I was the non-executive Chairman of the East Midlands Strategic Health Authority (“the SHA”) from July 2006 – April 2010 and am pleased to submit evidence to the Health Select Committee, as requested. I would ask that my evidence be read in conjunction with the SHA’s submission.

I have read Mr Bowles’ written evidence and the transcript of his joint hearing with Mr Walker. Most of their allegations were addressed in the 2009 Pyper / Goodwin (PG) report, which was commissioned by Sir David Nicholson. I was informed that Susan Pyper’s role (Lord Lieutenant of West Sussex and an experienced NHS Chair recently retired from an acute hospital trust) was to oversee the investigation and ensure its absolute impartiality and propriety. I have refrained from countering Mr Bowles’ more eclectic allegations, as I am mindful of the HSC Chairman’s guidance, at the start of his hearing, about the purpose of the HSC. Needless to say, the allegations made by Mr Bowles are without foundation.

PG found that:

“There was no evidence of bullying and harassment of the United Lincolnshire Hospitals NHS Trust by the East Midlands SHA, and every attempt was made by the SHA, particularly the Chief Executive and Chairman, to address the performance issues facing the Trust and the Lincolnshire acute health system. In our opinion the SHA was behaving with extraordinary patience during early 2009. The SHA’s approach was fair, consistent with its own procedures, equitable and patient”.

Patient safety

Repeated allegations have been made that the SHA ignored warnings in February 2009 about Patient Safety; they are fallacious. It was the SHA, through its Assurance System, which first raised concerns with the United Lincolnshire Hospitals NHS Trust (“ULHT”); and the SHA which commissioned a series of reports into the failings at ULHT. The SHA Board carefully monitored the situation throughout this process.

Due to the SHA’s concerns, reinforced by an e-mail from the Trust Chief Executive to the SHA Chief Executive, in which he expressed concerns over safety and mortality rates, the SHA initiated a review of the quality and safety of patient care in the Trust. The study was carried out by Dame Catherine Elcoat (the Elcoat Report), the SHA’s Director of Nursing and Patient Care. It was tasked with looking at the quality and safety of care in ULHT. To ensure objectivity, the review team included a number of senior doctors and nurses from other parts of the region. Mr Walker was interviewed, but did not represent any personal concerns about patient safety, or any on behalf of Clinicians or other front line staff.

It concluded that nine issues needed to be addressed, namely (PG Appendix 6): The development of a jointly owned clinical strategy; A review of the responsibilities of the Trust’s executive team; Medical leadership; Clarification of governance issues; Earlier Intervention when there is increased activity in A & E; Theatre efficiency and throughput; Environmental issues; Resuscitation Protocols; and Implementation of the European Working Time Directive”.

On a more positive note the study also reported that “the care delivered by individual staff members was good and in some cases exemplary”.

It was again the SHA which decided that a further review of ULHT was needed, the “Garland review”, to give assurance not just on patient safety, but also the quality of care, including the necessary leadership and governance.

Governance

Dr Heather Wood, the senior CQC investigator at Mid Staffs, hit the mark when she identified poor Governance as the prime cause of problems in that Trust. The issues at ULHT stemmed from exactly the same basic cause, namely a serious failure of Governance. Fortunately, the SHA was timely in identifying the extent of the problem. “Elcoat”, “Garland”, and PG all highlighted Governance failures; to quote just a few:

a) 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;
b) The paper trail does not provide evidence of robust, corporate decision making and action by the Board;

c) The ULHT board minutes do not show that capacity problems were discussed by the Trust’s own board or raised as a problem likely to impact on performance;

d) The Trust’s own internal analysis of last year’s poor performance concluded that there were problematic operational processes and a lack of capacity planning;

e) We were told that booking and other systems had already been improved and that that helped explain why the Trust was now hitting the targets without extra capacity;

f) Governance arrangements in the Trust failed to identify emerging problems and the board minutes do not indicate an appropriate level of challenge or support around performance. These need to be reviewed urgently;

g) Making the governance links from “Ward to Board” in a robust way was difficult;

h) The HCC has raised serious concerns about the Trust’s assurance systems;

i) There were a worryingly high number of patients for whom there was incomplete data;

j) Some of the interviewees described the Trust’s board meetings as often consisting of a dialogue between the Chairman and Chief Executive with limited discussion or challenge by other board directors.

10. The term “capacity” features in 3 of the 10 bullets above (c,d,e); sub paras 5(c) and (e) are particularly telling. Para 23 below, is also relevant.

Objectives and Targets

11. On 26 March 2009 I wrote to all Chairmen in the East Midlands asking, inter alia, for their proposed objectives (goals) for 2009/10:

“Your objectives can be very short (“one liners”) but I would ask you to include the following as “givens”:

- “Clear objectives on patient quality and safety which must be at the top of our agenda at all times.”

12. In my subsequent annual appraisal discussions all the East Midlands Chairmen said they fully understood, and agreed, that meeting a target was always to be subordinate to patient care and safety. I would have expected all the Chairmen to have shared this with their Chief Executives immediately, and to have told them to ensure that, through the Hospital’s management and information system, it was cascaded quickly down the chain of command to every member of the Hospital’s staff, from Chairman, Clinicians and Managers, to Porters and Ancillary staff. Each trust Board should also have put in place a mechanism for regular assurance that this objective was to be the primary focus at all times. I have seen no evidence that either Mr Bowles or Mr Walker took any such action on receipt of my letter.

13. I have never asked anybody to “guarantee” meeting an Objective, or a Target (dictionary definition – something to be aimed for); Trusts are anyway independent bodies, so responsibility for both Patient Safety and the Quality of Patient Care lies with the Hospital Trust Board at the time, led by the Chairman, with the Chief Executive and Accountable Officer responsible for leading the executive team and running the Hospital safely and effectively.

14. Mr Bowles also refused to accept a distinction between objectives and targets, and argued that both should be caveated, (eg: “Provided the PCT reduces demand ….I will ….). I explained repeatedly to him that, in accepted business language, objectives are “aspirational “goals” (which can often only be achieved by partnership working) – a leadership tool; and targets, which should be stretching but achievable, are an efficiency tool which in turn enables care improvements to be made (increased capacity; timely cancer treatment; reduction in MRSA; elimination of people dying on waiting lists, etc). I tried to convince him that an effective leader is one who generates a culture of “yes we can”, not “who can we pass the responsibility to”.

15. Surprisingly, a few days later I received the “ULHT Annual Report and Accounts 2008/09” signed by Mr Bowles and Mr Walker which listed quite sensible uncaveated Objectives for FY 2009/10, namely to:
“Goal 1 (Objective): Provide quality healthcare; and para 4: “meet all key national and local contractual targets by March 2010, including a financial surplus of £3.6m”.

16. Again no mention was made of any limitations on ULHT’s aspirations in the interests of patient care and safety, or any concerns over demand or capacity.

Foundation Trust status

17. The PG report comments on accusations from ULHT that they were threatened in relation to their wish to apply for Foundation Trust status. When I first met Mr Bowles he told me that this was his main aim; he also referred to the higher salary that a Chairman of an FT could command. I explained to him that there were certain financial and operational standards applied by Monitor, before applications would be accepted, that their requirements were reasonable, and that he should concentrate first on the Trust’s operational issues and senior staffing problems.

18. He didn’t like this advice and my impression was that FT status remained at the forefront of his thinking, to the detriment of more immediate issues. Inappropriate concentration on FT was highlighted by Francis as a contributory factor in the failings at Mid Staffs.

Relationships

19. What most worried me about Mr Bowles’ tenure at ULHT was the isolationist approach taken by the Trust. He and his team seemed unable or unwilling to work in true partnership with the Department of Health, the PCT (the most important relationship of all for a Hospital Trust), the Independent Review Panel, the Health Oversight and Scrutiny Committee, and the Trust’s auditors. The SHA had to intervene repeatedly to resolve contentious issues.

20. The SHA had been aware for some time of the poor relationship between the Trust and the PCT, and had been copied in on several harsh letters between their Chairmen and Chief Executives. The Garland study attributed the blame as 80% the fault of ULHT. Whilst the Garland study was ongoing, this came to a head when I received a letter dated 26 April from the PCT Chairman which said:

“Whilst having made significant progress over the past two or three years, ULHT’s performance towards the end of last year and in the first part of this financial year has not improved. Despite being the Trust’s performance manager, it has now reached the point where we have nothing left with which to try and drive up their performance”

21. In a last attempt to resolve relationships, I wrote jointly to both Chairmen on 5 May as follows:

“By letter, and in several conversations, you have both separately represented to me that you cannot achieve your PCT and NHS Trust responsibilities in light of what you see as intransigence by the other party.” I can see 3 possible ways forward, either:

- The SHA sends in an experienced team to investigate all the issues that you have both raised. It would be asked to identify where, and why, “partnership working” is not working, and to make fundamental recommendations as to how all the issues which are holding back performance can be resolved as quickly as possible. It would be charged with identifying individual as well as corporate failings; or

- The PCT and Trust Boards (together with the Boards of other parties with a legitimate interest and who wish to be involved) review all the issues that affect the Lincolnshire health economy, consistent with meeting all National financial and performance targets. You would then, jointly and without caveat, present me with a high level Report approved by both Boards, setting out an immediate recovery plan. The SHA would be pleased to help with finding the appropriate support for this process and would, of course, also need some independent assurance that the process had resolved the difficulties between you and that the plan for recovery would deliver swiftly and sustainably; or

- As I made clear, verbally, to both of you on 30 April, to ask one or both of you to “stand down”.

I went on to say that “My unequivocal preference is Option 2”.

22. On 8 May the two Chairmen wrote to me jointly that “We are committed to the second option in your letter…It has the support of our Boards and our executive teams”.
23. In another very upbeat letter received on 8 June they reported: “Substantial progress”; “full set of actions being prepared”; “we expect our respective Boards to formally sign off the plans in June/July”; “have achieved a significant improvement”; “we are pleased with the progress that has been made so far and believe that with continued effort and support from the SHA the performance of the Lincolnshire Health community will return to what it was six months ago”; “As Boards we have already identified a number of key issues which need further and more detailed work and this includes an improved understanding about demand and capacity”.

24. The last sentence appeared finally to be the breakthrough, facilitated by the SHA, in persuading the Trust and PCT to address together a range of issues, including capacity. This came as a great relief to the SHA Board which had become increasingly concerned over several months about safety and quality, and the ability of the senior ULHT team to deal effectively with the problem.

Mr Bowles’ resignation

25. I had a routine meeting programmed with Mr Bowles on 8 June 2009 to discuss his appraisal and other Trust issues. I thanked him for the joint letter (set out above) which had arrived in my in tray shortly before the meeting. However, he immediately and loudly made it clear that he was no longer interested in the joint recovery plan. I therefore showed him a draft of his appraisal which was based around the SHA’s concerns over issues within ULHT, and which I had prepared as a contingency; I had anticipated that Mr Bowles might at some stage change his mind about co-operating with the recovery plan. Having read it, he said that he thought he should resign. I offered him a dignified way out, and he undertook to write a formal letter of resignation to the NHS Appointments Commission within the next two days.

26. Two weeks later Mr Bowles asked me if I would amend his draft appraisal of 8 June, to reflect his achievements in his first two years. That seemed a reasonable request and I sent him a revised draft for comment; he didn’t reply. After 6 weeks of procrastination it was clear that Mr Bowles had reneged on his undertaking to resign and, accordingly, on 20 July I asked the Appointments Commission to suspend him. They agreed the suspension the same day, but were unable to contact him until 21 July (I was told that he was in the hospital on 20 July but declined to take the call). In a letter to the Appointments Commission, dated 21 July, Mr Bowles wrote: “I understand that I have been suspended. In the light of that I resign with immediate effect”.

27. Both before and since departure from ULHT Mr Bowles has repeatedly claimed that: “I have been under pressure to give an unequivocal assurance or a guarantee that the 18 week non emergency target would be met, without caveat”. I have never used the word “unequivocal” or “caveat” in relation to targets and, as previously explained, have never asked for a “guarantee” of anything; the word is not in my lexicon. The PG report (para 79) described the situation as follows: “The issue at the heart of the allegations (by Mr Bowles) is the SHA’s alleged demand for an unequivocal guarantee for the 18 weeks target to be delivered, and then bullying and harassing the Trust to meet that guarantee. We have explored the use of the word “unequivocal” thoroughly and we are satisfied that the SHA did not make such a demand for either the 18 weeks or any other target”.

28. Paul Richardson was appointed acting Chairman by the NHS Appointments Commission. He was selected for the substantive position after a fair and open competition. The panel was chaired by the East Midlands Regional Appointments Commissioner. I represented the SHA, and the 3rd member was an Independent Assessor nominated by OCPA. The Selection Panel’s recommendation was forwarded to the NHS Appointments Commission Board, who made the appointment.

29. As stated by Mr Bowles in his statement to the HSC, I did receive a warning letter from his solicitors about defamation. I interpreted the letter as an attempt to stop or gag me, or my agents or representatives, from airing our concerns, with particular reference to the Goodwin report.

Conclusions

30. ULHT’s declining performance in 2009 was caused by weak leadership, confused governance, over eagerness for FT status and very poor relationships.

31. Good standards of care appeared to have been maintained despite poor governance, to the credit of the Trust’s staff.
32. Cognisant of the Committee’s interest in policy I have set out, at Annex A, my suggestions on how to improve the recruitment and appointment processes for Chairmen and Chief Executives.

Sir John Brigstocke  
Non-Executive Chairman July 2006 – April 2010  
East Midlands Strategic Health Authority  
12 April 2013

ANNEX A

FRANCIS REPORT (ULHT) – WRITTEN EVIDENCE – SUGGESTIONS FOR IMPROVING SELECTION PROCESSES FOR HOSPITAL TRUST CHAIRMEN AND NON-EXECUTIVE DIRECTORS

1. A more rigorous system is required for the appointment of a Trust Chairman or Non-Executive Director. The three essential requirements are: proven leadership skills, a “team player”, and someone with both a thorough understanding of Governance, and the ability to implement it in a complex organisation. References should always be taken up, and due diligence should be thorough.

2. For Hospital Trust Chief Executive appointments there should be a template which shows the minimum competencies and experience required in relation to the size and complexity of the organisation. A much more sophisticated system for career management and development is needed; for example, proven ability and success in a small Hospital Trust should be a prerequisite for applying for a Chief Executive post in a larger Trust.

3. Potential Chief Executives should be offered a demanding, tailored, and examined Business School course prior to being eligible to apply for CEO posts, covering Leadership, Corporate and Clinical Governance, Management, Finance etc.

4. Taking professional competence as a given, it is only through outstanding leadership at every level that the NHS will achieve sustained improvement in Patient Care. Training is the key; leaders can be made as well as born.