HEALTH SELECT COMMITTEE

ANNUAL REVIEW MEETING WITH THE GMC - 10TH DECEMBER 2013

EVIDENCE SUBMITTED BY DR PHIL HAMMOND AND ANDREW BOUSFIELD

The purpose of this submission to the Health Select Committee is to demonstrate that the Committee can have little confidence in the GMC's regulation of its doctors or its commitment to systems of safe care.

In the wake of the Mid-Staffs Inquiry the Secretary of State has made his expectations clear. He expects there to be a new culture of openness and transparency with a commitment to candour by staff and organisations. He expects regulators such as the GMC to hold staff to account.

This submission will show that at its first key test, the GMC has failed to meet these expectations it and that its disciplinary arrangements are not fit for purpose.

On July 29, 2012, we referred Dr Hakin, currently Deputy Chief Executive of the Commissioning Board and previous Chief Executive of East Midlands Strategic Health Authority to the GMC for her conduct in relation to United Lincolnshire Hospitals NHS Trust (ULHT). The GMC have a key disciplinary role in relation to doctors in management. The complaint was wide ranging.

At the heart of our complaint was the requirement of doctors to put patient safety first and the potential conflict between targets and safety. The GMC would seem to condone the mindless pursuit of targets and its analysis of our complaint and response from the GMC on October 25, 2013 does not reflect the learning from Mid Staffordshire. The GMC accepts in their report that there is no dichotomy between targets and safety. Whilst that may be applicable in well funded, well staffed health systems with ample capacity it clearly cannot be said of health systems such as those of Mid Staffordshire or Lincolnshire which were under severe pressure. Indeed the first investigation into Mid Staffs highlighted the conflict between targets and safety and recommended that Boards:

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

The GMC found that in those parts of our allegations dealing with inappropriate pressure on staff there was generally insufficient evidence to have a realistic prospect of successful if the GMC moved to a disciplinary hearing.

However our complaints were much wider than 'bullying' and encompassed allegations of the pursuit of targets in overfull hospitals and that as a result patients came to harm. The GMC's analysis of Dr Hakin's response to these allegations can be broadly summarised by four assertions:

- It was not unreasonable to exert pressure on ULHT to meet the targets as there was nothing unusual in capacity or demand for acute care in Lincolnshire;
- It was government policy to meet targets and it would have been unacceptable to countenance ULHT not meetings it targets and as such Dr Hakin was only 'following orders';

- That the SHA did not refuse a Capacity Review and that furthermore a Capacity Review (which would have resulted in a derogation of targets) was not warranted;
- That the hospitals were safe and patients did not come to harm.

The GMC had ample evidence to refute all of these assertions.

Based upon its flawed analysis and untested assertions the GMC concluded that for that part of our complaint, allegations of the pursuit of targets in overfull hospitals resulting in patients coming to harm, there was also no realistic prospect of pursuing Dr Hakin.

The Committee will be aware that ULHT has been described by Prof Sir Brian Jarman as 'similar to Mid-Staffordshire' and so these matters are important. They are also important as the case involves one of the most senior doctors in NHS management who should set an example to others.

The quality of the investigation carried out by the GMC can give little confidence that the GMC as an organisation is capable of responding effectively to the expectations of the Secretary of State. Not only were there a number of serious procedural defects and flaws in the investigation carried out, its findings and conclusions were not consistent with the evidence before it.

We attach a critique of the GMC investigation at Annex A focussing in on the four false assertions above.

One of the procedural defects by the GMC was that it failed to show us, the complainants, the evidence put forward by Dr Hakin and as such it was not challenged. If the GMC report accurately reflects Dr Hakin's evidence then we strongly contest it. The failure of the GMC to comply with one of the most basic rules of an investigation and share with us conflicting evidence, as part of the inquiry process, is merely one of the grounds for considering seeking a Judicial Review of their decision. Indeed we have been informed that the GMC would normally share controversial and conflicting evidence and have given us no reason for not doing so in this case. We would only note that the complaint concerned one of its most senior members.

Finally we are also considering making a further complaint to the GMC that, on the assumption that their analysis of Dr Hakin's response is correct, she may have misled them. Whilst this submission is designed to inform the Health Select Committee in its annual review of the GMC, we are conscious that the evidence before you should cause concern about the leadership at the top of the NHS and the unlikelihood of the desired change to a safer, kinder culture whilst that leadership persists.

The GMC process is in our view unkind, untimely, unfair, inefficient and fails to protect patients or adequately consider the emotional health of those referred. Over two years ago, we reported the medical director of Great Ormond Street Hospital to the GMC for failing to act on the concerns of Baby Peter whistleblower Dr Kim Holt. The GMC is still investigating, apparently hampered by the lack of an independent expert. The GMC also does not appear to be proactive, relying on others making referrals to it rather than acting on media reports. The article that gave rise to both these referrals is authored and attached [Annex B], and yet despite the grave allegations the GMC has never contacted us proactively for information. Our published response to their assessment of Dr Hakin's referral is also attached [Annex C].

Finally, in investigating this matter the GMC instructed outside solicitors, Field Fisher Waterhouse, no doubt at great expense. However, this has another benefit for the GMC. It means that all communication in pursuance of the investigation is covered by legal professional privilege, and therefore not susceptible to a freedom of information request, or perhaps even Parliamentary scrutiny. Whilst it is reasonable to instruct lawyers if required to collate evidence, it should not be used to impede proper accountability.

Dr Phil Hammond,

Associate Specialist RNHRD FT, Bath (Revalidated September 2013)

Investigative Journalist, Private Eye (Pseudonym MD)

Andrew Bousfield

Investigative Journalist, Private Eye

Annex A

Failure of the GMC to respond to the evidence which has emerged from Mid Staffordshire and to challenge effectively evidence by Dr Hakin in their preliminary investigation into her conduct.

As we were not shown Dr Hakin's evidence the comments which follow about Dr Hakin are made in good faith and on the basis that they may be reasonably deduced from the GMC report of her evidence.

1. The first assertion is that ULHT was no different to any other hospital, there was nothing unusual in Lincolnshire in terms of demand or capacity which would have warranted Dr Hakin not insisting on targets being met.

Analysis of the report shows:

The implication of Dr Hakin's evidence is that *'The demands and pressures on the Trust to perform better were reasonable'.*

The GMC conclude '..*there is no evidence that the SHA could or should have allowed the Trust to derogate because of the demand and capacity problems'*

It is difficult to conclude other than such analysis is incompetent. Dr Hakin is aware of the following:

- Her own staff said that Lincolnshire's hospitals were a regional outlier and dangerously overfull raising significant risks in terms of patient safety and infection outbreaks;
- National data showed that Lincolnshire's hospitals we running at much higher levels of occupancy than other hospitals, so making it less able to cope with unplanned demand;
- Her own staff had advised her that the problems in Lincolnshire were unique due to its geography making the achievement of targets more difficult and so demonstrating that there were unusual factors in Lincolnshire;
- Finally, and most damning, Dr Hakin was aware of the fact that the capacity situation was so bad that ULHT was planning to build 3 new wards with over 100 beds, action which was almost unprecedented. The reason for this was that the EMSHA endorsed PCT plan to, in line with national policy, reduce the demand for acute beds had failed; demand was not 'winter pressures' but was a permanently increase. The EMSHA eventually agreed that the capacity issues were so severe that they signed off the investment in the proposed new wards.

This is a very significant point as Dr Hakin's assertion that there was nothing unusual in Lincolnshire is then used to justify her other actions.

The GMC had before it reports that ULHT was unusual due to its geography, witness statements confirming that new wards were to be built, data from Prof Sir Brian Jarman showing that Lincolnshire's hospitals had significantly less available capacity to meet

additional demand and reports from staff of the EMSHA expressing safety concerns arising from the hospitals being overfull.

Comments on Dr Hakin

If Dr Hakin asserted that there was nothing different in terms of demand and capacity in Lincolnshire it would in our view be deceitful and fall far short of the candour the Secretary of State is entitled to expect from a senior official. There are few hospitals in the country where the position was so dire that additional wards had to be built as a result of the PCT failing to reduce demand in accordance with its plans.

Comments on the GMC

The GMC had significant evidence before it to show that there were severe demand and capacity issues at ULHT and were of such magnitude that additional wards were to be built and were therefore were significantly worse than elsewhere.

The failure to recognise this is gross incompetence on behalf of the GMC but worse still it makes their remaining analysis fundamentally flawed as all of the rest of their analysis is based upon ULHT not having exceptional capacity and demand problems.

2. The second assertion in her defence, Dr Hakin has claimed that all she was doing was following government policy and that as such she could not countenance any hospital failing to meet its targets.

In March 2009 Dr Hakin sent an e mail to all East Midlands chief executives stating *'I need to make it very clear that I expect you personally to ensure that your organisations deliver 100% for the next three weeks.... We cannot afford even one day when one single organisation falters.'*

The GMC report states

"Her [Dr Hakin] argument is that safety and targets are inextricably linked and the complaint is based on a false dichotomy between the two.

She says she was accountable to the Chief Executive of the NHS, who in turn was accountable to the Secretary of State for compliance with targets, and that allowing Mr Walker's failure to meet the targets to go unchallenged would have been a breach of her statutory obligations, a dereliction of her duties as a doctor and denied patients' rights.

'as a matter of basic common sense, it is inconceivable that an SHA Chairman could reasonably agree with a request from a Trust Chairman to objectives which envisage local abrogation of national targets', which she says would have disadvantaged patients in the area."

This misrepresents the arrangements that were in place. **It was never intended that all hospitals be required to meet all targets at all times regardless of the circumstances.** It was policy under a published Code of Conduct that if a hospital had met more than its contracted demand and cannot continue to meet targets, then under a so called Capacity Review' the requirement to meet targets is temporarily suspended until for example new capacity can be built or other arrangements made. This interpretation of the

Code has been confirmed in writing by the DoH. Dr Hakin appears to have wilfully ignored this Code and led others to believe that her demand to meet targets was consistent with government policy and the arrangements in force when it was not.

Worse still given the learning from Mid Staffordshire, it is extraordinary that such a senior public official could take such a stance with hospitals so overcrowded and under pressure that there was a plan to build new wards.

Comment on Hakin

Dr Hakin by both ignoring the Code of Conduct on Capacity Reviews and the fact that the position at ULHT was such that a Capacity Review (which would have resulted in the temporary suspension to meet targets) would be warranted, appears to have misled the GMC investigation.

Comment on the GMC

The analysis by the GMC in accepting Dr Hakin's evidence was incompetent. It had received from witnesses explanations of what should happen in these circumstances and documents from the DoH confirming that targets should be temporarily suspended when Capacity Reviews are warranted. It also had data showing that the contractual situation at ULHT would have more than justified a Capacity Review and the suspension of targets.

3. The third assertion is that a Capacity Review which would have to allow a derogation of targets was not blocked by Dr Hakin, and was not in any case warranted.

The report states:

"Mr Bowles [the Chair of ULHT] refers to raising a capacity review with both the PCT and the SHA and that there was an "absolute flat out refusal', though he provides no evidence of the request to or the refusal by the SHA. Nonetheless, his evidence provides some limited support to the alleged fact of the refusal but no support as to the involvement of Dr Hakin."

It then however says the evidence of Dr Hakin about this matter was:

"as a matter of basic common sense, it is inconceivable that an SHA Chairman could reasonably agree with a request from a Trust Chairman to objectives which envisage local abrogation of national targets', which she says would have disadvantaged patients in the area ….."

The GMC report is internally inconsistent. On the one hand, it says there is little evidence of Dr Hakin's refusal to support a Capacity Review but then contains evidence from Dr Hakin that she would not support a abrogation of a national target in any event which is precisely what a Capacity Review would have delivered. Clearly Dr Hakin did not agree with a Capacity Review.

The GMC from the flawed analysis on the second assertion above clearly did not consider a Capacity Review necessary. Despite the national code dealing with Capacity Reviews, it is astounding that the GMC do not question why Dr Hakin placed pressure on demonstrably struggling hospitals.

Comments on Dr Hakin

Notwithstanding the GMC report it is evident from Dr Hakin's own evidence that she did not support a Capacity Review which would have suspended targets and eased concerns about safe care.

Comment on the GMC

As commented above the GMC had ample evidence before it to show that targets should have been suspended through a Capacity Review until new awards were built. Furthermore it had before it the Code on Board Accountability which clearly state that it is a role of the SHA to ensure that the local plans meet the needs of the population.

4. The fourth assertion is that no patients came to harm.

The report states:

"In fact, there is very little evidence to indicate that there was any risk to patient safety caused by anything said by Dr Hakin to Mr Walker. There is no statistical or expert evidence to demonstrate that anything said or done by Dr Hakin contributed to any diminution in patient safety or care.

Much of the complaint appears to be founded on the dichotomy between safety and targets for which there is so little evidence

We found very little evidence that there was any risk or harm to patients"

In its analysis the GMC only looked at safety reviews being carried out in July 2009.

The complaint to the GMC was not about patients coming to harm in July 2009, which appears to have been the focus of Dr Hakin's response. ***The complaint was that the continued pursuit of targets would result in patients coming to harm and patients did come to harm.***

It was not claimed that the hospitals were unsafe in July 2009; indeed the reverse as the Board of ULHT, unlike Mid Staffordshire, had passed a resolution in June 2009 making it clear that it would not pursue non-urgent targets at the risk of safety. The issue of concern is what happened after Mr Walker and his Chairman were effectively removed some months later. It is clear that after Mr Walker's removal targets did start to be pursued in a manner which compromised safety. Evidence was submitted to the GMC from the Clinical Director of Planned Care complaining, in early 2010, that following Mr Walker's removal as Chief Executive there had been a shift in emphasis to the pursuit of targets at the expense of safety. There is evidence that some patients did come to harm with letters from clinicians specially referring to targets in those cases. This correspondence was made available to the GMC which specifically identified cases and patient harm.

Indeed considerable evidence exists of significant failures at ULHT from 2010/11 onwards leading to ULHT being one of 14 hospitals subject to Keogh Review and is now in special measures.

Comments on the GMC

The GMC narrowed the scope of its investigation to the period round July 2009, to the benefit of Dr Hakin. The GMC had ample evidence before it to challenge safety post July 2009. There were allegedly no warning signals to the relevant SHA in the case of Mid Staffordshire. The same cannot be said of ULHT. The performance of ULHT in terms of the patient experience deteriorated sharply from 2010/11.

The GMC refused to take additional evidence when the Keogh report was issued. Whether this was just incompetence on behalf of the GMC or 'political' is not clear.

Taken together with the three assertions above, if our submission and the evidence of others had been properly examined the GMC could well have revealed that in a case liked to Mid Staffordshire there was evidence potentially implicating a senior doctor in a top management post in either acts of commission or omission. Due to such failures an opportunity to intervene properly and ensure that the PCT worked to deliver a healthcare system to meet the needs of Lincolnshire was lost. Even worse the failure to intervene in an appropriate way led to patients coming to harm.

Annex B

SHOOT THE MESSENGER

How NHS whistleblowers are silenced and sacked

A *Private Eye* Special by **Dr Phil Hammond** and **Andrew Bousfield**

THE NHS will always need whistleblowers. Healthcare is complex, rapidly changing and dangerous; staff are fallible, variably trained and widely spaced; and demands are huge and resources limited. No matter how much is spent on regulation and risk management, shit will always happen – mistakes, incompetence, inhumane treatment and corruption.

But the same shit doesn't need to keep on happening. If it's picked up and acted on, many lives and much money can be saved. If staff, patients and carers are encouraged to speak up, you can even stop mistakes in their tracks before harm is done.

As this special report highlights, however, the shocking treatment of NHS whistleblowers persists as the body that is trusted to care for us from cradle to grave systematically covers up scandals, crushes dissent and kills patients unnecessarily…

Dr Kim Holt, Baby P and Great Ormond Street Hospital

AFTER finally issuing an apology to whistleblower Dr Kim Holt last month, **Great Ormond Street Hospital** (GOSH – a foundation trust-in-waiting) and its Teflon-coated CEO Dr Jane Collins were doubtless hoping to draw a line under Baby P. But Lynne Featherstone MP is now calling for an investigation into Collins' actions in withholding vital information – the Sibert report – from the original serious case review into the death of baby Peter Connelly. Collins says this was on legal advice and her board is backing her.

The hospital has friends in high places: Ivan Cameron, the prime minister's severely disabled son, was treated at GOSH; and its charity is wooing Samantha Cameron as a patron. Collins, who removed herself from the General Medical Council (GMC) register and can't be referred over Baby P's death, has survived persistent calls for a public inquiry and a vote of no-confidence from 50 consultants last year. But she needs to be held accountable for the audit trail of suppression that has protected one of Britain's most cherished hospitals and deflected the blame for Baby P's death disproportionately on to sub-standard social services and one under-qualified consultant, Dr Sabah Al-Zayyat, who missed the child abuse.

Peter Connelly was found dead in his cot on 3 August 2007. In January 2008, Dr Collins commissioned a report, written by Professor Jo Sibert and Dr Deborah Hodes, two renowned paediatricians, entitled *Review of Child Protection Practice of Dr Sabah Al-Zayyat*. Normally NHS trusts "own" these expert reports and can publish the favourable bits and miss out the bad bits, but you are expected to come clean for a serious case review. Collins didn't.

The Sibert report exposes serious failings in the management at St Ann's child development clinic in Haringey, where GOSH employed the clinical staff: "Dr Sukanta Banerjee (a consultant) told us the state of affairs at St Ann's was a 'clinically risky situation'. We agree with her and we believe the present arrangements for seeing child protection cases at St Ann's cause grave concern. In particular, the lack of consultant staff."

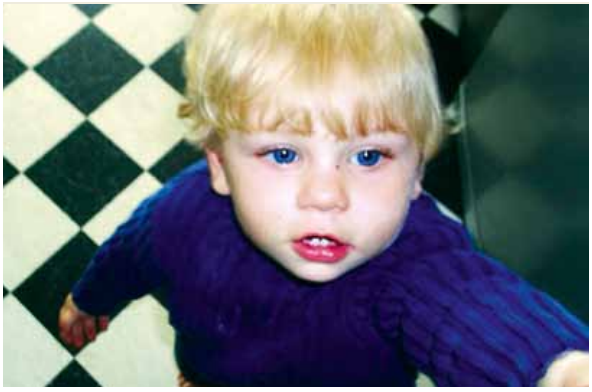
But GOSH already knew this. In 2003, it paid and gagged Professor Sam Lingham, who was then running the child development clinic single-handed. GOSH then hired four new consultants, who found the working environment very unsafe. They wrote a letter in 2006 highlighting their concerns about a "lack of unified records", "missing records" and "no child protection follow-up". To make safe decisions on the risk of child abuse, accurate and comprehensive notes are essential. Two of the consultants left. Kim Holt was put on special leave, having already written to management about the dangerous and poorly functioning clinic.

So GOSH hired Sabah Al-Zayyat into a consultant post that required two years' child protection training. Dr Al-Zayyat's CV made clear she had none. She was also to do a very difficult job with no notes. By the time Baby P presented at the clinic, he had already been to A&E three times previously, as the notes would have made clear.

At nine months, Peter had been admitted to the paediatric ward at the Whittington hospital with an unexplained haematoma. The hospital noticed bruising on Peter's head, cheek and buttock describing it as classic non-accidental injury. At the time, Peter's mother provided a variety of different explanations for the injury. At 13 months old, Peter arrived at A&E at North Middlesex University Hospital after a head injury. The CT scan was normal but Peter had bruising and scratching on his face, and his mother provided two different explanations for the injuries. At 16 months Baby P again presented at A&E, this time with a rash on his scalp, itchy left ear discharge and swelling in the ear lobe. He also had bloody scabs on his infected scalp, itchy hives and head lice. His mother again gave two different versions of events, blaming it on an "allergic reaction to Red Leicester cheese". A diagnosis of child abuse had already been made, but Dr Al-Zayyat knew nothing of this.

The Sibert report makes it clear **three times in bold** that "**This information was not in the St Ann's notes.**" This was hardly what Collins wanted to hear, as she could no longer blame Baby P's death on one doctor – who made serious clinical errors - when there was also a convincing written audit trail implicating GOSH and her leadership.

So what did Collins do? She tried to manage the problem. Immediately after Baby P's death, Kim Holt was offered a year's salary in November 2007 to leave. In December 2008, when Baby P's death had become a tabloid sensation, Dr Holt was offered £120,000 to sign a compromise agreement with a "super-gag" clause. But there was one catch. Lawyers for Great Ormond Street, Beachcroft, wrote to Dr Holt claiming: "Our client is not aware that Dr Holt has ever raised concerns over the management of child protection issues." This one sentence sought to rewrite the audit trail and ensure GOSH could escape blame. The offer of £120,000 was then made expressly



'If our concerns had been taken seriously at the time we raised them, we could have prevented the death of Baby Peter'

Whistleblower ***Dr Kim Holt***

'After someone has been killed in a patient safety incident, you can often see that all the ingredients were in place for a disaster... It was almost as if the person who died was a "dead patient walking" as they stepped through the entrance of the hospital.'

***Sir Liam Donaldson**, former chief medical officer for England, 18 November 2005*

subject to these allegations being withdrawn. Kim Holt bravely refused.

GOSH also failed to tell the Treasury that the £120,000 pay-off, at taxpayers' expense, would be tied to a silencing agreement. Faced with Dr Holt sticking to her principles, the strategic health authority sprang into action. NHS London spent £103,000 on a report from a firm of solicitors, which appears to exonerate NHS managers. GOSH spent £286,797.41 on Verita management consultants who also seemed to find no fault with management (and did not even interview the four consultants who signed the 2006 letter).

Dr Holt, meanwhile, remained on special leave at a cost of £95,000 a year, and GOSH had spent £82,218 on legal advice to date in her case. All of this is taxpayers' money. No manager has faced any sanction as a result of their failings in running the child protection clinic.

And what of the Care Quality Commission? In February 2009 Dr Holt sent it the letter written by all four consultants, and her letter to Cyril Chantler, GOSH chairman, and Jane Collins from November 2006. In May 2009, the CQC responded by releasing a report in which the problems at the child protection clinic were all put down to "communication". No blame was levelled at any manager and the whistleblowing letter of the four paediatric consultants was ignored.

When Dr Holt contacted the CQC to make it aware of previous whistleblowing disclosures, she was told that the CQC had considered her information. However, recently the CQC has "lost" all communications with Great Ormond Street and has said that the any information may have been used for "horizon scanning" or to contact people with concerns.

Were people contacted? Not that the *Eye* could ascertain. And certainly not the Camerons. They think GOSH is absolutely marvellous. As *The Lancet* observed: "If GOSH's management team had been in Wigan they would be gone by now."

In the meantime, health secretary Andrew Lansley has persistently refused to meet Dr Holt and has resisted calls for a public inquiry. Someone at GOSH has been protected; but it certainly wasn't Peter Connelly.

Gagging for it

PUBLIC money should never be used to suppress information that's in the public interest. There are several doctors at GOSH who've been gagged and who can't now speak about their safety concerns. Indeed, it's hard to think of a situation when it can ever be acceptable to gag an NHS employee. And yet 13 years after gagging was outlawed by the public interest disclosure act (PIDA), a Channel 4 investigation revealed that 55 of the 64 NHS compromise agreements it sampled had gagging clauses.

In some cases they prevent the doctor making derogatory statements about the NHS and/or telling anyone but close family that he or she has signed the agreement. The doctor or nurse cannot even tell anyone else about the existence of their super-gag. It's a brilliant way to bury bad news.

Gagging clauses can apply to whistleblowers, whatever their rank, and to incompetent staff who've been paid to move on. Either way, safety concerns are hidden and there's no guarantee lessons are learned or that harm will be prevented.

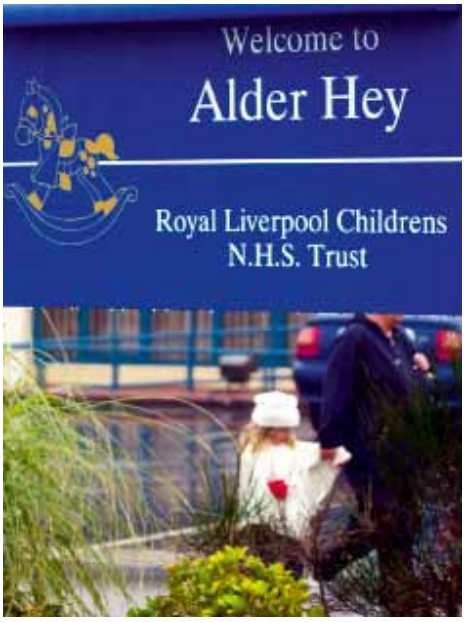
In November 2009 the Information Commissioner forced **Liverpool Women's NHS Foundation Trust** to give details of compromise agreements and their cost to the public purse. Thirteen members of staff had signed agreements at value of £440,000, all containing "gagging" clauses. Of those 13 silenced members of staff, four were specifically prohibited from making any contact with the media about any NHS matter. One senior consultant was threatened with a court injunction to prevent him from expressing his concerns to an MP. All in a single hospital.

Using this decision, the *Eye* asked *all* NHS trusts to provide us with the number and value of compromise agreements. More than 40 NHS organisations refused to provide the information. The arguments for exemption were many and varied: the information "would prejudice the effective conduct of the trust's public affairs"; "the dissemination of the information was highly restricted"; and "individuals may be subject to inquiry, comment or criticism". **Dudley NHS Foundation Trust** wanted £10,412.50 to provide the information; and **University Hospital Leicester** argued that we couldn't even publish its reasons for refusal.

To pay off and silence a doctor, a trust needs central government approval. We asked the foundation trust regulator, Monitor, for the pay-off approval forms but it said it had passed them on to the Treasury and not kept copies. The Treasury couldn't help as it said the forms were not stored.

The *Eye* then enlisted the help of Stephen Barclay MP of the public accounts committee (PAC). He raised the issue on the floor of the House but was brushed off. He also asked for details of foundation trust pay-offs three times at sessions of the PAC, and only got an answer when the chairperson, Margaret Hodge MP, threatened to call all the foundation trust accounting officers to parliament. At that point Sir David Nicholson, the NHS chief executive, graciously produced the figures.

As Barclay observed: "In 2005 the PAC made a recommendation that gag clauses on pay-offs be stopped – it's absolutely clear cut. The Department of Health responded by producing the NHS Circular and praying it in aid. Yet five years on it's all still going on. There is a systemic failure." So despite the public interest disclosure act, the efforts of MPs on the public accounts committee and the DoH circular, NHS managers are still hosing down bad news with taxpayers' money, silencing whistleblowers, signing deals off with the Treasury and escaping any form of accountability.



Behind the gag

NONE of the NHS trusts would provide names for the staff they had paid off and gagged, or the reasons why.

When the *Eye* contacted **Alder Hey Hospital** to ask about gagging orders, the answer was very firm: "Alder Hey has never placed gagging orders on any member of staff." But the *Eye* already had in its possession the compromise agreement relating to a senior child heart surgeon, Mr Marco Pozzi, and the amount he was paid, namely £156,000. That agreement prevents Mr Pozzi making any adverse or derogatory statement about the trust and communicating with any media. When we put this to the trust, it apologised for the "misunderstanding" but wouldn't say what it wanted to keep quiet.

Marco Pozzi gave evidence to the Bristol Inquiry and became the lead surgeon in children's heart surgery at Alder Hey. From 2003 to 2008, a freedom of information request reveals, his mortality rate for 80 arterial switch operations was an enviable zero. Not a surgeon one would want to lose. From a local MP, however, we have learned that Mr Pozzi had been instrumental in limiting the practice of an underperforming surgeon and had concerns about

Pay off, shell out, shut up

THE Treasury made 2008-09 a bumper year for non-foundation trust pay-offs, approving 192 at a cost of £5,990,504. Foundation trusts now hold the baton with 105 pay-offs worth £2,408,026 so far in 2010-11. The top five FTs for pay-offs are:

South Staffordshire and Shropshire (2010/11)	**£330,850**
Sherwood Forest Hospitals (09/10)	**£320,000**
Central Manchester University Hospitals (10/11)	**£224,253**
Alder Hey Children's (08/09)	**£198,726**
University College London Hospitals (10/11)	**£177,388**

For figures for all NHS trusts see www.medicalharm.org.

'My experience of the DoH is they have a tendency to shoot the messenger rather than embrace changes that need to be made.' ***Sir Ian Kennedy****, evidence to Mid Staffs Inquiry, 2011*

Lansley's broken promises

HEALTH secretary Andrew Lansley hasn't had a great year.

Having pledged to depoliticise the NHS, he's managed to turn it into a massive political bun-fight; and having promised to reduce top-down control, he's somehow increased it, junking two levels of bureaucracy to create four. Out go strategic health authorities and primary care trusts (SHAs and PCTs), in come a National Commissioning Board, Regional Branches of the Board, Clinical Senates and Clinical Commissioning Consortia.

But easily the most important pledge he made before the House of Commons on 9 June 2010 has been quietly shelved.

Then, the new health secretary announced a public inquiry into "events" at the **Mid Staffordshire NHS Trust**, where up to 1,200 patients may have died due to appalling standards of care. Three previous inquiries had unearthed a culture of fear, secrecy and bullying, where whistleblowers were being punished and silenced. Lansley pledged "a range of measures to build on and give teeth to the current safeguards in the public interest disclosure act 1998 (PIDA)". Thirteen months later, we're still waiting.

alleged manipulation of statistical outcomes. He approached the Department of Health for advice but was told – as all whistleblowers are – it was a local matter that needed to be sorted out locally.

Since Mr Pozzi has now been paid off at public expense, these problems will never be independently scrutinized. The gagging clause was negotiated by Louise Shepherd, the chief executive of Alder Hey. At her former hospital, the **Liverpool Women's NHS Trust**, she was also fond of gagging (see *Gagging for it*, above).

Even GPs are gagged. Dr Louis d'Arcy was a single-handed GP at Hanson Place surgery in Wyke, near Bradford, where he had practised for more than 25 years.

In 2004, **Bradford primary care trust** (**PCT**) sent in a nurse practitioner to his surgery to help manage his diabetic patients in a nurse-led clinic. Over a few years, d'Arcy became concerned that some might be testing "false positive" for diabetes and be wrongly diagnosed and treated for life. A consultant endocrinologist saw one patient and confirmed the error. But d'Arcy had concerns about 60 patients. In April 2007, he wrote to the PCT: "In light of the outcome of the review of the patient's case, I will be reviewing on a case by case basis those patients who have not had a glucose tolerance test in whom a diagnosis of diabetes was made."

The reply was swift and brutal. Dr d'Arcy was accused of challenging the "management authority" and submitted to a disciplinary procedure. He was alleged to have bullied the nurse and was eventually offered more than £100,000 to sign a compromise agreement, and asked to leave his surgery the next day. The local GP was there one day and gone the next, having signed a super-gag clause whereby not only his medical concerns but also the very fact of the agreement must be kept secret.

The PCT could not confirm whether the 60 "diabetics" were properly screened. The *Eye* approached the Department of Health who issued an immediate background briefing notice claiming Dr d'Arcy had been dismissed. No comment was made about the safety concerns. Later, the DoH reissued the statement admitting that Dr d'Arcy had not been sacked. But he has been gagged.

The National Harm Service

HEALTHCARE is an industry that causes significant harm while bringing enormous benefits. Overall, one in 10 patients are harmed by their healthcare; but if you're sick and over 75, the risk rises to 1 in 3.

Any other industry would be shut down with such an appalling safety record; but healthcare has an ingrained culture of denial. Errors are hidden, rather than owned up to; and many more pass unnoticed because nobody bothers to pick them up.

The NHS managed to write off its worst excesses until the heart scandal at the **Bristol Royal Infirmary** (**BRI**). The avoidable death and brain damage of a large number of babies there was too much even for the NHS to hide. Even worse, the whistle was blown from 1988, the Department of Health knew it had a problem in 1989, the *Eye* broke the story repeatedly in 1992 and yet the deaths and brain damage continued until 1995.

In 1997 Labour inherited a whole host of scandals from the Tories. In 1998 it introduced PIDA to try to outlaw the gagging of whistleblowers and to offer unlimited damages for those were punished for raising genuine concerns.

The Bristol Inquiry acknowledged that the heart scandal was the tip of a very unpleasant iceberg. It estimated that 25,000 patients a year die in the NHS in England and Wales "from adverse events that may be preventable from the exercise of ordinary standards of care". Inquiry chairman Ian Kennedy said he could not be confident that other systemic failures of care were not hiding in the NHS, and that radical action was needed to stop and prevent them. The report made 198 recommendations to enshrine transparency and patient safety as the organising principles of the NHS. These included:

- The creation of an open and non-punitive environment in the NHS in which it is safe to report and admit to "near misses" and patient harm.
- A compulsory analysis of all such events, taking into account both the conduct of individuals and wider contributing factors within the organisation.
- Disciplinary action against any member of staff in the NHS who covers up or does not report an adverse event.
- A duty of candour to ensure patients and relatives are told when they have been harmed by the care they've received.
- An acknowledgement, explanation and apology to those harmed
- A prompt system for providing compensation for those who suffer harm arising out of medical care based on patients' needs.
- An urgent investigation to ensure child heart surgery is not currently being carried out where the low volume of patients or other factors make it unsafe to perform such surgery.

Ten years on, none of these key reforms has been properly enforced. Labour tried to manage patient safety from the centre and it didn't work. The risks of healthcare change by the second and regulators haven't got a clue what's happening on the frontline. Hospitals learn how to pass checklist assessments and patients are conned into thinking a hospital is safe because it's passed an annual healthcheck.

A review in 2009 showed that NHS organisations were subject to 35 different regulators, auditors, inspectorates and accreditation agencies that demanded information from the various parts of the system. Not one of them can prove the NHS is getting safer, and none of them prevented the scandals at Stoke Mandeville, Maidstone and Tunbridge Wells, Basildon and Thurrock, Colchester or Mid Staffs.

The black box of general practice

GENERAL practice remained hidden away until the horrors committed by Dr Harold Shipman emerged. Whether he'd killed more than 200 people by murder or incompetence, the real shock was that no one had picked it up. He wasn't even offered retraining.

A decade ago, Dame Janet Smith called for reforms of death certification, coroners, controlled drugs and the regulation of doctors.

'The DoH deliberately and systematically suppresses sound evidence from reliable sources which they would prefer not to hear...'

***David Hands**, professor in health policy and management and former NHS CEO*

Her recommendations have been watered down or ignored to the point that she has openly questioned whether her £21m public inquiry was worth it.

But the NHS can get results. **Tower Hamlets PCT** has worked with whistleblowers and patients to remove the unacceptably bad GPs. Between 2003 and 2010, the careers of 23 GPs were terminated. They include:

- A whole practice of three partners and a locum who systematically oversaw the premature death of hundreds of people every year, by passivity, ignorance and neglect.
- A GP who was convicted of sexually assaulting a pregnant Somali patient at an ante-natal clinic in his surgery. This GP had asked partners to pray to help him resist "temptation from the devil" but no one had explored his "temptation" further.
- A GP who had come to the UK from Nigeria via Bulgaria and Germany who was woefully deficient in all areas of clinical knowledge and practice.
- A GP who kept records on patients that were unintelligible, and who failed to act on letters from hospital keeping hundreds of them in a cardboard box under the stairs.
- A husband and wife GP practice caring for 11,000 patients so poorly that thousands of them had to be recalled for immunisation checks after it emerged that refrigerators at the practice were totally inadequate. They also employed a "nurse" who was not qualified.

The process of removing dangerous doctors in Tower Hamlets took great effort and cooperation between those raising concerns and those acting on them. It's a beacon of how patients, clinical staff and managers should work together. But usually the system works against whistleblowers to suppress scandals that might be politically or commercially damaging.

Steve Bolsin and Ash Pawade

POLITICAL reforms often court disaster. Twenty years ago, the **Bristol Royal Infirmary** was keen to become a trust hospital under the Tories, just as Mid Staffs wanted to be a foundation trust under Labour and GOSH does under the current coalition. This means balancing the books and burying any scandal.

The BRI also wanted the money and status that goes with being a regional centre for cardiac surgery. Unfortunately, it wasn't very good at it. Stephen Bolsin, a cardiac anaesthetist, was shocked by what he observed after joining the BRI in 1988:

"My first indication that something was badly wrong with the technical skill of James Wisheart was the incredibly long time he took to complete cardiac operations in children and adults. This involved long cross clamp times, which is when the heart is starved of oxygen, leading to death, serious heart failure and other major complications after surgery. I had been in my consultant post two months. What could I do?"

In fact Bolsin did a huge amount, raising concerns repeatedly with senior consultants and the trust chief executive, and alerting the Department of Health and national leaders when he was knocked back. He collected figures to show how awful the results were for a whole range of complex child heart operations, supported parents who were fighting for a public inquiry and reported both surgeons and the chief executive to the General Medical Council (GMC). He was a hero; yet the medical and managerial establishments hated him for exposing how dangerous and self-protective they were.

It took 19 years from Bolsin's first concerns for a public inquiry to conclude that a third of the children undergoing surgery prior to 1995 had received "less than adequate care" and that between 30 and 35 had died unnecessarily. The fate of dozens of children who suffered severe brain damage after surgery was largely ignored and some families are still fighting for compensation.

The further tragedy of Bristol was that it was avoidable. Had those in authority acted promptly on Bolsin's concerns, the scandal would never have happened. Many more babies' lives would have been saved, many children and young adults would be living without brain damage and many more families would still be intact. After the inquiry, parents realised that everyone seemed to know about Bristol but them. The guilt of not protecting your child was too much for some to bear. Marriages split up and two fathers committed suicide.

Bolsin, a leading thinker in patient safety, would have been a huge asset to the NHS had he not been ostracised and briefed against. At a European cardiac surgeons meeting, he was described as "the most hated anaesthetist in Europe" and found himself unemployable in the NHS. He left the UK in 1995 to work – very successfully – in Australia.

That year Ash Pawade – a brilliant and brave paediatric cardiac surgeon – arrived at the BRI from Australia. He turned the unit around by achieving some of the best results in the UK and then publishing them. But child heart surgery was desperately in need of reorganisation into fewer, larger, better-staffed and equipped units that could expand and train for the future. Pawade was the only child heart surgeon in Bristol for four years, on call 24/7.

In 2004, Labour pushed to get waiting times down for adult heart surgery. This led to a severe shortage in Bristol of perfusionists who manage the bypass machines for adults and children. The chief perfusionist circulated an email saying his department would not be able to cope. Pawade supported him, writing to managers to say that children's lives were at risk. No more perfusionists were appointed.

In May 2005, a baby called Abbie Hattam died after an overworked perfusionist made a drug error. Pawade supported his colleague and called the trust managers to account for failing to address the staffing problems and trying to mount a cover-up at the coroner's inquest into Abbie's death. He was warned to "stop digging or shit will fly and some of it will stick to you".

The BRI had learned none of the lessons of the heart scandal. Pawade, the hero who had turned round a disastrous service, was ordered to the CEO's office and asked to apologise for "impugning the integrity of the trust's legal team". Pawade left the NHS shortly afterwards, without any recognition of his extraordinary achievements.

Last year the BRI Histopathology Inquiry - triggered by disclosures in the *Eye* - found a management culture that "veers towards the opposite of what is required... at times defensive, responds aggressively to criticism, is sometimes unwilling to acknowledge, let alone learn from, mistakes, and which is based on overconfidence bordering on arrogance". It's as if the Kennedy Inquiry into child heart surgery had never happened. The Bristol disease appears incurable.

As for child heart surgery itself, Labour bottled out of safely centralising the units, despite another scandal in Oxford and a report of another 76 "excess deaths" in four small units. Current attempts are being delayed by petty local politics, ego and intransigence. Meanwhile babies continue to be harmed unnecessarily (see Medicine Balls in the last *Eye*).

Nicholson and Bower: asleep at the wheel?

LIKE an angry doctor prescribing the wrong treatment again and again, Labour got annoyed that its vast army of regulators couldn't stop the scandals.

Mid Staffs hit the fan in the fag end of the Labour administration just as Bristol had done for the Tories. Labour blamed the regulators, the regulators blamed each other, the unions and Royal Colleges sat on their hands and the patients just died.

According to Bill Moyes, former head of Monitor, the foundation trust regulator, health secretary Alan Johnson tried to prevent the estimated death toll at Mid Staffs being made public. Were it not for the tenacity of Julie Bailey, whose mother Bella had died at Mid Staffs, and her Cure the NHS campaign group, the true extent of the scandal would never have emerged and there would be no public inquiry.

Mid Staffs is equally embarrassing for the current coalition because it implicates the two most powerful people in the NHS.

Cynthia Bower has been chief executive of the Care Quality Commission since 2008 and was chief executive of NHS West Midlands from 2006 to 2008. Her evidence to the Mid Staffs inquiry has been very revealing. The strategic health authority failed to act on very high death rates at Mid Staffs and other hospitals in the region, and failed to scrutinize complaints from patients or relatives about poor care. Even worse, it commissioned a lame piece of research from Birmingham University to justify not taking action.

The CQC under Bower even made Dr Heather Wood – lead investigator for the Mid Staffs scandal – sign a gagging clause when she left office. Dr Wood believes that the CQC in its current form would not spot another Mid Staffs.

David Nicholson was also soundly asleep at the wheel. He's been chief executive of the NHS since 2006 and has continued the culture of centralised, top-down enforcement. In 2003 he was appointed chief executive of

'Strategic heath authorities and most NHS trust boards are the hatchet men for the DoH. They operate a policy of buying the silence of anyone who stands against government policy.' ***Gary Walker****, former CEO United Lincoln NHS Trust*

Birmingham and The Black Country SHA and in August 2005 became chief executive of Shropshire and Staffordshire SHA and West Midlands South SHA. Mid Staffs started on his watch and his evidence to the public inquiry is likely to be equally revealing. Or at least it would have been if the DoH hadn't delayed producing key documents and postponed his appearance.

Nicholson has now been appointed – without any apparent competition – as chief executive of the coalition's new NHS Commissioning Board. The combination of rapid structural reform and impossible efficiency savings is a perfect storm for more scandals, particularly if the same leaders are enforcing the same culture of denial and blame. At Mid Staffs staff have even been blamed for *not* blowing the whistle. In fact there is evidence that plenty of concerns were raised over a period of years. The problem is that they were not acted upon.

Raj Mattu

IN 1999, managers at **University Hospitals Coventry and Warwickshire NHS Trust (UHCW)** – a neighbour of Mid Staffs – came up with a clever policy to hit Labour's waiting time targets. They decided to stuff five beds into wards designed for four, so three beds had no easy access to suction or oxygen sockets and there was very little space to move between them.

In December, a 35-year-old man was admitted to the cardiology ward having arrived at A&E the night before and had a cardiac arrest. Unfortunately he was put in one of the beds with no suction or oxygen supply nearby.

With the patient blue and choking, Dr Raj Mattu – a consultant cardiologist and world-renowned researcher – looked down his throat and found a large blood clot. This could have been removed by suction, but there was none available and the crash trolley could not get to the side of the bed. Dr Mattu could not remove the clot as the crash team looked on helplessly. The patient died soon after.

Mattu filled out a clinical incident form, also signed by two of the emergency nurses. There were other alleged deaths implicating the 5-in-4 beds policy, one just three weeks later. Mattu received no response to his clinical incident form and wrote to CEO David Loughton chasing a response. None came. Sixteen months later, 80 clinical incident forms had been filled in by doctors and the trust had still not acknowledged Mattu's letters. Mattu was twice voted in by his colleagues as clinical director and twice vetoed by management.

In September 2001, the Commission for Health Improvement (CHI) visited the site. It issued a damning report, saying the practice of 5-in-4 was "wholly unacceptable" and "must stop and cease immediately". To add to the trust's woes, the mortality ratio was higher than even Mid Staffs. Loughton went on local TV and claimed that there had been no deaths he knew of as a result of the "5 in 4 policy". In consultation with his union, Mattu went on TV a week later and described the death he had witnessed.

Loughton then commissioned a secret review of the death from an anaesthetist, Dr Mark Porter, now the BMA's lead spokesperson on whistleblowing. Dr Porter's report declared "this is a failing that should not have happened", but adds: "There are records of medical problems sufficient to conclude that his death may have been unavoidable, or was not avoided by medical management that could have been taken." The report was a godsend to Loughton.

Mattu's representative, Stephen Campion, was called to an off-the-record meeting with Loughton at a local hotel. At that meeting, Campion claims Loughton said: 'I'm not interested in giving Dr Mattu a parking ticket, I want him off the road." Two months later, Mattu was suspended on an allegation of bullying. He remained suspended for six years. Loughton left the trust in 2002.

An independent QC was employed by the trust to conduct an internal review at a cost of more than £1m in 2005. He recommended that Mattu be reinstated. After the suspension was finally lifted in 2007, the trust sent more than 200 allegations about Mattu to the GMC. Every allegation was dismissed by the GMC, but the stress was huge. Finally in November 2010, the hospital sacked Mattu for becoming ill during the process. Mattu suffers with a multisystem autoimmune disease which comprises sarcoidosis, pancreatitis and lung disease, and is known to be exacerbated by stress. The trust had been fully aware of his condition since 1999.

Throughout Dr Mattu was offered pay-offs with gag clauses that he courageously refused. The entire episode has cost the trust £5m; it has destroyed the career of one of the finest consultants it ever had; and staff at nearby Mid Staffs were left in no doubt about the dangers of whistleblowing.

UHCW told the *Eye* it had conducted an independent review into deaths from 5-in-4 wards. However, the trust was unable to provide the name of the reviewer or the text of the independent review. The review therefore remains secret and we have no evidence that it took place. UHCW denied that 200 complaints had been made to the GMC about Dr Mattu but did not provide the real number.

Gary Walker

THE **United Lincolnshire Hospitals Trust** was in trouble, with seven CEOs between 2000-2006, each lasting on average only nine months. During that time, seven doctors were on the receiving end of compromise agreements, all with gag clauses.

In 2006, the trust appointed Gary Walker, a turnaround chief executive who would stay. One of the first things Walker did was to abolish a middle manager fix which had seen A&E beds being pushed into corridors and cupboards without an oxygen supply to ensure that waiting time targets were achieved.

Within two years financial deficits had been paid off and targets were met. In the winter of 2008, the trust experienced a dramatic rise in A&E admissions, sustained for eight months. Clinicians approached Mr Walker about the increased risk of hospital acquired infections




CUSSED QUARTET **From left, Dr Jane Collins, Great Ormond Street's Teflon-coated chief executive; Cynthia Bower, current boss of the Care Quality Commission and late of NHS West Midlands, who has given evidence to the Mid Staffs inquiry into unacceptably high death rates; David Nicholson, NHS chief executive and former local health boss whose appearance before the Mid Staffs inquiry has been postponed; and Dr Barbara Hakin, the Department of Health's director of commissioning, who believes: "You need to meet targets whatever the demand."**

'The disgrace is that considerable public funds are squandered crushing whistleblowers and hiding the truly culpable...'

***Bob Schofield**, former NHS manager and friend of whistleblowing NHS CEO, John Watkinson*

and avoidable mortality in the overstretched department. The overwhelming view was that targets could not be met without compromising patient care.

Mr Walker wrote a letter to his SHA: "I believe the health system is in distress. I am extremely concerned about safety and have asked for a series of reports on safety issues including mortality." The chief executive of the SHA, Barbara Hakin, wrote on an internal email seen by the *Eye*: "You need to meet targets whatever the demand." Two months later Hakin took to the local airwaves to voice her "considerable concerns as to whether governance arrangements in the trust were right".

In internal board documents seen by the *Eye*, it is claimed that at a meeting with Walker the SHA suggested Walker should leave and construct a story for the hospital board, and that he was told if he did not leave, "his career would be in ruins". Mr Walker was offered £43,000 to sign a compromise agreement with a gag clause and leave. He refused. He was then summarily sacked, in February 2010, for the gross misconduct of allegedly using the "f-word" nine times at three meetings over a two-year period, not directed at any one individual but in general. He is now claiming unfair dismissal.

Since Walker was sacked, mortality rates and debt at the trust have risen and safety concerns have continued. Recently, after a road traffic accident, it is claimed that an experienced surgeon was pulled out of theatre to operate on an 18-week target patient. A staff grade surgeon took over but ran in to difficulties and it is claimed the patient has since had a leg amputated. Another patient died unexpectedly after a prostatectomy.

In May 2010, the CQC undertook an unannounced site visit but did not contact or speak to any doctors with concerns. The regulator says it checked the notes of six patients but otherwise left the hospital untroubled. Since the *Eye* started sniffing around, it has now decided to go back in. No one should hold their breath.

Barbara Hakin, meanwhile, has been promoted to the DoH's director of commissioning, slotting in beside David Nicholson. In a statement, the DoH denied the allegations Walker had made about his career being threatened with ruin by the SHA and claimed that they had been found to be without substance by an independent investigation. So that's all right, then.

SUPER SEXTET: From top left, Dr Kim Holt, sent on 'special leave' for four years after whistleblowing at Great Ormond Street; cardiac anaesthetist Steve Bolsin and cardiac surgeon Ash Pawade, whose outspoken but valid criticisms led to their parting company from the Bristol Royal Infirmary; Raj Mattu, the consultant cardiologist in Coventry who knew that five beds into four simply won't go; Gary Walker, a 'turnaround chief executive' at the United Lincolnshire Hospital Trust, who said government targets were putting patients at risk and was duly sacked for using the f-word; and Dr Peter Wilmshurst, godfather of whistleblowers, whose outspoken campaigning means he faces bankruptcy. Again.

John Watkinson

ONE of John Watkinson's first actions as CEO of **Royal Cornwall Hospitals NHS Trust** (**RCHT**) in January 2007 was to bring back to work two employees who had blown the whistle on the trust for making false declarations. Eighteen months later, Watkinson was suspended and subsequently dismissed for whistleblowing plans to move cancer services without the legally-required public consultation.

RCHT was the worst performing trust in England, with a £35m debt and staff utterly demoralised. Within a year, Watkinson delivered a £1.2m surplus and RCHT was in the top four A&E performers in the country. Then NHS South West, the SHA, decided to concentrate upper gastro-intestinal services in Plymouth, with Cornwall and Exeter forming a centre of excellence. Two statutes say that such major service changes require formal public consultation – "no decision about me without me" – but neither the SHA nor the PCT wanted delay. Watkinson's chairman, Peter Davies, resigned over the issue and when Watkinson sought legal advice confirming the obligation to consult publicly, his days were numbered. He was sacked six months later.

An employment tribunal found Watkinson had been "got rid of" because of his support for doing what the law requires. The findings were damning of RCHT and the SHA and it awarded him £1.2m compensation, now reduced to £900,000. The trust admitted he had been unfairly dismissed, but appealed the finding of whistleblowing, the outcome of which is awaited.

An *Eye* freedom of information inquiry revealed that RCHT has already spent £400,000 on legal costs. Watkinson has spent a similar, non-recoverable, amount of his own; and if the trust keeps throwing public money at appeals he may never get any compensation.

In doing the right thing, Watkinson lost a 35-year career, any prospect of employment and a £150,000 a year salary. Suspension required him not to talk with former colleagues, while not a single NHS chief executive – of whom he knows dozens – has been in contact since his case began. Worst of all, RCHT – like ULHT – has lost an excellent NHS manager who had the balls to stand up to the bullies at the centre on behalf of patients.

Be a fraud...

NATIONALLY renowned cancer expert Dr K had a brilliant career both academically and as a caring and much-loved doctor to his patients. In 1990 he began training in clinical oncology at **Christie Hospital, Manchester** – the largest single-site cancer centre in the UK – and became a consultant in 1996.

Dr K became concerned that the trust was not treating a sufficient number of cancer patients with radiotherapy. He was also worried that pathology results were missing

'Criminal sanctions should be enforced against individuals and NHS bodies for the victimisation of whistleblowers and the corporate manslaughter of patients who are harmed as a result of the failure to act.'

***Dr Peter Gooderham**, academic lawyer and whistleblowing expert*

from patients' notes and that the medical cover for patients on a private ward called Nathan House was insufficient.

The *Eye* has seen an unrelated four-page letter from a patient who wrote "to demonstrate a remarkable, disappointing and very alarming drop in the quality of care" at Nathan House. Chemotherapy tablets were allegedly not prescribed; a dose of erythropoietin was lost; a nurse didn't know where vital equipment was and couldn't take blood; urine collectors were removed without gloves; a patient was told to swallow a tablet that was meant to be chewed; and a diagnosis of septicaemia was delayed because a thermometer wasn't working.

The trust investigated Dr K's concerns and found no substance to them. However, it did launch an investigation into his conduct and referred him to the GMC for fraud.

Dr K's BMA rep said the charges were "completely incredulous" (*sic*) but they placed him under enormous stress. The GMC summoned him to an interim orders panel, where he collapsed and died of a brain haemorrhage at the age of 46.

When *Private Eye* contacted the Christie to ask about the concerns on pathology notes and radiotherapy treatment, the trust said a "serious untoward incident" process had been completed, and that a "senior oncologist" investigated the concerns and found no substance to them. The trust was unable to say whether the oncologist was from within the trust, nor to provide any details of the investigation.

Gideon's libel

IN JULY 2010, the GMC suspended surgeon Gideon Lauffer for six months. He'd previously been banned by **Barking, Havering and Redbridge University Hospitals NHS Trust** in Essex from carrying out laparoscopic and varicose vein surgery, but neglected to tell three private hospitals because he was too "embarrassed".

The GMC also declared that he operated outside his competence and had failed to tell a patient that he had damaged the man's left testicle during an inguinal hernia repair. In March 2008 he had failed to tell a patient who was due to undergo a laparoscopic cholecystectomy that he would not be operating on her and that another surgeon would perform the procedure. And although he was not allowed to do laparoscopic surgery, he performed the first stage of the operation by putting the umbilical port into the patient before the other surgeon arrived.

A finding of dishonesty normally leads to erasure from the medical register, but the panel decided that his dishonesty was "at the lower end of the spectrum" and took account of evidence that as a surgeon he was "too busy". Or it could have been because the GMC had known about Lauffer since 2000 and not acted to protect the public, and is now itself too embarrassed to do so.

This was the third time Lauffer had been in front of the GMC. The first time, in 2005, followed the deaths of three patients: Arthur Rogers, 53, from Ilford, in December 1998 after Lauffer allegedly failed to close his oesophagus following a cancer operation; Mohammad Anwar, 61, in July 1999 after his punctured bile duct led to blood poisoning; and another, 41-year-old widow Manjit Dhillon, of Ilford, who needed a transfusion of 27 pints of blood after having her gall bladder removed.

The GMC decided that what Mr Lauffer needed was "a performance assessment". But in 2005, **King George Hospital** in Essex claimed to have no concerns about his performance and promoted him to clinical director of surgery.

In 2008 Lauffer was back in front of the GMC following four deaths, including those of Allan Scamell, 63, who died in September 2007 flowing surgery for a hernia in which Lauffer allegedly sewed his bowel to the wall of his abdomen; and Terry Harris, 68, who died after his bowel was punctured during a routine gall bladder operation.

Anne Harris, Terry's wife, has counted 32 grieving families who lost someone or suffered serious injury following routine surgery with Mr Lauffer. In July 2008 the GMC ordered the interim suspension of Lauffer for 18 months.

But could much of this harm have been prevented? *Private Eye* has learnt from a local MP that in July 1999 Mr F – a courageous gut surgeon who can't be named – was the audit lead at King George Hospital and wrote to the medical director about the "much higher than expected number of hospital deaths for elective major upper GI [gastro-intestinal] cases... Before this gets out of hand we ought to clarify the situation and see if there is any need for concern." The letter was headed "Hospital Elective Surgical Deaths".

He got no reply and documents show that Mr F wrote again a month later. He noted that another patient had died "following benign laparoscopic cholecystectomy… as well as the case of elective major gastrectomy who bled and died immediately after the operation". Within two months, Mr F was facing disciplinary charges for allegedly calling a patient at home. An internal hearing followed and he was summarily dismissed by the trust. Mr F took the trust to an employment tribunal and, three years later, the trust packed the employment court with five lawyers and a barrister at public expense.

After two weeks in court, Mr F accepted £200,000 in a compromise agreement and an apology from the trust which accepted he was a good faith whistleblower. His own lawyers swallowed up £125,000 and the agreement, which included a "gagging" clause. Mr F could only talk to his immediate family and could not, directly or indirectly, make any comments about the trust. When the *Eye* asked for details of compromise agreements from Barking, Havering and Redbridge University Hospitals Trust, Mr F's agreement was omitted. His concerns, and the record of his gag, remained secret. Mr F has been unable to talk to *Private Eye*.

None of the surgeons recently involved in restricting Lauffer's practice has heard of the concerns raised back in 1999. Whistleblower Mr F has since found NHS employment hard to come by. Mr F wrote to the GMC about Lauffer in 2000. On one occasion that Lauffer ended up in front of the GMC, Mr F received a letter from lawyers warning him to remain silent. King George Hospital told the *Eye* there was "nothing illegal" about gagging clauses and that they no longer held Mr F's details on file. No one we asked has any idea where Mr Lauffer is working now, who is auditing his work and whether he is safe. The GMC is just hoping it all quietly goes away. Anne Harris will make sure it doesn't.

Dr Peter Wilmshurst

DR PETER Wilmshurst is the godfather of healthcare whistleblowers. He has taken on corrupt colleagues and the pharmaceutical industry for more than 30 years, and is still holding down a job as consultant cardiologist at **Royal Shrewsbury Hospital**.

He is currently fighting three defamation actions brought by an American medical device company, NMT Medical, which is suing him in the English high court after comments he made at a cardiology meeting in the US in October 2007 were published on an American cardiology website by a Canadian journalist. Neither the website nor the journalist is being sued (see *Eyes passim*.)

Wilmshurst was the principal cardiologist in the MIST trial, which was sponsored by NMT and aimed to see if closing a hole in the heart could reduce migraines. He and another researcher refused to be authors of an article about the trial in the cardiology journal, *Circulation*. They were concerned that the data submitted was inaccurate and incomplete. After publication, Wilmshurst sent the editor of *Circulation* hundreds of pages of documents, which led to a long correction, a four-page data supplement and a new version of the paper.

Despite that vindication, NMT did not drop the libel action, which has gone on for more than three years. It cost Wilmshurst £100,000 in legal fees before his lawyers agreed to act on a "no win, no fee" basis. Dealing with thousands of pages of documents has taken up all his free time for the last three years. He works each weekend and during his annual leave. And the case has been very stressful for his family. If he loses, he will be bankrupt and may lose his home.

NMT recently went into liquidation so Wilmshurst's ordeal seems to be over, no thanks to English libel law which does nothing to protect whistleblowers acting in the public interest. But Wilmshurst knows the score.

In 1981 he started research on amrinone, a heart drug which did not have the desired actions and had severe side effects. Amrinone's manufacturer, Sterling-Winthrop, offered Wilmshurst and a colleague money if they did not publish their findings. "When we refused, they threatened legal action if we published. Doctors who were paid consultants for the company, tried to discredit me when I presented our findings at scientific meetings."

Wilmshurst discovered that the company had conducted illegal clinical trials in the UK and had submitted falsified documents for applications to market the drug in other European countries. By publishing his results

'NHS management is all about reporting up the chain and making those up the line look good, including politicians. The organisation has completely forgotten its primary purpose.' ***David Bowles**, former NHS trust chair*

and speaking to regulators in other countries, he was able to prevent amrinone getting a European licence.

In 1984 Sterling-Winthrop announced it was withdrawing the drug worldwide because of its unacceptably high rate of life-threatening side effects. However, in 1986 Wilmshurst discovered that it was still selling amrinone over the counter in parts of Africa and Asia. Wilmshurst asked Oxfam to use its representatives in developing countries to collect evidence and the drug was finally withdrawn worldwide.

In 1996 Wilmshurst gave a seminar to 40 editors of UK medical journals, highlighting 16 cases of misconduct that were all well known in the medical profession, but in no case had the scientific record been corrected or the guilty punished. He has reported more than 20 doctors to the GMC for research fraud and other forms of misconduct. Usually the wrongdoing was known to individuals in authority for some time but Dr Wilmshurst was the only one to act. He deserves a medal.

Something must be done

WHISTLEBLOWING is bad for your health. Stress-related illnesses, relationship breakdown and financial hardship are very common. Even if you win it can feel like a defeat.

Consultant surgeon Ramon Niekrash was suspended from his job at **Queen Elizabeth Hospital, Woolwich** for 10 weeks after raising concerns about the impact of closing a urology ward was having on patient care. The tribunal found in his favour but left him with £160,000 legal bills. The trust used taxpayers' money to pursue its vendetta. All the managers involved are still employed by the NHS and some have been promoted.

The GMC obliges doctors to raise concerns about patient harm or risk being struck off, but it then fails to support them and will even spend years investigating vexatious complaints against those who blow the whistle. Many surveys have found doctors and nurses are still too frightened of repercussions to report concerns about patient safety.

The BMA claims to support whistleblowers but the largest portion of compromise agreements with gag clauses are negotiated by... the BMA. Professor David Hands knows why: "Professional bodies frequently collude with managers to define the problem as an employment issue because the sacrifice of one employee (who will shortly no longer be paying subscriptions) is better than losing a cosy relationship with an employer."

NHS whistleblowers are not always right, but are usually genuine in their concerns. They often end up leaving employment while those who suppress their concerns are promoted. Their dedication and altruism are lost forever, and the harm they've tried to expose is buried. Lessons are not learned, dangerous care is repeated and thousands of patients die from avoidable harm.

America has its own National Whistleblower Centre and offers huge support to whistleblowers. Why? There is good evidence that whistleblowing is more effective than regulatory authorities, saves vast sums of public money and many lives. The UK should follow suit.

What's needed is not just better statutory protection for NHS employees who raise concerns, but statutory enforcement of sanctions for any professional – managerial or clinical – who fails in their duty to investigate the concerns. And the investigation needs to be truly independent.

The NHS needs its own crash investigation team, free from the NHS brotherhood, that goes in fast and dirty in response to poor outcomes, an unexpected death or injury, serious patient complaint or whistleblowing concern, do a thorough analysis and publish it. This was proposed by Dr William Pickering in 1998 and endorsed by the *Eye*. The CQC cannot be both regulator and inspector.

The key Bristol Inquiry reforms must now be enforced to enshrine safety, humanity and transparency at the heart of the NHS. All gagging clauses in public services should be revoked. Junior staff must be properly trained, not left unsupervised and dangerously overworked. Managers must be free to serve patients, not ministers. Patients need to be given an independent voice, not hidden inside the CQC. The NHS needs an Outcomes Board not a Commissioning Board. Above all, patients, relatives and staff must be encouraged to speak up to stop shit happening. Patient harm must be monitored and displayed in real time, like a smoke alarm for the NHS.

There are still plenty of brave NHS whistleblowers out there, and they need to be recognised and rewarded. And those in authority must be held to account for ignoring them. Dr Peter Gooderham (see below) had no doubt what needs to be done: "Criminal sanctions should be enforced against individuals and NHS bodies for the victimization of whistleblowers and the corporate manslaughter of patients who are harmed as a result of the failure to act on the whistleblowers' concerns."

For more whistleblowers' stories, references and supporting documents go to www.medicalharm.org.

How to skin a whistleblower

PETER GOODERHAM (1965-2011) was an academic lawyer and former doctor who devoted much of his life studying and supporting NHS whistleblowers. Before his death, he worked with the Eye to define the methods the NHS uses to shoot the messenger…

- Inflict subtle sanctions beyond legal protection – like cutting secretarial help and teaching budgets, blocking appointments and merit awards, "briefing against" informally. Whistleblowers are said to have "attitude problems" and to be obsessed with historic issues and not prepared to move on.
- **Gather dirt on a whistleblower and inflict reprisals for actual or invented misdemeanours as the "official" reason for action against them. Allegations of mental illness are common and may be self-fulfilling as a whistleblower buckles under the stress.**
- Refuse to disclose documents. NHS trusts breach the data protection and freedom of information acts with impunity.
- **Take or threaten reprisals against colleagues who support a whistleblower.**
- Threaten the whistleblower. Dr Peter Brambleby, ex-director of public health for Norwich PCT, was told he might "end up in the woods like David Kelly".
- **Accuse a whistleblower of not raising concerns early enough. This lays doctors and nurses open to censure by their professional bodies for delay.**
- Claim it's an employment conflict, argue that the public interest disclosure act does not apply and suspend the whistleblower.
- **Apply to the Treasury for public money to pay off and gag the whistleblower. Some silencing agreements require whistleblowers to sign statements suggesting all concerns have been addressed even if they haven't.**
- Threaten whistleblowers and the media with libel suits if concerns that could affect the reputation of a trust are to go public.
- **Rely on the cowardice and apathy of the Department of Health. It usually refuses to intervene, saying it's a local employment matter.**
- Make vexatious complaints to a professional regulatory body. The General Medical Council's "Duties of a Doctor" guidelines are so vague they allow trusts to concoct dozens of complaints.
- **Throw public money at an employment tribunal (ET). Trade unions rarely give adequate legal support to members, who are usually tribunal novices while NHS trusts are "frequent flyers" with unlimited public resources. Whistleblowers can be saddled with crippling legal bills even if they win.**
- If the trust loses the ET – or any legal ruling - it can keep appealing, using public money, until the whistleblower is bankrupt.
- **Arrange an "in house" investigation. Often this is a sham instigated by the trust's own managers who are not impartial.**
- If the press insists on an external investigation, the trust can still organise and pay for it, recruit the panel, agree the terms of reference, hold the inquiry in secret and control how much, if any, of the report reaches the public.
- **Don't fear public inquiries. They're belated exercises in grief management that seldom change anything. They occur long after the event, when many of those in the dock have moved on and problems, like whistleblowers, are dismissed as "historical".**

Annex C

MEDICINE BALLS

Bully for Hakin

BULLYING is the cancer at the heart of the NHS. It stops staff, patients and relatives raising concerns about care, it destroys many who do and it allows political directives to be enforced on the frontline even when they're unsafe or untrue, just to keep Downing Street happy. The only time politicians see the light is when they are forced to in response to a disastrous public inquiry.

On 6 February, David Cameron said of the Francis Report into Mid Staffordshire hospital: "You can identify in the report three fundamental problems with the culture of our National Health Service. First, a focus on finance and figures at the expense of patient care. He says that explicitly. This was underpinned by a preoccupation with a narrow set of top-down targets pursued to the exclusion of patient safety or listening to what patients, relatives – and indeed many staff – were saying."

These were precisely the reasons M.D. and *Eye* journalist Andrew Bousfield referred Dame Barbara Hakin, now deputy chief executive of NHS England, to the General Medical Council (GMC). We alleged that she oversaw a "hit your targets or else" policy when she was chief executive of the former East Midlands strategic health authority, despite concerns raised by Gary Walker, then chief executive of United Lincolnshire NHS Trust (ULHT), that this – combined with an unprecedented rise in demand – was putting patients at risk of harm. Indeed, it is alleged that one died and another had an avoidable amputation. Walker also raised his concerns in detail to NHS chief executive Sir David Nicholson and asked to be protected as an NHS whistleblower. He was subsequently sacked for "swearing", gagged from voicing his concerns to anyone and £500,000 of public money was spent getting rid of him. Surely somebody has to be accountable for this?

Dame Barbara Hakin

Carry on as usual

It's certainly not Hakin – at least not according to the GMC, which, just 15 months after we referred her, has decided that anything that she may have said or done does not bring into question her fitness to practise, nor the safety of patients, and she can carry on as usual.

The GMC found "some support" for the core allegation, that Hakin told Walker the four-hour accident and emergency and 18-week waiting time targets must be met despite his concerns that to do so could compromise patient safety.

In March 2009 Hakin sent an email to all East Midlands chief executives stating: "I need to make it very clear that I expect you personally to ensure that your organisations deliver 100% for the next three weeks… We cannot afford even one day when one single organisation falters." Whether this constitutes bullying is beside the point. The Francis inquiry found such an approach is very unsafe and puts patients at risk. And Walker was telling her precisely that.

The GMC accepted Hakin's argument that "effective and suitable chief executives ensure patient safety whilst meeting targets and that she did not bully or harass Mr Walker… Safety and targets are inextricably linked and the complaint is based on a false dichotomy between the two." The targets themselves make some sense – no one wants to wait more than four hours in casualty or 18 weeks for an operation – but healthcare is very complex and dangerous, especially when there is overcrowding, and even Sir David Nicholson has recognised the dangers of "hitting the target and missing the point". A "100% insistence" is particularly dangerous, and creates a climate of fear. Francis found at Mid Staffs that the fear of breached targets created bullying in A&E, and an "emergency assessment" room where "breached patients" were stuffed and suffered. How can the GMC be so misinformed?

M.D. asked the GMC who its independent experts were (it isn't saying) and to forward Hakin's evidence (not allowed, even though passages in the judgment are strongly disputed by Walker). M.D. has asked Hakin for her evidence (no reply yet), and has also asked the GMC what its definition of bullying is (yet to be provided) and whether it considered the evidence of Francis on the dangers of enforced targets (it hadn't). It also hadn't considered evidence from the urgent investigation of ULHT by Sir Bruce Keogh triggered by consistently high mortality rates after Walker was sacked.

Severe harm and deaths

In June 2013, ULHT was rated red for MRSA infections and clinical negligence payments. It had 12 "never events" (severe harm to patients that should never occur) since 2009. Eight of 13 mortality indicators were "outside the expected range" with severe concerns about emergency care. There were serious concerns about fluid balance monitoring, delayed treatment, poor documentation, palliative care, failure to spot deteriorating patients, risks of falls and patients not being properly reviewed after operations. On a "patients with cancer" survey, 22 of 58 responses were ranked in the bottom 20 percent in the NHS, while only two were in the top 20 percent. "The main negative focus relates to overall care and care and treatment for inpatients."

There is much else besides to show not just a hospital now in crisis, but a crisis predicted by Walker. Patients have suffered severe harm and deaths at ULHT that would have been avoided with proper standards of care. The GMC's response? "The GMC (whilst aware of the recent publication of the Keogh Review) is unclear what, if anything, could be added at this late stage in the investigation."

The GMC also rejected key parts of Walker's evidence. Findings of an employment tribunal judge determined that Walker had made protected disclosures regarding patient safety to Hakin. Parliament's health select committee also found the NHS was wrong to attempt to sue Walker for raising "genuine patient safety concerns". The GMC claims that it was restricted by a gagging order and confidentiality clause in examining the matter. Yet the GMC has powerful legal privileges that extend to obtaining this information. In any case, the gagging order was waived by the NHS and the health secretary in March 2013.

Just obeying orders

The GMC's decision is puzzling but unsurprising. No one at the top of the NHS is ever accountable for anything. Its leaders are only ever carrying out the orders of politicians as interpreted by civil servants. If you try to tell them this is putting patients at risk, you're told to hit the targets or else.

In M.D's view, Walker has ample evidence to back up his claims and his and Hakin's evidence need to be tested fairly in public. M.D also thinks that the process of the GMC investigation was itself open to severe criticism (no equal and full disclosure of the evidence; relevant evidence not considered fairly or rejected; and a breach of the GMC's duty to protect the public). ULHT is now one of the most dangerous trusts in the country and has had nine chief executives in 11 years. Could the two be related? Don't ask the GMC.

Last week, police were called to Colchester General hospital, another on the Keogh special measures list, following allegations that staff were bullied into falsifying cancer care records to meet targets. Move on. Nothing to worry about here. They were only following orders.

More than two years ago, M.D. reported the medical director of Great Ormond Street hospital to the GMC for failing to act on the concerns of Baby Peter whistleblower Dr Kim Holt. It is apparently still investigating, hampered by the lack of an independent expert.

David Prior, chair of the Care Quality Commission, recently berated doctors for not blowing the whistle in the NHS but, given the cast of brilliant, brave people destroyed in the whistleblowing process – blackballed, smeared and gagged by the NHS and not protected by the law or regulators – it's hard to see why anyone would be mad enough to do it.

M.D.

The Agri Brigade

NEWS that a new 1,000-cow dairy unit has got the go-ahead in Mid Wales worries opponents of large scale industrial dairy farming.

Until governments in England, Scotland and Wales issue clear planning guidance against such "farms", however, they will continue to threaten the character of the British countryside, the future of small family farms and the quality of life of dairy cows. Very cheap milk is their only apparent benefit.

In the case of the dairy at Leighton, near Welshpool in Powys, the planning process reads like a farce. In November 2011, Powys council's planning committee said it was "minded to approve" an application for a 1,000-cow dairy, subject to a report on "outstanding issues". This ignored council officers' advice that approval should be withheld because the dairy conflicted "fundamentally" with the local plan.

The proposed Powys dairy was then gradually swept up in the larger controversy over the planned mega-super-dairy at Nocton in Lincolnshire (*Eyes passim*) which hoped to house more than 8,000 cows. Nocton raised national awareness of the potential for air and water pollution, and animal welfare problems caused by such a concentration of housed cows, which led to the Welsh government "calling in" the Powys proposal for special consideration.

John Griffiths, the Welsh environment minister, said he was concerned that Powys council had not fully considered the risk of pollution from slurry, nor the dairy's visual impact on the landscape. By October last year, all looked lost for the dairy as even Powys, which had by now changed its constitution and some members, voted by 11 votes to 5 to reject it. A public inquiry earlier this year then concluded that permission should be refused because the economic benefits did not justify the harm the development would do to the landscape.

Welsh government planning minister Carl Sargeant has now decided to ignore the public inquiry, however, on the basis that the economic benefits of a seven-figure investment in dairying and the creation of up to seven permanent jobs *do* outweigh the other concerns. But it is not remotely fanciful to suggest that the creation of these seven super-dairy jobs could end up destroying three times that number of jobs on family dairy farms which cannot compete by producing such cheap milk.

There are now around 25 dairy farms with more than 750 cows in England and Wales; and the creation of each new super-dairy puts more pressure on traditional farms either to expand greatly or get out of dairying altogether.

The random nature of the Powys planning process highlights how applications for mega livestock farms are handled. The Nocton application was not refused on animal welfare grounds or because of concerns about the effects of smell or noise or traffic on those living nearby. It was withdrawn after the Environment Agency objected because it threatened to pollute underground water – something unique to that site and not a template for how super-dairies should be considered by planners. What is needed is a coherent national policy on industrial dairying in the UK that simply says "no".

'New Bio-Waste Spreader'