

13. If the analysis by Dr Foster was accurate it would be very alarming to put it mildly. Even though Gary Walker alerted the SHA to the analysis it warranted no more than a brief discussion in my meeting with John Brigstocke on 30th May. In fact rather than talk about death rates the conversation was overwhelmingly about 18 week targets and the implications of failing to meet them.

14. ULHT carried out a review of every single death over the preceding 12 months. These showed that there were no clinical concerns but the way that some of the data was being recorded and was used by Dr Foster was inaccurate. It showed that there was a tendency that where for example terminally ill patients were being admitted to hospital although their illness had been recorded their prognosis was not. This was creating a false impression of the trust's performance with regard to death rates.

15. This review was carried out by ULHT's clinical staff but the Board but, particularly the non-executive directors were not satisfied with only an internal review. Therefore an external organisation, Weritas and CHKs were commissioned to review the internal review. As a result of that it was confirmed in June that there were no problems with HSMR at ULHT. This is referred to in Catherine Elcoats report, see 346p.

16. It should of course also be noted that Catherine Elcoat confirmed that within her report that there were no other safety concerns in the Trust and commented favourably on the culture. See 346g.

Financial performance

17. On a true and fair basis (removing the effect of the double counting of losses referred to in my original statement relating to Resource Accounting and Budgeting) the Trust had an underlying deficit for many years, in 2006/7 making a loss of £8.8m. In the first full year that Gary Walker was with the Trust it made a small surplus of £1.5m. In 2008/9 the Trust made a surplus of £0.4m.
18. Barbara Hakin refers in her statement in paragraph 48 to the support of £11m from the SHA and PCT in 2007/8. This support is excluded from these figures and in my original statement at paragraphs 46-54 I refer to the SHA’s conduct in this matter.

**Demand – not winter pressures**

19. It is not clear to me why the statements from the SHA only look at the excess demand for emergency admissions for the period up to March 2009. In the 17 week period (November to February) Dale Bywater refers to in his statement the average number of weekly admissions at ULHT was 496. See document 570a. However in the 14 weeks immediately after that there had been further increases in admissions and they had risen to an average of 526 per week with a record being set for the 1st week in June 2009.

20. Some statements alluded to the fact that the additional pressures on ULHT were normal winter pressures that every Trust experiences. Clearly they were not because there was a trend in increased emergency demand which commenced in 2008 and continued to rise with the first week in June being a record level of emergency admission; that is hardly a winter pressures issue as Dale Bywater claims.

21. ULHT was actually treating record numbers of patients as shown in document 570j.

**Subsequent events**

22. I’m very surprised that the tenor and tone of particularly Barbara Hakins and Dale Bywater’s statements. It was clear to me that up until January 2009 ULHT was ‘off the radar” the only real and substantive interest from the SHA was the minute the 18 week target started being missed and to present this now as broader performance concerns is misleading.

23. The SHA say that they had serious concerns about ULHT’s performance beyond the 18 week target. Dale Bywater states that considerable support was given to ULHT. John Brigstocke says, see document 1207, in his media interview,

‘we are providing all the help we can with help teams and turnaround teams and so on to get this Trust to perform to the same very high standards the others in the East Midlands do’
24. Since all this alleged support from the SHA has been a sharp deterioration in performance of ULHT as evidenced by the following table

**Recent ULHT Performance: 18 weeks and A&E (source Department of Health)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Period</th>
<th>Actual</th>
<th>England Target/average</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks</td>
<td>Aug 2011</td>
<td>84.8%</td>
<td>90.0%/90.4%</td>
<td>Missed, significantly, target/&quot;standa rd&quot;</td>
</tr>
<tr>
<td></td>
<td>July 2011</td>
<td>81.6%</td>
<td>90.0%/90.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>June 2011</td>
<td>82.2%</td>
<td>90.0%/90.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>May 2011</td>
<td>84.8%</td>
<td>90.0%/90.8%</td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Apr-June 2011</td>
<td>93.98%</td>
<td>95.0%/97.0%</td>
<td>17th lowest (262 organisations achieved better results)</td>
</tr>
<tr>
<td>Finance</td>
<td>2010-2011</td>
<td>£13.9m deficit</td>
<td>Surplus or breakeven</td>
<td>Failed financial duty</td>
</tr>
</tbody>
</table>

25. Following a visit by inspectors to Boston Pilgrim Hospital, the second largest one run by United Lincolnshire NHS Trust, the Care Quality Commission (CQC) has declared that it failed to meet 12 of the 16 core standards and said via a press release that the seriousness of the issue was such that,

*The trust must fully address these issues by 31 May 2011. If the Trust fails to comply, our next steps may include prosecution or closure of services. See document 1511*

26. The position became worse and in June the CQC stated,

*The Care Quality Commission (CQC) has launched an investigation into concerns about the care provided by United Lincolnshire Hospitals NHS Trust at Pilgrim Hospital....*

*Following an inspection in February, CQC ordered the trust to make improvements. However, the Commission was not satisfied with the speed with which the trust responded, or with the trust’s ability to proactively identify and address problems. In*
addition, there are currently several safeguarding investigations in progress relating to abuse and neglect allegations at the trust. CQC is working closely with the police and local authority with regard to these.

27. The position further deteriorated in July when the Nursing and Midwifery Council issued the following statement,

We have asked The University of Lincoln, The University of Nottingham and The Open University to withdraw 82 nursing and midwifery students. Following serious concerns that have formally been raised with the NMC, we have asked The University of Lincoln, The University of Nottingham and The Open University to withdraw 82 nursing and midwifery students from Pilgrim [Boston] Hospital with immediate effect. We are working with the universities to review the suitability of the learning environment at Pilgrim Hospital and to support all students affected at this time.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are accurate and true.

Signed:........