Report of the Independent Investigation

Into

Management Response to Staff Concerns Relating to the Validation of the Cancer Waiting List 2011/12 at Colchester Hospital University NHS Foundation Trust

Conducted By

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September 2014

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Acknowledgements

- We would like to thank and pay tribute to the work of Cara Gosbell in supporting us during this investigation which she completed diligently, competently and with great integrity.

- We would also like to acknowledge the support of Darren Atkins and Sarah Shirtcliff in helping us access some of the information we required and generally to thank all interviewees and their representatives for engaging constructively with us in this challenging investigation at a very difficult time for the Trust and individuals.

- Our acknowledgement too goes to Helen Parr, who was instrumental when acting as SID in unlocking some of the blockages we experienced during the investigation in accessing some information, which was much appreciated and enabled the investigation to progress.

- We would also like to thank Anglia Ruskin University for providing us with use of their Iceni Education Centre at the Colchester General Hospital site which enabled a neutral and discreet venue for the conduct of our interviews.

- Finally we would also like to emphasise that in the course of our investigation we found many staff that whilst genuinely distressed by the recent events remained very committed loyal and proud of the Trust and the clinical care it provides.

- All the staff we saw showed a strong willingness to contribute towards improvements and rebuilding the Trust's reputation with its patients, their families and carers, the local community and other stakeholders.

Declarations

- Neither Professor Pat Troop nor Ms Carole Taylor-Brown has previously had a direct professional relationship with the Trust.

- Ms Taylor-Brown has immediate relatives who have or are treated by the Trust; Ms Taylor-Brown received obstetric care at Essex County Hospital/Halstead Hospital and the former Colchester Maternity Home during the mid-eighties.

1. Executive Summary

1.1. Following the publication of the Care Quality Commission (CQC) report of its inspection of Colchester Hospital, conducted during August and September 2013 in response to concerns raised to the CQC about cancer waiting times at the Trust, Monitor determined with the Trust that there was a need for an independent investigation into the staff concerns the report highlighted.

1.2. The Trust with regulatory oversight from Monitor commissioned two external independent investigators, Professor Pat Troop and Carole Taylor-Brown both experienced investigators with extensive NHS backgrounds to jointly review the issues raised. The investigation commenced in November 2013 and concluded in August 2014, during which time an extensive number of interviews were conducted amongst the relevant staff and various computer records and documents were reviewed and analysed.

1.3. There were some delays in the progress of the investigation due to difficulties in retrieving historical documents and as a consequence of further information which arose during the consultation on the draft report and which required investigation.

1.4. The remit of the investigation included establishing the facts behind a series of events from the end of 2011 relating to cancer waiting times, the appropriateness of the management response and the implications this held for Board assurance processes in relation to such concerns, and if for any employees remaining in the employ of the Trust at the date we submitted our report we considered disciplinary action was appropriate. As the primary individuals concerned had left the Trust during 2013 we have made no recommendations for disciplinary action and consider that instead the Trust should focus on the learning and improvements that the report highlights.

1.5. We were not asked and investigation did not involve an assessment of any clinical issues.

1.6. In addition the investigators were asked to consider the handling of some specific email correspondence received in March 2013 which related to the concerns, the effectiveness of the Trust's whistleblowing policy and any wider issues around bullying and harassment which they identified during the course of the investigation. The investigators were also asked to identify any lessons to be learned.

1.7. For contextual reference we considered as part of the investigation, the guidelines which apply to cancer services and the issues facing the Trust when these concerns arose in 2011/12.

1.8. Cancer services are underpinned by guidelines that reflect national and international standards; these include a number of key waiting standards which must be adhered to. Patients suspected of cancer must ideally be seen by the relevant specialist within two weeks (93% to be seen this quickly). Patients referred with the suspicion of cancer must start their treatment within 62 days (85% or 90% if detected through national screening programmes) with any patient found to have a cancer starting treatment within 31 days of being informed of the diagnosis (94% or 98% if only needing chemotherapy).

1.9. In 2011 the Trust was facing a number of challenges in regard to its achievement of national cancer standards and as part of a range of wider initiatives to improve the performance of cancer services, a new validation system of cancer information (a routine process to correct errors and update information commonly performed across the NHS) was introduced. This required two Associate Directors to undertake the majority of cancer validations and to review any breaches utilising root cause analysis so that future breaches could be prevented and improvements identified and implemented.

1.10. Shortly after the introduction of the new validation process in 2011, one of the Multi-Disciplinary Team Co-ordinators (MDTC) out of a team of 13 began to notice changes in the data which the MDTC believed were incorrect and after initially discussing the matter with a peer colleague and subsequently with the Cancer Services Manager Ms West, began to email their Associate Director, Mr Jarman-Howe about their concerns.

1.11. Mr Jarman-Howe believed that he had discussed the particular matter of concern with the individual and determined that his, rather than the MDTC's, interpretation of the relevant Cancer Waiting Time Guidance (CWTG) was correct and did not accept the challenges made by that MDTC. The MDTC did not consider they and Mr Jarman-Howe had satisfactorily discussed the matter and/or resolved it between them and that Mr Jarman-Howe had not explained the rationale for his decisions in the email correspondence between them.

1.12. The principal issue of dispute between them was the application of the 'decision to treat date' when a patient was under consideration for *active surveillance* as a treatment option.

1.13. The MDTC concerned shared their concern with a colleague; and both approached the Cancer Services Manager Ms West who advised them to discuss it directly with Mr Jarman-Howe. They also shared the issue with peer colleagues who also supported the MDTCs in their contention that Mr Jarman-Howe may be incorrect in his application of this aspect of the guidance and agreed the MDTC should email Mr Jarman-Howe and record their concerns as they arose.

1.14. By early 2012 the situation between the individual and Mr Jarman-Howe had not been resolved and although the validations were small in number, a further meeting to discuss the concerns took place involving most of the MDTC colleagues, when they considered how to escalate the matter further; however they did not come to an agreed approach.

1.15. Around this time a second MDTC observed changes in their data after validation by Mr Jarman-Howe and also considered he was incorrect; after emailing Mr Jarman-Howe they said they did not receive a satisfactory explanation. A third picked up a change in their data and also challenged Mr Jarman-Howe directly who, after discussion, reversed the amendment he had made. These other observations were in different specialties and were not about *active surveillance*.

1.16. The concerns of the MDTCs grew and they considered the amendments made by Mr Jarman-Howe to be incorrect and/or inconsistent with their understanding of the CWTG; three of them alleged that the amendments were made to reduce the number of breaches of the cancer waiting times standards being experienced by the Trust at that time and were concerned that in some cases this may also have resulted in a patient dropping off the vital tracking systems and thereby they considered this presented a potential risk of delays in a patient's treatment.

1.17. As the concerns grew one MDTC in the group began to discuss the matter with a colleague in the informatics department at the Trust, and during a routine conversation with that colleague shared some information which led that colleague to escalate matters to their line manager which resulted in the internal preliminary investigation into the concerns in February 2012.

1.18. The subsequent investigation was commissioned by the then Director of Finance Mr Baker who sought advice from the Director of Workforce in post at the time, Mr Bowman. Consequent to the discussion with Mr Bowman, Mr Baker established a preliminary investigation led by Mr Agrippa in the informatics department and informed Dr Coutts the Chief Executive at the time of the issue who advised him to involve a clinician in the preliminary investigation.

1.19. After approaching the individual recommended by Dr Coutts who declined because they did not have the experience, Mr Baker did not pursue the suggestion to involve a clinician any further.

1.20. Mr Agrippa completed his preliminary investigation within a few days and sent an email on 9 February to Mr Baker, Mr Bowman and Mr Lehain the Deputy Director of Finance (who had been involved in the initial discussion of the concerns), and recommended that the issues needed further investigation whilst highlighting that the concerns amongst the MDTCs were growing and beginning to be shared by other (unspecified) staff.

1.21. Mr Agrippa attached to his email three different cases from one specialty MDTC all of which were principally concerned with the application of *active surveillance* and the consequent impact on the recording of the decision to treat date. These cases were not representative of the wider concerns that the two other MDTCs were raising at the time.

1.22. Mr Agrippa and Mr Baker met to discuss the three cases; Mr Agrippa took a hard copy of the three cases but not his covering email (which we concluded was not discussed at that meeting) and although neither felt they had the necessary knowledge to fully appreciate the detail of the issues being raised, Mr Baker determined that it was essentially a staff communication issue.

1.23. Mr Baker then discussed the matter with Mr Bowman (although Mr Bowman did not recollect this discussion), when Mr Baker said it was agreed between them that he should meet with Mr Jarman-Howe to discuss the concerns that had been raised. Neither Mr Bowman nor Mr Baker recollected the 9 February 2012 email from Mr Agrippa and we therefore concluded they did not discuss this at this meeting between them.

1.24. Mr Baker met with Mr Jarman-Howe on 23 February 2012 when they discussed the three cases identified by Mr Agrippa; the email from Mr Agrippa was not referenced in the discussion. Mr Jarman-Howe explained his position on the matter to Mr Baker which he also confirmed in an email to Mr Baker later that same day. Mr Jarman-Howe's response exposed, in two of the cases, the distinction in his application of the decision to treat date in regard to *active surveillance* and that of the MDTC; Mr Jarman-Howe also set out the transparency of his decision making and recording of that in the CWT, and invited a peer review of the process he was using. Mr Baker did not respond to the invitation for a peer review.

1.25. Mr Baker said he discussed the outcome of his meeting with Mr Jarman-Howe with Mr Bowman which although Mr Bowman does not recollect, Mr Baker recorded that he had done so in a note. Mr Baker said when he spoke with Mr Bowman, they agreed Mr Jarman-Howe should meet with the MDTCs to explain his position and listen to their concerns.

1.26. Mr Jarman-Howe did not arrange that meeting and it was eventually initiated in late March by a MDTC; the MDTC sent an email to Mr Agrippa to say there had been a frank and open exchange where Mr Jarman-Howe agreed in some cases he may have been wrong and that he would amend the validation process so that MDTCs were informed of any changes and that he intended to get increased clinical involvement in the decisions he was making.

1.27. Whilst waiting for the meeting with Mr Jarman-Howe, some MDTCs continued to raise concerns with Mr Agrippa about some validation amendments made by Mr Jarman-Howe and at this stage were also joined in those representations by Ms West who, in addition to raising two concerns herself, also began to review and advise informatics colleagues on some of the issues being raised by MDTCs.

1.28. Ms West also highlighted one case to the Internal Auditor who was conducting a review of the 62 day cancer waiting standard in support of the External Auditor who was preparing the assurance Trust's Quality Report Indicators.

1.29. During this period Mr Agrippa continued to press Mr Baker for an outcome following his discussion with Mr Jarman-Howe and also reviewed with an informatics colleague the application of *active surveillance* over comparative periods but concluded that this was not statistically significant and did not take it any further.

1.30. On 14 March 2012 the Internal Auditor submitted a draft report in which he indicated that from his sampling of 20 cases he had identified two cases that suggested there was a difference in the data shown in the patient administration system (PAS) and the CWT and that as a result the Trust had incorrectly reported performance. The draft report was sent to Ms West and two other individuals in respect of other non-cancer related targets also included in the audit and copied to Mr Lehain. It was also reported to the Audit Committee that the draft report had been submitted; however no details of the findings were shared with the Committee which was consistent with normal practice because the report was still in draft format.

1.31. No action was taken in respect of that report, it remained a draft and it was never completed, however the External Auditors report, which considered the same indicator did not reach the same conclusion in regard to the impact on performance indicators and the 62 cancer standard and was reported in full to the Audit Committee in May 2012.

1.32. On 19 March 2012 Mr Agrippa wrote to Mr Baker and Mr Lehain to highlight the continued concerns of the MDTCs and suggested that the matter may need further discussion and invited them to share their thoughts. Mr Lehain thought he was more likely than not to have raised the email with Mr Baker but Mr Baker did not recollect any such discussion or have any recollection of the email or the Internal Audit report received a few days earlier by Mr Lehain.

1.33. After March 2012 the only reported continued concern was that of the original MDTC who had identified the issues concerning validation adjustments and those concerns continued to be registered with Mr Jarman-Howe by that individual until autumn 2012.

1.34. Relationships between Mr Jarman-Howe and the MDTCs throughout this period and with the MDTC raising the original concerns were generally good and there was no evidence of any bullying or any suggestion that the MDTCs were instructed to amend data inappropriately by Mr Jarman-Howe or any other senior manager. However we found that Mr Jarman-Howe did not adequately explain his rationale for his decision making to his subordinate staff and this led to the rising tide of concern amongst them which was never properly resolved.

1.35. In some cases Mr Jarman-Howe's decisions during validation were inconsistent with his wider contemporary colleagues' understanding of the CWTG particularly (but not exclusively) on the aspect of the application of the decision to treat date around *active surveillance* where the difference of understanding centred on whether it was when the patient discussed this in clinic or actually agreed the treatment plan – the latter being the accepted interpretation for the decision to treat date and which Mr Jarman-Howe did not always apply in his validation decisions.

1.36. Mr Jarman-Howe accepted and took personal responsibility for his validation decisions and although one individual felt pressured by those decisions there was no evidence to suggest that this was as a result of Mr Jarman-Howe acting in a repressive or oppressive way towards that individual, although he did not appear to fully appreciate or adequately engage with the individual to understand the impact the continued disagreement was having on the individual concerned.

1.37. We concluded that this lack of engagement was the causal factor in the initial escalation of the concerns outside the normal line management arrangements. However the preliminary investigation that followed as a consequence was flawed and mismanaged; Mr Baker did not act on the advice of Dr Coutts to involve a clinician; Mr Agrippa's focus on three cases failed to represent the full extent of the concerns and would have been a fundamental flaw in the preliminary investigation had he not recommended to Mr Baker, Mr Bowman and Mr Lehain the need for the concerns to be investigated further by suitably knowledgeable people.

1.38. The discussion between Mr Baker and Mr Bowman that followed the submission of Mr Agrippa's email reporting the outcome of his preliminary investigation was pivotal in the subsequent management of the investigation because neither gave consideration to the recommendation he made and the matter was then determined as a staff communication issue.

1.39. The concerns were never therefore fully and adequately investigated and even though further issues were raised by Mr Agrippa these were not followed up by Mr Baker and Mr Lehain who, although he had stood back during the initial stages of the preliminary investigation, was aware of the initial concerns and received two separate indicators in March that matters had not been resolved and he did not act to bring this matter back to Mr Baker's attention.

1.40. The outcome of the preliminary investigation was haphazardly communicated to other executive colleagues who had initially been made aware of the concerns and as a result was considered to be nothing more than a staff communication matter which had been resolved and was not therefore discussed any further amongst them.

1.41. On 6 March 2013 the Trust was alerted through an anonymous third party who contacted a clinician to advise the Trust that a member of their staff was contacting the media about the inappropriate management of cancer lists. The clinician shared the information with Mr Prentice in the communications department at the Trust, who in turn shared it with Dr Coutts and Ms Shirtcliff, Acting Director of Workforce. Dr Coutts passed the information to Ms Barnett the Deputy Chief Executive and Director of Operations with the intention they should discuss.

1.42. Ms Shirtcliff considered from reading the email from Mr Prentice of 6th March 2012 that the person concerned might be an individual who was at the time pursuing an HR matter as a grievance which was under external investigation at the time and advised the same to Dr Coutts and Mr Prentice. This was not the same individual who had originally raised concerns.

1.43. Nothing further was heard about the matter and no further actions or consideration was taken of the concerns although one senior colleague recollected it had been raised in passing when a meeting was assured that the issues had previously been investigated and resolved.

1.44. On 26 March 2013, the individual who had been identified by Ms Shirtcliff as the most likely individual connected to the email of 6 March 2013, wrote to Dr Coutts to ask his assistance in resolving their concerns about their HR grievance and in a lengthy email in which they set out their grievances made a passing reference which alleged that a meeting with their new manager was really because they wanted to put the employee under pressure to change patient data and that a colleague left the Trust because the employee concerned refused to change (cancer) data. The allegation did not involve Mr Jarman-Howe who was no longer employed by the Trust at this time.

1.45. Although Dr Coutts read the email it did not appear he did so in detail (which whilst not ideal we thought was a reasonable response given the email was lengthy and the primarily a lengthy list of HR grievances - the references to cancer data were some way into the email); he responded to say he would take the matter up with HR. Dr Coutts neglected to send the email onto HR but did discuss the email with Ms Shirtcliff who told him the grievances being raised by the employee were being investigated externally.

1.46. The Trust asked us to consider the appropriateness of the actions and responses to these emails and why the second email was not drawn to the attention of the non-executives in their fact finding review in September 2013, (which had been requested by the Chair in order to inform her of the facts concerning the events and issues relating to the cancer pathways and whistleblowing concerns following the emergence of the concerns in 2013).

1.47. We concluded that there was no obvious rationale as to why these two emails would have immediately been linked to the issues which arose in 2012 in either Dr Coutts or Ms Shirtcliff's mind.

1.48. Ms Shirtcliff never received the email of 26 March 2013 and was neither involved in the February 2012 investigation, nor aware of its existence. In so far as Dr Coutts was concerned he had heard no more of the issues raised by Mr Baker in February 2012 following their initial discussion and the primary concern of the issue in email of 26 March 2013 was the resolution of the employees HR grievance (unconnected to cancer data). Dr Coutts was also aware that the individual concerned, from his early contact with this individual, had previously made allegations and complaints and was assured by Ms Shirtcliff that the current complaint was under external investigation and had the full involvement of the Trade Union.

1.49. As part of our investigation we were asked to give consideration to the effectiveness of the Trust's Whistleblowing Policy, its implementation and any wider issues around bullying and harassment that arose in the course of the investigation and we considered to be relevant. In addition we were also asked to consider related governance issues and how the Board could assure itself further in regard to staff concerns.

1.50. We found little awareness of the Whistleblowing Policy during our detailed investigation of the MDTC concerns in 2011/12 amongst the MDTCs and little if any evidence that the policy was considered by the senior managers at the time as part of their investigation of those concerns, even though in January 2012 a weekly blog from Dr Coutts had highlighted the policy to staff.

1.51. This lack of awareness was also shared by other staff we interviewed and local staff representatives described the policy and the bullying and harassment policy as complex difficult to access and not adequately supported by training of managers and staff in how to report and manage staff concerns. They felt the process needed simplification and training – both of which we were told were to be initiated during 2014.

1.52. During the investigation period and up until 2014, there were no clear processes that enabled the reporting of statistics and key trends in staff grievances and concerns systematically and regularly (apart from the national staff survey) to the executive team and relevant Board Committee/Board; this had led to a concern for local staff representatives that the matter was very much considered a HR issue and not a mainstream issue on the wider "dashboard" of performance indicators for the Trust which on balance we concluded was probably an accurate reflection at that time.

1.53. We could find no evidence to support the view that there is a systemic culture of bullying in the Trust and this suggestion was strongly rejected by the staff and their representatives whom we interviewed who said they simply did not recognise the media reports as consistent with their experience of working at the Trust some of whom had been there a long time.

1.54. There was a mature acknowledgement amongst staff representatives that there can be a fine line between performance management and individual perceptions of bullying although they highlighted some areas where they felt the Trust had in the past been slow to deal with issues (which was in some cases supported by the HR professionals' evidence) of individual bullying behaviours by isolated managers.

1.55. Our review of key indicators in the staff survey results for 2012 and 2013 indicated that Trust performance was worse than average against peer comparators on these indicators, which suggests that notwithstanding the comments by the staff representatives there is room for improvement in this aspect of the Trust's culture.

1.56. Our observations and findings in regard to the specifics of governance in the cancer services division mirrored the findings of the NHS England report *"The Immediate Review of Cancer Services at CHUFT"* published in December 2013, specifically the shortcomings of the cancer governance structures, the lack of functionality and clarity in regard to clinical leadership, information governance and the role of the Cancer Committee. Although we could see that plans had been put in place to address these issues during 2011/12 progress had been slow.

1.57. We also make some wider observations in the report in regard to governance which included a review of appointment procedures for interim executive directors, integration of performance and quality data across committees and adequate follow up on actions and individual accountabilities, balance of public and private business in Board meetings and consideration of the inclusion of relevant sector and ideally NHS operational service or clinical management experience in the non-executive composition of the Board.

1.58. Our overall conclusion was that the MDTCs concerns which arose in 2011/12 were not properly attended to by Mr Jarman-Howe as the Associate Director responsible for the division and central to the issues being raised nor adequately investigated when they were escalated to the Executive Directors of the Trust.

1.59. We think it is important to stress for the avoidance of doubt in light of the media presentation of these issues, that the interview evidence of the individuals concerned including those who raised specific concerns, clarified that at no time were individuals instructed or bullied to amend cancer or any other data inappropriately by any senior manager including Mr Jarman-Howe and Ms West.

1.60. The circumstances giving rise to these concerns and their inadequate resolution provide an opportunity for learning which others in addition to Colchester Hospital NHS Foundation Trust may also benefit from and which we have set out in this report.

2. Introduction and Background to the Investigation

2.1. On 5 November 2013 the Care Quality Commission (CQC) published a report of its inspection of Colchester Hospital conducted during August and September 2013. The inspection was undertaken in response to concerns raised to the CQC about cancer waiting times at the Trust. The report identified a number of problems with cancer services and stated that:

"The inspectors were provided with examples by three members of staff where they were told that they felt they had been pressurised, bullied or harassed to change data on the cancer pathways to prevent a breach of the pathway".

2.2. In response to this specific aspect of the report Monitor determined with the Trust that there was a need for an independent investigation of the management response to the issues that had contributed to this aspect of the CQC inspection and report and, that this investigation should be conducted by experienced investigators who were independent to the Trust.

2.3. The remit for the investigation was agreed between us (Carole Taylor-Brown and Pat Troop, the investigators), and the Trust's Senior Independent Non-Executive Director (SID) Sir John Ashworth, and Monitor on 18 November 2013. It was established that the investigation would be commissioned by the Trust with regulatory oversight from Monitor.

2.4. It was also agreed that the investigation would focus on establishing the facts behind a series of events from the end of 2011 relating to cancer waiting times and the appropriateness of the management response to those concerns together with the implications this held for Board assurance processes in relation to such concerns.

2.5. We were asked to give specific consideration to the following points in our investigation:-

- The circumstances around why, at the end of 2011, concerns raised by MDT Coordinators (MDTCs) about changes in data relating to cancer pathways were presented in the way that they were, via the Informatics team, and not through the normal line management route.

- How appropriate and complete was the investigation carried out in February 2012 in relation to those concerns

- Whether the responses to the email of 6 March 2013, sent by Mr Mark Prentice to Dr Gordon Coutts, and copied to Ms Sarah Shirtcliff, were adequate and appropriate.

- The facts behind the receipt of the email of 26 March 2013 sent by an employee to Dr Gordon Coutts including, but not limited to, the sequence of events of communications and actions taken, sources of information available to those involved and key decisions taken.

- Why the existence of the email dated 26 March 2013 was not disclosed during the course of the reviews conducted by Mr Jude Chin and Mr Tom Fleetwood in September 2013.

- In light of the above and the Board review of the email of 26 March, how appropriate were the responses by the recipients of the email and those to whom it was forwarded

- The effectiveness of the Trust's Whistleblowing Policy and its implementation, and any wider issues around bullying and harassment relevant to the matter.

- If the Board's approach to assuring itself in this area was adequate and how the Board's assurance process could be strengthened to ensure it is alerted to such serious staff concerns more promptly.

- What lessons can be learnt from the handling of the concerns raised, and what could be done differently in the future.

2.6. We were also asked to identify whether or not there may be a case to answer under the Trust's Disciplinary & Performance Management Policy & Procedure by any Trust employee concerned in either handling of, or response to, any of the concerns that were raised either by email or through any other route. (It was subsequently clarified by the Trust in July 2014 that this should only be determined in relation to current employees and not former employees in our final report).

2.7. We agreed with the SID, that the primary period for the focus of our investigation was the period September 2011 – March 2012, (referred to in the report as the investigation period); although this would not preclude our consideration of any other information we considered to be relevant outside of these dates.

2.8. It was also agreed between Monitor, the SID and ourselves, that the draft report and our final report would be submitted concurrently to Monitor and the SID.

2.9. At the end of March 2014, Sir John Ashworth resigned as a Non-Executive Director of the Trust and his role of SID was then undertaken by Helen Parr also a Non-Executive Director of the Trust. Following the handover between the SIDs we met with Helen Parr and Monitor to update them on the Investigation and agree the arrangements for consulting on our draft report with individuals who may be directly or indirectly criticised within the report (for a factual accuracy check) as required by our Terms of Reference.

2.10. It was agreed that this consultation would take place during the latter part of May 2014 and that the consultation period would be extended from the seven days set out in the Terms of Reference to 14 days (although it was noted that due to other commitments, both of us were largely unavailable during June 2014 to consider and review the responses, and that this would, in turn, impact on the timescales for final drafting of the report).

2.11. It was also agreed at this meeting that we would only identify by name senior individuals in our final report and that the identity of more junior staff would not be shown in the report and that in so far as was possible we have done this in order to protect the identity of the junior staff concerned. However in order to explain the evidence and present a balanced account it has been necessary to provide detail of key concerns and issues highlighted by the individuals concerned and this has the potential for internal readers within the Trust to recognise individuals if the Trust determines to publish our report.

2.12. Having given careful consideration to this point we have concluded that the exclusion of this detail may unbalance the report and in particular not fully represent the issues which may have the potential to be to the disadvantage to other personnel who are identified in the report. We also noted that the publication of the report was set out in the Terms of Reference as a matter for the Trust to determine and that it would determine if it wished to further redact detail of the identity of the individuals within the report.

2.13. In early July 2014 we reviewed the responses received from our consultations with the relevant individuals and the Trust, and identified some areas of evidence particularly as a result of Mr Jarman-Howe's further comments, which we received at that time, which we wished to explore further before compiling our final report.

2.14. At the end of July 2014 Helen Parr resigned as a Non-Executive Director of the Trust and her role as SID was then undertaken by Diane Leacock a Non-Executive Director of the Trust who remained in that role until we completed our final report and submitted to her and Monitor electronically in week commencing 1 September 2014.

2.15. In our investigation we reviewed a number of key documents including the CQC Report published in 2013,Trust Cancer Action Plans relating to the investigation period (and either side of that period), various emails, electronic diaries and Trust Committee reports concerned with the issues raised under our Terms of Reference.

2.16. We also requested and received details of a number of historical individual email accounts and various documents relevant to the investigation period. There were some delays in gaining access to all the documents we requested in a timely way and on some occasions it proved difficult to complete all of the requests we made of the Trust. The information we received was sometimes incomplete, which necessitated us on several occasions, to have to review and repeat lines of enquiry which impacted significantly on the timely progress of our investigation.

2.17. We did not consider that this was due to any particular resistance on the part of individuals but related to staff capacity, staff turnover combined with a lack of appreciation of the importance and significance of the requests we were making against other competing priorities. Ms Parr, who took over as the SID in April, played a significant part in facilitating a timely flow and response to the outstanding issues.

2.18. During the investigation we also took account of other concurrent investigations which reported during the course of our investigation including the NHS England Report "*The Immediate Review of Cancer Services at CHUFT*" and the Trust's internal clinical review of the "*CQC 30 - Patient Records*" (December 2013).

2.19. We commenced our interviews of witnesses on 25 November 2013 and completed our last interview on 25 February 2014. We experienced some delays in agreeing the scheduling and attendance of individuals over this period due in part to the impact of the Christmas period, precedence of other investigations, and the pressures on some key staff supporting a range of inquiry lines from ourselves, Essex Police and NHS England Area Team and enabling the Trust response to the CQC report.

2.20. We re-interviewed one individual and for several others submitted additional email questions particularly following the consultation on the draft report when it was necessary to follow up on some key points. This required us to provide a reasonable period for responses which also impacted on timescales for completion.

2.21. In total we interviewed 47 people in our investigation including those identified in the CQC report; summary notes of each interview were prepared and shared with individuals for factual accuracy checks and agreement. one individual (Ms Barnett), did not respond to our request to agree her notes; one individual (Mr Lehain) agreed his first set of interview notes but did not agree his second set of interview notes; all other interview notes were agreed by the interviewees. One witness, Mr Jarman-Howe provided a written submission which we have discussed further in the paragraphs below.

2.22. The interviews were supported by a dedicated notetaker seconded to us by the Trust; the Trust did not feel it appropriate to digitally record our interviews as they considered it may be intimidating for some witnesses. Each interviewee confirmed their agreement to the presence of the notetaker. The only exception to this arrangement arose when for logistical reasons when Mr Bowman was interviewed by us without the support of the notetaker. Mr Bowman's notes were agreed with him after some minor amendments.

2.23. The full individual records of interviews and/or any submissions made by interviewees in support of their interview evidence have been retained by the Trust.

2.24. We were unable to interview Mr Jarman-Howe (who we considered a critical witness in our investigation) and initially experienced some difficulty in contacting him which was due to the Trust providing the incorrect contact details to us. However once this matter was rectified, Mr Jarman-Howe advised he was unwilling to be interviewed because he had concerns about the Trust's approach to the matter overall which specifically included his perception of the lack of willingness by the Trust to engage proactively with him when issues contained in the CQC Report first began to emerge, despite his own willingness to assist at the time.

2.25. Mr Jarman-Howe also considered the Trust's position in regard to confidentiality to be compromised and held concerns about the independence of our investigation and about the Trust's intended approach to the publication of our report. (The latter point was outside our scope as investigators and was a matter raised by other individuals; we referred such issues to the SID for advice and or response).

2.26. Mr Jarman-Howe also he considered he was disadvantaged in our investigation because as a former employee, he would not have access to various computer records including his email account and other records in order to respond to issues we may raise.

2.27. Mr Jarman-Howe emphasised however, that notwithstanding these reservations, he was willing to assist us in so far as he was able and on 22 February 2014 provided a written submission, highlighting various records and emails that he considered may be relevant to our Investigation. In the same letter he also responded (in part), to a set of draft indicative questions we had previously shared with him (to advise him of the key lines of enquiry we were likely to follow at an interview with him) whilst also indicating that this was his final response on the matter.

2.28. We gave full consideration to the points that Mr Jarman-Howe made in his submission and to address his specific concerns about the potential for him to be disadvantaged by no longer having access to his historic emails and related documents, we arranged for searches of his historical email account and other computer records identified by Mr Jarman-Howe. We subsequently shared the information we had identified with Mr Jarman-Howe during the consultation on our draft report.

2.29. During our consultation on our draft report with Mr Jarman-Howe he highlighted a number of additional areas for us to consider, which he had not previously referred to in in his earlier correspondence with us.

2.30. As a result we initiated further computer searches for historical information. This included (with the support of the IT Department) "rebuilding" Mr Jarman-Howe's electronic diary for the investigation period (and a few months either side), a repeat of our earlier searches of emails using a wider spread of key words.

2.31. We also rechecked specific points that Mr Jarman-Howe highlighted in this later correspondence with individuals identified by him, cross-referenced this information with the initial interview records of witnesses, related email correspondence and other documents. We informed Mr Jarman-Howe of the outcome of these further investigations.

2.32. We consulted with the Trust and individuals named in our draft report and received responses from all but one consultee (Mr Chin) on our draft report; we responded to each and we took account of the responses we received when compiling our final report.

2.33. Our Terms of Reference did not provide for any further consultation on our final report; some individuals raised concerns in this regard particularly in anticipation of publication of the report by the Trust. We directed these concerns to the SID for response and rechecked the position on further consultation. The SID responded to advise that we should only consult further if we felt it was absolutely necessary; having regard to our consideration and response of the various representations made to us we determined this was not necessary.

2.34. In compiling our final report we have sought to provide a summary of the key points of evidence collected during our investigation consistent with our Terms of Reference. As investigators we have made every effort to ensure that we have produced a fair and balanced report and in so doing, considered and accurately represented the evidence we have received from all the witnesses and from our review of the relevant documents and emails.

2.35. We found some documentary evidence we reviewed helpful to our considerations, although we have taken care to avoid assuming that this meant that it was indisputably reliable, and equally we have not assumed that if it was written down there was nothing else to consider. We have therefore balanced the documentary evidence with witness statements we received and have taken account that of the fact that many of these statements were largely reliant on memories of events some two years ago, at what was reported to us as a very busy time for the Trust and the individuals concerned.

2.36. Where it has been necessary for us to apply a judgement and in cases where we found a conflict of evidence or a lack of supporting documentary evidence, we have used our best judgement, applied objectively, using the test of the balance of probabilities, by which we mean, that having considered all the evidence, we have reached a conclusion that something is more likely than not.

2.37. We would also acknowledge that we may not have seen every relevant email, document or report however we consider that we have seen sufficient and heard adequate evidence from witnesses to enable us to produce a fair and balanced report and set of judgments against the issues we were asked to investigate.

2.38. The full evidence base, individual records of interview and submissions together with other relevant documents we considered have all been logged and are retained by the Trust.

2.39. During the course of our investigation two issues arose which we considered to be outside the scope of our Terms of Reference. We have set out our involvement and actions in regard to these below.

2.40. The first concerned alleged issues relating to the management of waiting lists in dermatology which we referred to the Trust on 6 February 2014 for further investigation.

2.41. The second related to issues concerning the management of an endoscopy list for which an investigation was planned by the Trust but paused at our request to allow us access to a primary witness in our investigation. We advised the Trust that a pause on this investigation was no longer necessary on 3 February 2014.

3. Context for the Staff Concerns - 2011/12

3.1 Cancer services are underpinned by guidelines that reflect national and international clinical quality standards and include a number of key waiting standards which must be adhered to. Patients suspected of cancer must be seen by the relevant specialist within two weeks (93% to be seen this quickly). Patients referred with the suspicion of cancer must start their treatment within 62 days of receipt of the GP referral (85%) or if detected through national screening programmes (90%). Any patient found to have a cancer should start treatment within 31 days of the patient agreeing the treatment plan with the consultant or member of the consultant's team (94%) or 98% if only needing chemotherapy or 96% if only needing radiotherapy. These standards are incorporated and contained within the NHS National Operating Framework.

3.2 There is national guidance or what are generally accepted as "rules" relating to the application of the guidelines and these are contained in the Cancer Waiting Times Guide (CWTG); the current version (v8.0) was published in July 2012. The CWTG is underpinned by national clinical quality standards which incorporates the National Cancer Manual and further guidance on a national single data set (the Cancer Outcomes Services Dataset – COSD). This combination of guidance sets out the national standards for delivering cancer services, the timeframes patients should be treated in, and the data that should be collected and submitted nationally. Treatment and diagnosis data is collected by all providers monthly and submitted to the national database known as Open Exeter.

3.3 There are some areas of the CWTG where there is very clear direction on the actions to be taken and a limited number of areas where there is scope for local discretion. The overriding intent behind the guidance is to ensure a consistent approach to the implementation of CWTG and in the CWTG it states that "*whilst there is scope for local interpretation it should be in the "spirit" of the rules*". To support local NHS organisations there is a national contact point for clarification of any areas where the user(s) requires further guidance.

3.4 The Trust serves a local catchment population of approximately 370,000 patients and offers a full range of routine cancer services and is a Specialist Cancer Centre for Urology cancers (kidney, bladder, testicle, penis and prostate). Radiotherapy services are provided to the 700,000 people of Mid Essex and North Essex CCGs combined. Radiotherapy and chemotherapy services are commissioned by NHS England Specialist Commissioning; other services are commissioned by the CCGs.

3.5 Cancer services are part of the Clinical Support Services and Cancer Division at the Trust and are split over two sites with most services based at Colchester General Hospital (CGH) and others Radiotherapy, outpatient clinics and inpatient oncology wards at the Essex County Hospital (ECH). Cancer services are organised around specialities and multi-disciplinary teams of clinicians, health care professionals and relevant support staff of which one is the multi-disciplinary team co-ordinator (MDTC).

3.6 The Clinical Support Services and Cancer Division are overseen and led by a Clinical Divisional Director (although this post does not have line management responsibility for the management/administrative support staff) who is accountable to the Chief Executive. The administrative and managerial functions of the Division are managed by an Associate Director Cancer and Clinical Support Service who reports to the Director of Operations.

3.7 The Associate Director for Cancer and Clinical Support Services is supported in the management of cancer services by a Cancer Service Manager and an Assistant Manager Cancer Services and together these posts lead the Multi-Disciplinary Team Co-Ordinators (MDTCs) and data clerks.

3.8 Information about cancer services during the investigation period was managed through a number of separate computer recording systems at the Trust including in some instances paper records;(the NHS England report *"The Immediate Review of Cancer Services at CHUFT"* published in December 2013 noted that at that time not all were not all linked or adequately governed).One of the principal information systems was (and is) the Cancer Wait Time system (CWT) which records the patients' progress through the pathway using patient records and other information.

3.9 The information on CWT is a working record and normally (but not always) amendments are supported by individual comments by the person entering the data. Another key local information system used by the Trust is QLIKVIEW a local system which is used to report the performance of the Trust across a range of standards and includes data that has been entered into the CWT system.

3.10 As part of the monitoring and tracking processes for cancer there is a record known as the Priority Treatment List or PTL; this key record is used to monitor the time a patient has waited to ensure they are diagnosed and treated in a timely manner and in accordance with the national standards and is used by the teams for tracking and reviewed regularly by relevant managers.

3.11 Cancer information is routinely validated by all providers approximately every 5-6 weeks and subsequently uploaded to the national data base - Open Exeter when it is "frozen" i.e. not open to further adjustment. Validation is conducted to ensure that the data being provided to the national database is accurate and provides an opportunity to correct any errors and to add new information which may not have been available when the initial entry was made.

3.12 Sometimes Trusts undertake a further level of local validation to try and understand the reason for breaches; this was the case at the Trust during the investigation period. The managers responsible for this additional local validation of cancer data at the Trust during the investigation period were Mr Jarman-Howe Associate Director for Cancer and Clinical Support Services with advice from Ms Raeburn-Smith Associate Director for Surgical Services. Once these two managers completed their validation and made any necessary adjustments it was then passed to the Trust's information team who conducted some further checks before uploading the data to Open Exeter. This is important data because it provides information on the Trust's performance against national standards including cancer standards for waiting times.

3.13 In 2011/12 the Trust was facing a number of concerns in regard to its performance against national cancer standards. These concerns extended over a number of areas and included specific challenges around the management of compliance with the cancer waiting standards particularly the 62 day waits, where the Trust was breaching the required standard in some specialities notably, urology and upper and lower GI on a more frequent basis.

3.14 There was considerable senior management, regulatory and commissioner focus on achieving the necessary improvement in the cancer services, with a range of action plans and interventions in order to support the Trust's achievement of the national cancer waiting and access standards.

3.15 An internal "*Cancer Waiting Time Standard Action Plan*" (CWTSAP) was produced in March 2011 which was subject to regular update, review and discussion; a *"Cancer Standards Remedial Cancer Action Plan*" (CSRAP) was introduced in January 2012 (and updated regularly) to respond to particular challenges relating to a failure to meet 62 day standards at that time for three areas: - breast symptomatic patient; 62 day screening and 62 day 'firsts'.

3.16 The Trust's CWTSAP was initially drafted by Mr Baker, Director of Finance in early 2011; Mr Jarman-Howe, Associate Director Cancer and Clinical Support Service (who had joined the Trust at the beginning of 2011) assumed responsibility for the plan in March 2011. Mr Jarman-Howe subsequently wrote and was responsible for leading the programme of work to improve the Trust's performance against the National Cancer Waiting Standards including associated remedial action plans.

3.17 Both sets of plans contain a series of actions intended to improve the quality of the services and achieve compliance with the national cancer standards and involve actions not only for staff in the Cancer Division but other staff such as Service Managers, informatics staff and clinicians. Such plans are a normal procedure when a Trust is seeking to improve performance/quality against national standards[1].

3.18 The CWTSAP for May 2011 (the first we could establish from the records made available to us by the Trust, after Mr Jarman-Howe assumed responsibility), showed that there were five key themes to the work being undertaken:

- Cancer Information and Patient Tracking
- Shared Care Pathways (where care is shared with another provider)
- Roles and Responsibilities
- Diagnostics
- Site Specific Cancer Pathways

3.19 The plan(s) were subject to monthly update and review by Mr Jarman-Howe and reported to the Executive Operational Committee and in a more summarised form to the Board level Performance Committee. Comments from the Director of Operations, Ms Barnett were recorded as included in the various iterations of the plan(s) as they were updated. The local commissioners the (PCT/CCG) were also actively engaged in the development of the plan(s) and Monitor was aware of the plan(s) as the Regulator.

3.20 Given the focus of our investigation, we took particular note of the entries contained in the CWTSAP on Cancer Information and Patient Tracking. This showed that the use of root cause analysis to understand the reasons for breaches at service manager level within the Trust had been introduced so they could implement necessary actions to avoid breaches.

3.21 In the May 2011 CWTSAP, it is stated that validation was more consistent and it appeared that to all intents and purposes the changes were regarded as on track. In the September 2011 CWTSAP, it is confirmed that pathway breaches were being reviewed by both Mr Jarman-Howe and Ms Raeburn-Smith and again that matters were on track.

3.22 The CSRAP plans we saw also had five key themes:

- Encourage Timely Patient Engagement with early Stages of Pathway
- Expedite Diagnostic Pathway
- Improve quality of Information and Timely Referral between Trusts
- Improve Clinical Leadership and Accountability
- Primary Care Support

[1] The Trust was unable to provide us with a chronological set of these plans for the investigation period and either side of it. Two IT searches on various drives were conducted by the IT Department including accessing the specific files identified to us by Mr Jarman-Howe. In the event we were provided only with some plans dated immediately prior to the investigation period and some within it, however we noted they remained fairly consistent in core content over this period with various updates on progress being made.

3.23 The issues driving the need for the CSRAP were recorded in the document as arising in response to the Trust's December 2011/ January 2012 performance where there had been a failure to meet three cancer standards:- the 2 week wait for breast symptomatic patients, 62 day screening and 62 day "firsts" and the plan was to specifically focus on:-

- Improving 62 day "firsts" performance
- Generally consolidating cancer performance management arrangements to achieve more 'headroom' in meeting all standards

3.24 A consistent set of introductory comments was included in the CSRAP which identified that for 62 day screening: -

- *"The failure to meet this standard in January 2012 was as a result of a slightly higher than typical number of breaches and a much lower than usual total number of patients treated in the month. A root cause analysis of each of the breaches identified no obvious process or pathway problems – clinical factors or patient thinking time were the predominant factors in each case. As February performance was compliant and there are no problems envisaged with March performance no further remedial actions have been identified as required at this stage"*

3.25 For the 62 day "firsts" the plan consistently reported that from a review of the 62 day breaches in early quarter 4 the following were key factors:-

- Clinical reasons relating to patient circumstances and co-morbidities
- Patient choice – particularly with regard to diagnostics and arranging first outpatient appointments
- Delays in the diagnostic pathways
- Delays in agreeing shared pathways with other Trusts
- Delays in agreeing treatment plans once a diagnosis had been made

3.26 Both sets of plans provide an important balance in improving understanding of the range actions that the Trust was taking (and that were being led by Mr Jarman-Howe)at this time to improve its cancer services and set the issues regarding validation of cancer data discussed in this report in that wider context.

3.27 The Multi-Disciplinary Team Co-Ordinator (MDTC) post provides important administrative support to the multidisciplinary cancer team. They perform a key role in ensuring that a patient is tracked on their cancer pathway, ensuring the various computer records are up to date and that clinicians and senior managers are aware of a patient's progress through the system. Some but not all are supported by data clerks. MDTCs are required to have a working knowledge of the CWTG and the relevant patient pathways for which they are responsible.

3.28 At the time we undertook our investigation there were 13 MDTC posts in the Trust some of which were responsible for more than one speciality area. Most MDTCs were based in Colchester General Hospital (CGH) with some at Essex County Hospital (ECH) and that had been the case during the investigation period, although at CGH there had been some accommodation moves within the site for some MDTCs.

3.29 We observed during the interview evidence that there appeared to be a mutually supportive culture within the group particularly on work related or technical issues, although it was apparent that contact between the two physical sites was not particularly strong. We did not identify any significant relationship issues amongst the MDTC team although some reported there had been some difficulties for them in working with one particular colleague at times.

3.30 In general, the majority of MDTCs we interviewed described a good relationship with their line managers specifically Ms West, the Cancer Services Manager, and the Assistant Cancer Services Managers (there were staff changes and vacancies in this role over 2011/12); only one individual commented adversely (MDTC **B**) and evidence showed that this individual had complained about both Ms West and one of the Assistant Cancer Services Managers in separate complaints at different times.

3.31 The complaints made by **B** had been investigated by the Trust and on one occasion this included an external investigator; the other MDTCs told us they considered this to be an individual matter for that colleague rather than a shared experience of those managers.

3.32 The Trust's turnover figures for the Directorate showed a reasonably high level of turnover amongst the MDTC posts during 2011/12/13 ranging from 15% - 42% although this included some internal movements. Overall we found that amongst the clinical interviewees there was a perception that turnover appeared to be creating some instability and increased workload pressures for the MDTC team over the investigation period which they were concerned about, but unsure how to, support as they were not directly responsible for the staff concerned.

3.33 MDTCs separately reported to us they had high workloads and had to work extended hours to meet the demands of their role to which they were individually highly committed. They reported a feeling of "*a weight of responsibility and pressure*" to meet the expectations placed upon them by the Trust, which they said was not supported by adequate training. They held particular concerns about the arrangements for training new staff or where existing staff assumed responsibilities for new speciality areas which they said relied heavily on mentoring by more experienced colleagues rather than a bespoke induction training programme.

3.34 The evidence we saw supported the reports of a strong reliance on mentoring by more experienced staff for new recruits, however we also saw evidence of some other training for new recruits including some case study work and computer based training. We also saw that efforts had been made to increase the number of MDTCs and data clerks which was initiated by Mr Jarman-Howe and to some extent, Ms West.

3.35 The CWTSAP referred in paragraphs 3.15 -3.20 above, also showed that there were some wider training initiatives in place to support the development of MDTCs. We established evidence of some training although it did not appear to be part of a systematic programme.

3.36 Ms West told us she ran update sessions as necessary and was available to answer queries (which she normally did by email or in PTL discussions); this was confirmed by the MDTCs we interviewed (with the exception of **B**); all interviewees we saw considered that Ms West had a very good knowledge of the CWTG.

3.37 All the MDTCs we saw reported confidence in their working knowledge of their pathways and the CWTG and were able to refer to other more experienced colleagues where they considered this necessary.

3.38 The MDTCs also reported that they had good relationships with the majority of clinicians and reported that at this time clinicians were not actively involved in the application of CWTG or validation; this was confirmed by the clinicians we interviewed who said that at the time this was considered to be a management responsibility.

3.39 The clinicians we interviewed all showed awareness of the key cancer waiting standards and some key areas of CWTG in relation to their speciality although they agreed they would look to the MDTC or Ms West to provide more definitive guidance.

4. Summary of the Staff Concerns 2011/12

4.1. We interviewed eight MDTCs. Three individuals told us they had concerns about the way that validation of their data had been conducted by their former Associate Director, Mr Jarman-Howe.

4.2. Two (referred to as **A** and **B** in this report) of these three, alleged that they considered that Mr Jarman-Howe had amended the patient records to avoid reporting breaches. The third (identified as **C** in this report), said they were concerned because they considered the changes he made to be incorrect and that this may impact on the tracking of patients and potentially present a risk of a delay in treatment.

4.3. The other five MDTC's we interviewed did not report any concerns about the validation of their data by Mr Jarman-Howe although they were aware of their colleagues concerns and reported a shared concern on their behalf.

4.4. **A**, **B** & **C** said Mr Jarman-Howe made amendments on their records when he conducted the routine validation and they considered some of his amendments to be contrary to their understanding of the CWTG. **A** & **B** said that from their perspective although they raised their concerns with Mr Jarman-Howe in emails in late 2011/2012 he did not really give them an adequate explanation of the changes he had made and was not willing to change his mind when they challenged him.

4.5. **C** said that when they had challenged Mr Jarman-Howe on data amendment, he had reversed the change when challenged, although they said they remained concerned because they might not be aware of any other changes and felt this may result in a risk of them losing track of a patient if the changes "dropped" the patient(s) off the PTL.

4.6. When asked, none of the eight MDTCs (including MDTCs **A**, **B** and **C)**, told us of <u>any</u> incidence where they had been directly instructed or had witnessed a direct instruction by any senior manager including Mr Jarman-Howe, to amend their data for patients prospectively.

4.7. **A** and **B** said that if Mr Jarman-Howe contacted them to amend data, it was related to the routine validation (i.e. retrospectively) and normally his approach was in the manner of a request, for example *"could you or do you think"*. **A** and **B** said that if they were uncomfortable with a change being proposed by Mr Jarman-Howe they would refer if back to him or on occasions refer him to Ms West. (We saw some email evidence that supported these reported comments).

4.8. **A**, said they felt "*pressured and concerned"* by some of the changes being made or proposed by Mr Jarman-Howe during validation, because they considered those adjustments to be incorrect and because in some of the PTL meetings attended by Mr Jarman-Howe (which we were told by Ms West and the eight MDTCs was not frequent, although Mr Jarman-Howe said he felt he was a regular attendee), where breaches had been identified, Mr Jarman-Howe would propose some changes which **A** felt would incorrectly impacted on the recording of some data and the reporting of breaches externally.

4.9. **A** said that because of Mr Jarman-Howe's seniority, they felt "*under pressure to accept*" those proposed changes in the meeting; however none of the interviewees offered any evidence to suggest that Mr Jarman-Howe had in fact acted in an oppressive manner when proposing the validation changes.

4.10. **A** said that as they were not always confident they were correct and did not want to challenge a senior manager directly in a meeting, they would go away to check the CWTG and discuss the proposed change with some colleagues.

4.11. Later in 2011 (and in 2012), **A** began to email Mr Jarman-Howe to express their views about changes they considered to be incorrect. **A** said, that although Mr Jarman-Howe normally acknowledged their emails, he did not normally revise his position on the patient record concerned or explain his decisions.

4.12. **A** also said they also felt "*under pressure*" from Mr Jarman-Howe to change their interpretation of some areas of the CWTG because Mr Jarman-Howe regularly questioned them individually about the application of some aspects of the CWTG particularly during 2011; and further alleged that Mr Jarman-Howe showed a particular interest in the how "*active surveillance and thinking time*" was recorded in the CWT records for prostate cancer patients[2].

4.13. **A** said that they had challenged Mr Jarman-Howe on this point by email and had referred him to the relevant sections of the CWTG where the individual felt Mr Jarman-Howe had used the wrong date in his validation adjustment; however they said the challenge was not usually accepted by Mr Jarman-Howe. (We saw some email evidence to support this claim; Mr Jarman-Howe represents he discussed this matter directly with the individual and considered that he had applied more discretion and had explained and resolved the matter the individual concerned. The individual concerned did not accept this to be the case).

4.14. **A** also said they considered that the validation changes began to occur shortly after Mr Jarman-Howe joined the Trust. (Whilst the interviewee did not provide any documentary evidence to support this claim, the CWTSAP referred to earlier in our report shows that Mr Jarman-Howe who joined the Trust at the beginning of 2011 assumed responsibility for validation during the course of 2011).

4.15. **A** said that as they began to notice the changes in 2011,they discussed their concerns with a peer colleague at length (**B**),after which they both raised their concerns with the Cancer Services Manager, Ms West. Both said Ms West was supportive but told them she could not do anything about the issue and advised them to raise their concerns directly with Mr Jarman-Howe.

4.16. Neither **A** or **B** nor Ms West were able to recollect when this conversation took place; from our assessment of the email and interview evidence we concluded that this was most likely to have occurred around mid-September 2011.

[2] *Active surveillance* is a way of monitoring prostate cancer that's contained inside the prostate rather than treating it straight away. It usually involves regular hospital tests, such as prostate biopsies and MRI scans.At this time the Trust's patient pathway for suspect urology cancers required patients to have TRUS biopsy and if this confirmed a suspect cancer then to have a MRI scan which followed four to six weeks later, the delay was to enable healing; (this was a common pathway in other NHS organisations at the time, although some were beginning to introduce a MRI scan at an earlier stage). Following the subsequent MRI a discussion between the consultant and the patient would take place in clinic about treatment options. If the patient reached a decision in the clinic this would be recorded and treatment commenced, however not all patients were (and are) able to agree the treatment plan at this first discussion and need time to think referred to as "thinking time". These patients go away to think about the treatment options discussed with the consultant for a few days (or weeks) before contacting the consultant or a member of his/her team to inform them of their decision. Following the notification of the patient decision this was (and is) recorded as the agreed treatment in the CWT. We were advised that in the CWTG use of active monitoring can normally only be applied to the CWT after the patient has made a decision. It is not to be used to "stop the clock".

4.17. **A** & **B** said that subsequent to the discussion with Ms West they had a wider discussion with some other MDTC colleagues at CGH. Other MDTC colleagues confirmed that the conversation as taking place around the latter part of 2011.

4.18. **A** also alleged they had also raised their concerns with two consultant urologists, two Clinical Nurse Specialists (CNS) and another former service manager around late 2011 and further alleged that the individuals concerned did not seem to want to get involved in the matter; this was strenuously denied by the individuals and we could not substantiate evidence to support this allegation.[3]

4.19. **A** said they also began to maintain their own tracking system of patients (and breaches) which they kept on a local computer desktop that could not be accessed by others and claimed, that this showed more breaches were occurring than those being recorded in the final Open Exeter submission after Mr Jarman-Howe's validation. (We did not see this system and we are therefore unable to evidence the substance of the claim in relation to the alleged differences in the number of breaches being reported nationally; however we noted that some other MDTCs reported using their own local tracking system at this time in addition to those approved by the Trust).

4.20. **A** said they kept a hard copy file of the concerns that they had raised with Mr Jarman-Howe. This was not made available to us by **A**; however, we obtained a copy of the file from Essex Police.

4.21. We reviewed the file as part of our investigation; it contained 12 documents relating to 13 patients and covered the period September 2011 – January 2012. The cases related to the amendments made during validation by Mr Jarman-Howe (some with advice from Ms Raeburn-Smith),and included emails showing issues being disputed by the individual with Mr Jarman-Howe, relating to definition of the recorded decision to treat date (DTT) for cancer patients. The exchanges were cordial and included in the file screen shots where Mr Jarman-Howe had recorded his validation decision on the CWT. There was no evidence in the file that Mr Jarman-Howe explained his decisions to **A**.

4.22. In the file, one email contained a request by Mr Jarman-Howe to **A** for an amendment to be made by **A** in regard to a DTT on the CWT; **A** declined to action and referred the request back to Mr Jarman-Howe to seek advice from Ms West; in another email **A** wrote to Mr Jarman-Howe to say that they considered they had incorrectly made an adjustment to a record when previously requested to do (however the person making the earlier request was not identified in the email) and that the further change being requested was therefore unlikely to make any difference as the early action had been incorrect.

4.23. **B** said that they began to notice changes in their data around November/December 2011 and raised their concerns with Mr Jarman-Howe in emails. The concerns they raised were about issues other than *active surveillance*.

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[3]This allegation was strenuously denied by the clinicians who claimed they had no knowledge of these concerns until the emergence of the CQC report in 2013; 1 consultant agreed he had seen a document that made reference to data manipulation but contained no detail and in any event, considered this was directed to the manager receiving the document and was not a concern that was directed to him but to Mr Jarman-Howe for consideration. We decided that on the strength of the 4 clinician interviews we conducted, we would not contact the former service manager as on balance we considered that it was more likely than not that this individual would present a similar account.

4.24. **B** alleged that the normal response from Mr Jarman-Howe when challenged by them was to tell them to leave the records as he had amended them.(We saw some email evidence to support this latter claim in the email records supplied to us by the informatics team discussed later in the report).

4.25. **B** also alleged they saw further changes in early 2012 made by Mr Jarman-Howe and Ms Raeburn-Smith which they also challenged unsuccessfully, and alleged changes in validation data were "*stepping up a gear*" around this time.

4.26. **B** was requested to, but did not, provide any documentary evidence to support their claims and although they claimed to have submitted evidence to the file kept by their colleague there was no evidence in the file to support this claim; **A** denied that **B** had submitted emails to the file.

4.27. **B** also alleged that specific sections of their personal database which may have contained relevant evidence to support their allegations, for example minutes of a meeting with Mr Jarman-Howe after the internal investigation in February 2012 and other retained relevant information, had been *"purged"* by someone at the Trust in their absence. We found no evidence to support this claim following a careful and thorough search over the period identified by **B** which was conducted by the IT Department at our request.

4.28. In our review of the email evidence submitted to the informatics team in February and March 2012 by MDTC co-ordinators, we found seven emails from **B** where they had alleged incorrect adjustments had been made by Mr Jarman-Howe during validation. These spanned a period from February - March 2012 and the concerns related to alleged incorrect allocation of DTT in the CWT and alleged incorrect designation of *active surveillance* and/or dates related to *active surveillance*.

4.29. Overall in our review of the emails identified as relating to the concerns raised by **A** & **B** we saw some examples where Mr Jarman-Howe advised the individual concerned to leave matters as they were and although the exchanges were cordial we saw no evidence in the emails that Mr Jarman-Howe instructed a change equally no evidence that when he responded he explained the rationale he was using, nor any indication that he would or was intending to engage further with the two individuals on the points they raised.

4.30. In one email (January 2012) to **A**, Mr Jarman-Howe, did however explain that he and Ms Raeburn-Smith undertook regular validation and made a small number of adjustments as part of that process.

4.31. **C** said that in February 2012 they had picked up a change on a patient record made by Mr Jarman-Howe and this had happened only because they had been particularly tracking the patient concerned following the discussion at a Multi-Disciplinary Team (MDT) meeting.[4] **C** said they challenged Mr Jarman-Howe directly and strongly about his amendment which they felt incorrectly recorded a clinical intervention as a treatment and as a consequence had "*dropped*" the patient off the PTL.

4.32. **C** alleged that if they had not picked this change up, it could have resulted in a delay to treatment for the patient concerned; (however as **C** did not provide the evidence to us as we requested, to support this allegation we could not establish the details of the allegation and actions taken).

[4]MDT meetings are multi-disciplinary meetings where clinicians and relevant support staff discuss the individual patients' care and treatment pathway.

4.33. **C** said that although Mr Jarman-Howe had contended he was right initially, they had challenged him directly and robustly and had shown the guidance to him; following this intervention **C** said Mr Jarman-Howe had revised the change he had made. **C** said they had a residual concern following this discussion with Mr Jarman-Howe that other patients may have been or be potentially affected similarly and they or their colleagues may not necessarily pick this up.

4.34. Two emails from **C** were included in the emails supplied by the informatics team and from this we identified two other concerns highlighted by the individual to informatics (but not to Mr Jarman-Howe) where they considered that Mr Jarman-Howe had incorrectly entered a treatment date.

4.35. The eight MDTCs that we interviewed told us that around January 2012, the issues around validation changes being made by Mr Jarman-Howe were discussed again amongst the MDTC colleagues based at CGH; in that meeting they discussed a number of options that might be available to address by now their shared concerns about the changes their colleagues had identified and the general view that the responses their colleagues had received from Mr Jarman-Howe were unsatisfactory

4.36. Some of the eight we interviewed recollected a discussion about raising their concerns with Monitor, but reported there was a common concern amongst the group that this might result in adverse consequences for the Trust because they said that in other discussions with managers they had been told "*it was not good to get Monitor involved in the Trust*". The MDTCs did not identify the managers concerned and we were therefore unable to validate this claim.

4.37. Others of the eight we interviewed, said the group had thought about taking the matter up internally and they agreed between them that the next logical person in the chain of management was Ms Barnett; they said they all felt that she may be too senior and that she may be difficult to approach because of her seniority and their comparative junior status[5]. The group also said they also held a general concern about the consequences and reaction of senior managers (generally) if they took the matter further although they did not offer evidence to support the grounds for this concern.

4.38. **B** said they had discussed with the group the Trust's Whistleblowing Policy and suggested involving ACAS, but this was not confirmed by other interviewees who said they had no recollection of this and did not consider the whistleblowing policy or know much about it at the time. (Our review of IT records showed that **B** downloaded the Trust's Whistleblowing Policy on 9 February 2012 which was after this meeting and the completion of the internal preliminary investigation conducted by Mr Agrippa Associate Director for Informatics (discussed in section five below).

4.39. After the meeting the eight interviewees said there was no clear consensus on what to do next and that they went back to their work with their concerns unresolved and uncertain how they could take matters further.

[5]Ms Barnett does not accept she was difficult to approach by more junior staff and said she could provide examples to repudiate this point. We heard mixed evidence from others who worked directly and less directly with her; on balance we concluded this suggested that for some, she was considered to be a formidable individual to approach.

4.40. **A** said shortly after this meeting, they shared their concerns (informally) with a colleague from the informatics department (referred to as **D** in our report) who asked them to send some examples of the concerns; in a subsequent routine discussion about data completeness which followed shortly thereafter, **A** and **D** had a more substantive discussion and agreed between them **D** should raise the matter with Mr Agrippa.

4.41. **A** said that shortly after the discussion with **D**, they and another MDTC (referred to as **E** in our report) had a meeting on behalf of their colleagues with Mr Agrippa. We dated this conversation from the email evidence we saw (discussed below) to have been around 2 February 2012. **D** confirmed the discussions with **A** took place and the agreement about escalation between them; **D** had reviewed some cases and felt the concerns may be valid.

4.42. **A** & **E** said that after listening to the initial concerns, Mr Agrippa asked **A** and **E** to ask their colleagues to submit their concerns to **D,** who he asked to review the cases and send on to him.

4.43. **A** & **E** said they had a further discussion with Mr Agrippa after some emails had been sent through to **D** and passed to him; at this meeting Mr Agrippa told them he was going to take the matter to the "*Executive*", which they understood from him to mean the Chief Executive and other Executive Directors.

4.44. **A** & **E** said that they shared this information with their colleagues and they all felt "*relieved*" when told this as they believed that at this stage their concerns were going to the "*top managers*" in the Trust and that their concerns which they had previously raised with their own line managers would now be looked into.

4.45. **A** & **E** said that shortly after their meeting with Mr Agrippa, he told them that he had spoken with Mr Baker who had asked him to investigate the matter further. They in turn advised their colleagues and asked them to submit some further information to Mr Agrippa (via **D**) to support his investigation, which **A, B** and **C** did. No other MDTC submitted any emails to **D**; Ms West submitted two cases to **D** which were also sent through to Mr Agrippa by **D**.

4.46. **A** & **E** said that around in mid-February 2012 Mr Agrippa told them that he had submitted his preliminary report to Mr Baker and that a proper investigation would follow. **A** said that shortly after this conversation, Mr Agrippa advised that it had been agreed by Mr Baker in discussion with some other executives that Mr Jarman-Howe should meet with them as a group to explain the validation changes that he was making to the data.

4.47. **A** &**E** said they told their colleagues and that whilst waiting for this meeting **A**&**B** continued to submit evidence of their concerns to **D**.

4.48. **D** said the emails they received were from **A**, **B**, **C** and Ms West; there were 16 emails in total during February - March 2012 and all related to validation adjustments made by Mr Jarman-Howe which the individuals, and **D** on review, considered to be incorrect. (When we reviewed the emails; 22 patients were identified in the emails and some but all not cross-referenced to the patient cases in the CQC report).

4.49. By 22 March **A** & **E** said they had not heard anything further about the meeting with Mr Jarman-Howe; **E** decided to take the initiative to organise the meeting, and sent an email inviting Mr Jarman-Howe, Ms West and Mr Agrippa to meet with them as a group. Mr Agrippa declined to attend because he said felt at this stage it was a matter best handled between Mr Jarman-Howe and the MDTCs.

4.50. The meeting took place on 27 March 2012 and was attended by Ms West, Mr Jarman-Howe and a number of MDTCs. **E** said it was a frank and open exchange with Mr Jarman-Howe and that they felt confident that as a result a number of changes were to be implemented.

4.51. Two days after the meeting **E** wrote to Mr Agrippa to say that they considered the meeting went well from the MDTCs' perspective and that Mr Jarman-Howe had conceded that in three cases he may have got the changes he made wrong. **E** also reported in the email, that Mr Jarman-Howe had agreed that in future he would notify the MDTCs of any patients that he looked at with Ms Raeburn-Smith and that they had the impression as a result of the meeting that in future the changes would be signed off by a service manager and clinician.

4.52. **A** & **E** said that a few weeks after the meeting on 27 March with Mr Jarman-Howe, there were further changes to **A's** data and that these continued until **A** left the Trust.

4.53. Whilst **A** did not submit any documentary evidence to support this allegation, we identified an email dated 17 September 2012 in which **A** challenged a validation decision made by Mr Jarman-Howe concerning *active surveillance* and set out in the email the relevant sections of the guidance.

4.54. No other concerns were reported by any other MDTC interviewees in regard to validation conducted by Mr Jarman-Howe post the meeting they had with him in March 2012.

4.55. When one of the three MDTC's raising concerns left the Trust in 2012, they had an exit interview with Mr Jarman-Howe. In an email sent to Mr Jarman-Howe the following day. The MDTC concerned said:

- "*Thank you for listening to me yesterday and showing interest in what I had to say. I wish this had been the case a while ago before I decided it was time to seek employment elsewhere. I am motivated by new ideas and innovations and if the workplace does not provide an environment to let this flourish I lose all my motivation and want to move on".*

4.56. The MDTC concerned also thanked Mr Jarman-Howe for the offer to rescind their resignation and retain them at the Trust, but said the offer and conversation between them had come too late although they had given the matter serious consideration and would be happy to work again for the Trust at some point in the future.

4.57. The MDTC concerned attached to the email 4 documents; a set of PowerPoint slides relating to training around cancer waiting times for their speciality; a document called Pathways Explained; a document called Reducing Breaches and a document summarising the issues they had discussed together at the exit interview.

4.58. The summary of the exit interview had seven headings each with a set of bullet points underneath; one heading was PTL – the last of 6 bullet points contained the following statement - "*Data manipulation to meet targets, but not learning from why patients breached".* The MDTC closed their email by inviting Mr Jarman-Howe to discuss any of the documents further prior to their final day at the Trust.

4.59. The subsequent email trail shows that Mr Jarman-Howe forwarded the email and attachments later that same day to the newly appointed Assistant Cancer Manager who responded to ask if she could share the document with Ms West and another individual and set out some of the initiatives she had begun to implement and intending for the future. There was no evidence that Mr Jarman-Howe responded.

4.60. The MDTC concerned also forwarded the email they had sent to Mr Jarman-Howe two clinicians by email and in the covering email which was headed "*exit interview*" and in the text said that they were sending the email because they wanted them to know why they were leaving.

4.61. One clinician told us they did not open the email because they did not consider it was directly related to a clinical matter and was a management issue; the other clinician opened the documents but said they had read the documents about the service matters and had not really given much attention to the summary of the exit interview as they thought this was a matter between Mr Jarman-Howe and the individual concerned.

4.62. Ms Raeburn-Smith said that she also met with the MDTC concerned immediately prior to them leaving the Trust to thank them for their work, when she said the individual also left some documents with her. Ms Raeburn-Smith said she did not read the documents in detail, but on seeing some of the content which referred to data issues, she went to see Ms Barnett and mentioned the issues it contained to her.

4.63. Ms Raeburn-Smith said that Ms Barnett told her the matter had previously been investigated and resolved. (Ms Barnett did not recollect this conversation between her and Ms Raeburn-Smith). Ms Raeburn-Smith said that she did not retain the documents and did not consider the matter any further as a result. The MDTC concerned said that they had not left or sent any documents to Ms Raeburn-Smith when they left the Trust.

4.64. Another interviewee advised that when the MDTC concerned had left the Trust they had also left a folder of documents with them for "*safekeeping*", and said they had passed the documents to Essex Police[6]. The MDTC concerned said that they had not left or sent any documents with this individual.

4.65. During our interviews it was identified to us that during February and March 2012 an internal audit had been conducted by Deloittes, the Trust's Internal Auditor, which had looked at one of the cancer waiting time standards and as a result had identified a mismatch in some of the sample records that had been looked at including an inconsistency between the Patient Administration System (PAS) and the CWT.

4.66. The draft report compiled by the Internal Auditor was submitted to the Trust on 14 March 2012 and was concerned with auditing three areas; Cancer - Urgent Referral to Treatment Times - (62 day timeframe for GP urgent referrals); Clostridium Difficile, (national standard) and Reduction of Inpatient Falls resulting in serious harm against the 2010 baseline (local standard).

[6] The evidence related to the some of the informatics emails; the individual who had retained the documents for safekeeping had not read the documents but put them in a safe place and had forgotten about their existence and only realised the potential significance of the documents when the CQC issues emerged in 2013, when they submitted the documents to Essex Police (unread).When we reviewed the documents they directly linked back to a specific MDTC and the evidence given at their interview.

4.67. A review of the Trust's Audit Committee minutes and reports for 3 May 2012, identified that the Internal Auditor advised the Committee in a standard update report, showing the progress of planned internal audits overall, that the draft of the Quality Indicators report had been submitted to the Trust on 14 March.

4.68. There was no detail provided in the update report of the findings or recommendations of this particular report, which the Internal Auditor advised is standard practice when a report is in draft.

4.69. We reviewed the draft Internal Audit Report in regard to the entries relating to the selected Cancer standard - 62 day timeframe for GP urgent referrals. Under the summary findings, "Cancer Referrals", one entry referred to the lack of documented training for new users of the CWT database. Under the heading "Accuracy and Consistency of Data Input and Output – Cancer Referral", it showed that in the random sampling conducted by the auditor of 20 cases:-

- "…*data was found not to always match between the date of referral receipt from the General Practitioner (GP), date of appointment and treatment date recorded in the relevant records (source patient notes, PAS, and CWT database). Reporting against target was therefore inaccurate in such cases and as a result a recommendation has been raised (Recommendation 2)".*

4.70. Recommendation 2 in the Internal Auditor's draft Report, suggested a quarterly audit to independently check the consistency and accuracy of the patient data in relation to the 62 day CWT standard. It also recommended this should include a completeness and accuracy check of the records held on patient files with that of the PAS and CWT and that the subsequent uploads to Open Exeter should also be checked to ensure accurate reporting of data by the Trust.

4.71. The rationale provided in the Internal Auditor's draft Report for Recommendation 2 showed that the auditor concerned had sampled 20 cancer patient records and identified four cases with administrative inconsistencies; one showed the CWT had not been amended to show a change of appointment date, the other recorded a date of referral later than the true date although this had not impacted on the reporting of compliance with the 62 day reporting; the other two cases showed a difference between the PAS and CWT record which had been incorrect and in consequence the Trust had incorrectly reported these patients as meeting the 62 standard.

4.72. In our review of associated emails we identified that Ms West had sent one of the cases to the auditor which demonstrated the mismatch in the PAS and CWT data to the auditor, which in turn had been investigated by **D** who confirmed to the auditor there was an inconsistency and that the last amendment was recorded as being undertaken by Mr Jarman-Howe. (This was also included in the bundle of information provided by informatics to our investigation discussed earlier).

4.73. The email trail relating the draft Internal Auditor's Quality Indicators Report, shows that the draft report was never finalised between the Internal Auditor and the Trust. When the draft Report was initially provided to the Trust on 14 March 2012, it was sent to the Director of Infection Prevention & Control, a Consultant Nurse for Older People, Ms West (each of whom had a responsibility for one of the indicators relevant to their professional responsibilities) and copied to Mr Lehain as the Trust "link" for Internal Audit.

4.74. On 17 April 2012 a further email was issued by the Internal Auditor which was sent to the same individuals, requesting a response to the draft report. Only the Consultant Nurse responded in relation to her indicator.

4.75. The Internal Auditor wrote again on 17 October 2012 requesting a response to the report and on this occasion wrote to the Director of Nursing, the Consultant Nurse, Ms West and copied in Mr Lehain; the email specifically asked Ms West to respond which she did on the 22 October confirming that she had added the management response for her section of the report.

4.76. The Internal auditor wrote again to Ms West on 23 October 2012 asking for the officer responsible for the management actions but did not receive a response.

4.77. The Internal Auditor wrote to Mr Baker on 28 August 2013 highlighting that he was still awaiting the details of the responsible officers to enable completion of the outstanding report and again to Ms West, the Nurse Consultant with a copy to Mr Lehain on 9 September 2013 advising that they will still awaiting the officers responsible details.

4.78. The Internal Auditors told us that in addition to the emails they shared with us, they had also regularly raised the outstanding report with Mr Baker and other staff including Mr Lehain, in routine meetings and discussions during 2012 although said this was not recorded. We noted that in the emails of 2013, the Internal Auditor acknowledged that he had not followed up the matter for some time.

4.79. Mr Baker did not recall any specific internal audit reports relating to cancer data when we interviewed him in December 2013 and the email trail suggests that he was not directly sighted on the draft Internal Audit Report.

4.80. Mr Lehain said that although he received the report he was not directly involved as it sat outside of the normal Internal Audit Programme.

4.81. We established that the Internal Auditors draft Report was linked to some wider work being undertaken by the External Auditor (The Audit Commission[7]) in preparation of their External Assurance on the Trust's Quality Report, which was presented to the Audit Committee on 24 May 2012. We could not establish if there was a direct link between the two reports (see footnote below) however on balance considered it would seem unusual if not given the coincidence of the selection of targets.

4.82. In the External Audit Report submitted to the Audit Committee on 24 May 2012 the External Auditor reported that their testing had sampled 20 individual cases and had identified 6 cases where the start date and or stop date entered into the system did not agree with the underlying evidence.

4.83. The External Auditor's Report concluded that the error was not systematic but caused by human error when reading or typing the start date; the External Auditor recommended that the Trust ensure that data input staff are appropriately trained to understand the impact of the start/stop dates entered into the system. The report also concluded that "*There was no impact PI[8]percentage of cases meeting the 62 day target as reported"*.

[7] The Audit Commission's Audit Practice was, transferred to private providers on 1 November 2102; We attempted to trace the auditors concerned with the CHUFT audit in early 2012, however established they no longer had access to the relevant records; we were therefore unable to pursue our line of enquiry any further in which we wanted to establish the link if any between the data sampled by both the Internal and External Auditor and if there had been cross referencing of findings and the outcome of those discussions.

8 Performance Indicator

4.84. At the meeting on 24 May 2012 the following minute was recorded in respect of the External Auditors Report and comments on the 62 day wait:

- *One recommendation had been made regarding the 'Maximum wait – 62 days for all referrals to treatment for all cancers' target. This related to 6 cases where the start/stop date entered onto the system did not agree with the underlying evidence. It was confirmed that this had not affected the target however a recommendation was made suggesting that data input staff were appropriately trained to understand the impact of the start/stop dates entered onto the system. The Trust had responded to the recommendation and confirmed that it had already enforced the issue with the respective data entry staff. An audit would take place in* three *months to ensure compliance was being met.*

We were unable to track if this follow up audit happened.

4.85. In a similar report issued in May 2013 by the then External Auditor, Grant Thornton, to the Audit Committee, when once again the cancer target was considered as part of the report, the Auditor submitted they had identified differences recorded on the PAS and that on other source documents (GP referral forms) and recommended that the Trust should consider if it has adequate processes in place for ensuring information is accurately recorded.

4.86. The External Auditor sampled 20 cases and found three instances where data did not match between the PAS and GP referral form although also found that this did not impact on the reported performance for the Trust and two other instances where no referral form could be found. The External Auditor provided a "limited assurance opinion" on this indicator although nothing had come to their attention which had led them to reach a "qualified conclusion overall"; in the minute of the meeting the auditor also reflected concerns about the difficulties in obtaining the relevant database from the Trust for them to test.

4.87. The minute of the meeting in May 2013, shows the discussion of the report focussed on how to ensure the difficulties reported by the External Auditor were not encountered in the future.

4.88. There is no indication in the minute that any discussion took place which linked back to the issues regarding data consistency in the previous report issued in 2012 by the Audit Commission, or to set arrangements to follow up work identified in this regard, for example further audit of the inconsistency issues that were raised in the report. The minute shows that the report made by Grant Thornton was noted by the Committee.

4.89. Mr Baker was not present in the 2012 discussion referenced above and Mr Lehain was not present at 2013 discussion referenced above.

5. Summary of the Management Response to the Staff Concerns 2011/12

5.1. **Mr Agrippa** said that after discussing **A** & **E**'s concerns with them, he went to see Mr Lehain, the Deputy Director of Finance (who he considered to be his line manager at the time) to let him know of the concerns that had been raised with him. Mr Lehain does not accept that he was Mr Agrippa's line manager at this time due to some changes in line arrangements which took place on 1 February 2012 however agrees that he suggested to Mr Agrippa they should raise the matter with Mr Baker and accompanied Mr Agrippa to meet with Mr Baker.

5.2. Mr Agrippa says the three of them discussed the concerns and Mr Baker said he would take advice from Mr Bowman Director of Workforce and Company Secretary, on how to handle the matter and come back to them. Mr Agrippa said that subsequent to the discussion with Mr Bowman, Mr Baker contacted him and asked to undertake a discreet preliminary investigation. Mr Agrippa said that Mr Baker also mentioned that he was going to make Dr Coutts the Chief Executive and Ms Barnett, Deputy Chief Executive and Director of Operations aware of the issue.

5.3. Mr Agrippa said as part of his preliminary investigation he met again with **A** & **E** and in his deliberations looked at approximately 10 cases. He selected three cases which he considered best represented their concerns and prepared an analysis and some comments on each of these which he attached to an email which he sent to Mr Lehain, Mr Baker and Mr Bowman. The three cases selected by Mr Agrippa represented different issues from **A** and did not include issues submitted by **B** or **C**.

5.4. Mr Agrippa's email to Mr Lehain, Mr Baker and Mr Bowman was sent on 9 February 2012; a review of the email accounts by the IT department confirmed the email was received in the relevant individuals' accounts, although for Mr Bowman's historical account (as he was no longer an employee when this check was made), were unable to confirm if he had opened the email to access the attached documents.

5.5. In his covering email of 9 February, which was marked as of high importance and headed "*Cancer Findings Confidential*", Mr Agrippa reported he had completed his review and attached summary reports (with hard copies available for full details) and went on to say that in his view:

- "…w*e would need someone with a more in-depth understanding of both the Clinical and MDT aspects of the Cancer pathways to assure us of why these changes would have been made"*

He also suggested that two individuals from within the Trust should be commissioned to do the work to independently give good assurance on the outcomes.

5.6. Mr Agrippa also said in the same email, that the MDTCs seem to be

- "*…getting a bit uneasy of* (sic) *what will be done to remedy this and have mentioned that other members of staff have recently started to allude* (sic) *to the AD Cancer and his team changing numbers to suit performance".*

Mr Agrippa also suggested that the situation needed to be investigated before it became a challenge for the Trust and asked the three email recipients to let him know their thoughts.

5.7. We could not identify any email response from any of the individuals concerned. Neither Mr Baker nor Mr Bowman recollected the email.

5.8. Mr Agrippa also asked **D** to undertake an analysis of the use of active monitoring over 2010/ 2011 and 2011/12 for comparative purposes, and to include with the submission details of the CWTG guidance on *active surveillance*. **D** completed the analysis and submitted it to Mr Agrippa and suggested that in the comparison they had undertaken a distinct increase in the application of *active surveillance* in Q3 of 2011/12 in comparison to the previous year.

5.9. Mr Agrippa undertook a further analysis of **D'**s submission himself and concluded and advised **D,** that after factoring in additional patient volumes it was not substantially statistically significant. We did not receive any evidence which suggested that Mr Agrippa or **D** took this matter any further.

5.10. In support of the preliminary investigation, **D** reviewed the concerns being raised by **A**, **B** & **C**, (in some cases with input from Ms West); together they identified some cases where they thought the entries made by Mr Jarman-Howe were incorrect and sent this information by email to Mr Agrippa.

5.11. In an email to Mr Agrippa of 15 February, **D** requested an update on the progress following the outcome of the preliminary investigation; Mr Agrippa responded to say he was "*working on it*".

5.12. On 20 and 23 February **D** sent some further emails from the MDTCs raising concerns; Mr Agrippa responded on 23 February to say that Mr Baker was speaking with Mr Jarman-Howe later that day about the matter.

5.13. After responding to further issue being raised by **D** on 29 February; Mr Agrippa wrote to Mr Baker, Mr Bowman and Mr Lehain asking if there was "*any sense when Mr Jarman-Howe was to come back on the issues".* We could not identify any documentary evidence of a response to this email from any of the three individuals to whom it was sent. Mr Baker and Mr Bowman did not recollect the email; Mr Lehain recalled seeing a couple of emails but did not consider he was directly involved in the matter at this stage, which we accepted.

5.14. On 5 March **D** expressed concern to Mr Agrippa about the continued submission of emails by the MDTCs and asked Mr Agrippa what was happening; Mr Agrippa responded to say he would discuss the matter with Mr Lehain and Mr Baker. We could not evidence if such a discussion took place and neither Mr Lehain nor Mr Baker recollected such a discussion.

5.15. On the 19 March after further concerns were raised with Mr Agrippa by **D**, Mr Agrippa wrote to both Mr Lehain and Mr Baker and advised them that concerns were still being raised by the MDTCs and suggested they may need to discuss the matter again. We could not find any evidence to support that a further meeting took place.

5.16. Mr Baker did not recollect this email and could not recollect any discussion about it with anyone. Mr Lehain recollected the email and told us that although he did not have any involvement in the MDTCs concerns beyond the first discussion at the beginning of February with Mr Agrippa and Mr Baker, and whilst he did not recollect a discussion about the email, (due to the passage of time) he considered it was more likely that he would have done so than not. Mr Baker said he did not recollect such a discussion with Mr Lehain.

5.17. Mr Agrippa said he had three meetings with Mr Baker about the MDTCs concerns; the first when he raised the concerns, a second when they discussed his preliminary investigation and a third when Mr Baker confirmed he had spoken with Mr Jarman-Howe. Mr Agrippa said he only discussed the issue with Mr Lehain when he first raised it with him.

5.18. On 22 March **D** passed details to Mr Agrippa of a concern raised by Ms West and the Internal Auditor in regard to an amendment made by Mr Jarman-Howe to a patient record; we did not find any response to this email by Mr Agrippa, although he did ask the Internal Auditor to direct the concerns through him rather than **D**, which we concluded was because **D** had expressed discomfort about the concerns being raised with them to Mr Agrippa.

5.19. Mr Agrippa told us that he spoke with Mr Jarman-Howe after he completed his preliminary investigation when he had discussed the MDTC concerns and asked about progress in organising the meeting with the MDTCs which he understood was in hand.

5.20. He said he had also discussed some of the issues arising out of his preliminary investigation with Ms Barnett, which Ms Barnett acknowledges but says, was not in any great detail.

5.21. Mr Agrippa said he felt that Mr Baker had not really grasped the significance of the issue he had raised with him and he was surprised the matter had not been investigated further at the time as he had recommended. He also said he had suggested to Mr Baker that Mr Jarman-Howe should be suspended whilst investigation of the concerns was underway; Mr Baker said he could only recollect Mr Agrippa mentioning that he thought the matter may be serious and had no recollection of a discussion about a suspension of Mr Jarman-Howe.

5.22. **Mr Lehain** confirmed that Mr Agrippa had approached him about the concerns being raised by the MDTCs in early 2012 and that together they had discussed the matter with Mr Baker as Mr Lehain said he could see the potential for the issues being raised to be serious.

5.23. Mr Lehain said that as of 1 February he was no longer Mr Agrippa's line manager because responsibility for the Informatics Team had passed to another colleague and presumed that Mr Agrippa approached him because they had a good working relationship. Our assessment of the evidence relating to this point is that this change of responsibilities was very much in transition at that time and there was no established line management relationship between Mr Agrippa and the newly allocated line manager for informatics.

5.24. Mr Lehain said that following the discussion between the three of them, he took no further part in the matter, as Mr Baker had said he was going to take up the concerns and discuss the matter with Mr Bowman. Mr Lehain said Mr Baker subsequently told him that he had spoken with Mr Bowman, had asked Mr Agrippa to undertake a preliminary investigation and had also spoken with Dr Coutts and Ms Barnett about the matter.

5.25. Mr Lehain said that he had received the email sent by Mr Agrippa on 9 February 2012 but had stood back because as far as he was concerned the matter was with Mr Baker and Mr Bowman; Mr Lehain said that at some point shortly after the email had been received Mr Baker had told him that he had spoken with Mr Jarman-Howe and that the matter had been resolved.

5.26. Mr Lehain said that in regard to the email of 19 March from Mr Agrippa raising the ongoing concerns, that whilst he could not recollect a conversation with Mr Baker about this he thought it more likely that he would have mentioned it to Mr Baker than not. Mr Baker did not recollect such a conversation.

5.27. In regard to the draft Internal Audit Report submitted in March 2012; Mr Lehain said that he was not involved in the original agreement about the selected targets but subsequently became aware of the chosen targets which he believed may have been externally prescribed. Mr Lehain said the report had not been part of the normal audit programme but driven from the need to complete the quality account for the Trust and was a matter between that team concerned (nursing) and the External Auditors.

5.28. Mr Lehain said he had queried the inclusion of the report in the internal audit programme at the time, but took no further action in relation to it, although he did recollect escalating the lack of response to the completion of the report with Mr Baker.

5.29. Mr Lehain told us that he felt that he had no role in the preliminary investigation or the subsequent issues once he had raised it with Mr Baker.

5.30. **Mr Baker** confirmed that the concerns of the MDTCs were first raised with him by Mr Agrippa and Mr Lehain at the beginning of 2012 and that he was not completely surprised because he was aware that a new validation system had recently been introduced and considered that this change may have resulted in a staff communication issue.

5.31. Mr Baker said after his meeting with Mr Agrippa and Mr Lehain he approached Mr Bowman "*to sound him out*" on what he should do. Mr Baker said that Mr Bowman advised that he should undertake a preliminary investigation to establish if there was a case to answer and that he should make Dr Coutts and Ms Barnett aware of the issue. Mr Baker said that Mr Bowman had also advised him, that Ms Barnett could not be involved in the preliminary investigation as the issue concerned staff in her area of responsibility.

5.32. Mr Baker said consequent to this advice from Mr Bowman he arranged for Mr Agrippa to undertake the preliminary investigation and also advised Ms Barnett and Dr Coutts to let them know about the matter. Mr Baker said he told Dr Coutts he had taken advice from Mr Bowman; Dr Coutts advised him to seek clinical support for the preliminary investigation and identified someone he thought may be able to help.

5.33. Mr Baker said when he approached the senior clinical manager concerned, the individual declined because they did not feel they had the relevant expertise for the issues being considered. Mr Baker said that although he considered another individual at this stage, (possibly at Ms Barnett's suggestion) he felt that individual was too closely associated with Ms Barnett and did not pursue the suggestion to obtain clinical input any further. Mr Baker said he had no explanation for this decision.

5.34. Mr Baker said he received three cases from Mr Agrippa a few days after their initial discussion; he and Mr Agrippa met briefly, to discuss the three cases reviewed by Mr Agrippa although he said this had been a brief discussion, partly because Mr Baker said he felt unfamiliar with some of the issues that Mr Agrippa had raised, and also because it still struck him at the time, as an issue of staff communication. Mr Baker said that Mr Agrippa had brought a hard copy of the three cases to their meeting (Mr Agrippa confirmed this) and that he left this with him.

5.35. Mr Baker said that after his meeting with Mr Agrippa, he had spoken again with Mr Bowman and they agreed that Mr Baker should meet with Mr Jarman-Howe and talk to him about the concerns and share the details of the three cases Mr Agrippa had reported. Mr Bowman does not recollect this discussion.

5.36. Mr Baker said he met with Mr Jarman-Howe on 23 February 2012 and showed him the cases that Mr Agrippa had highlighted and informed of the MDTCs' concerns. Mr Baker said Mr Jarman-Howe was generally very open in the meeting and that he felt that the explanations Mr Jarman-Howe gave him in their meeting satisfied him that it was a staff communication issue.

5.37. Mr Baker said that after the discussion with Mr Jarman-Howe he verbally updated Mr Bowman on the outcome of the meeting between him and Mr Jarman-Howe and agreed with him that Mr Jarman-Howe should meet with the MDTCs to talk matters through. Mr Bowman does not recollect this discussion.

5.38. Later that day (23 February) Mr Jarman-Howe sent Mr Baker an email setting out his responses to the three cases they had discussed, in which he also invited a peer review of his actions. Mr Baker said this response underlined to him that Mr Jarman-Howe was not doing anything *"surreptitiously",* and that as there was a clear audit trail of the changes made by Mr Jarman-Howe, Mr Baker concluded that Mr Jarman-Howe was acting in an open manner and this issue was as he originally thought a matter of staff communication.

5.39. Mr Baker said he subsequently completed a handwritten note of his discussions with Mr Jarman-Howe and Mr Bowman on 25 February and put in a file. He confirmed that he took no further action to follow up on the matter including when and if, Mr Jarman-Howe met with the MDTCs as agreed between them.

5.40. Mr Baker said that apart from the conversations with Mr Bowman, he did not discuss Mr Agrippa's preliminary investigation or the outcome of his discussion with Mr Jarman-Howe with any other senior executive colleague, although he may have mentioned it in passing to Ms Barnett and Mr Lehain at some point.

5.41. Mr Baker said although he had taken the view that it was a staff communication issue at the time, he also felt his lack of NHS experience and familiarity with the issues being raised was a factor in how he managed the investigation overall, as were the pressures of the workload he was managing at the time. He told us he was extremely busy at the time these issues were raised with him and was engaged in leading a number of work streams in addition to his Director of Finance portfolio, including The Transforming Pathology Programme (TPP) which he said was a major additional programme of work.

5.42. **Mr Bowman** confirmed that Mr Baker had approached him informally in early 2012, to discuss some concerns that had been raised with him by Mr Lehain and Mr Agrippa about an allegation that some data may have been recorded inappropriately in relation to cancer waiting times.

5.43. Mr Bowman said in the discussion, they had discussed the potential that issues may be serious or may be a technical issue although they did not discuss any particular Trust Policy at the time; in response to our consultation on our draft Report, Mr Bowman said they had considered in this discussion it may be a whistleblowing matter. Mr Baker did not confirm that in his account of their discussion.

5.44. Mr Bowman said he advised Mr Baker that he should establish a preliminary investigation to see if there was a case to answer. Mr Bowman said he also advised Mr Baker that as the matter involved personnel in Ms Barnett's directorate she should not be involved in the preliminary investigation and he should also advise Dr Coutts of the matter. Mr Bowman said he also discussed the need to get technical input to the preliminary investigation. Mr Baker did not confirm this latter point in his account of their discussions together.

5.45. Mr Bowman said that he did not recollect any subsequent discussion with Mr Baker or any other executive colleague on the matter apart from an informal and passing conversation with Mr Lehain some days after he had spoken with Mr Baker when Mr Lehain told him something to the effect that things had been sorted. (Mr Lehain did not reference such a conversation in his statements).

5.46. Mr Bowman said he had no further involvement in the matter although he had an informal conversation with Mr Jarman-Howe, when Mr Bowman says they both mutually acknowledged the issues and both understood to have been resolved by Mr Baker. Mr Jarman-Howe's account of the conversation between them is set out in his response below.

5.47. In relation to the email of 9 February 2012 sent to him by Mr Agrippa, Mr Bowman said he had no recollection of the email; the IT Department confirmed that the email had been received in Mr Bowman's email account but could not confirm if it had been opened.

5.48. Mr Bowman said that the events in February 2012 took place at a particularly difficult time for him when he was also engaged in a complex piece of work in his capacity as Trust Secretary; this piece of work had taken him away from the focus on his normal role. He also said he could not recollect in detail, events which had taken place some 22 months earlier (dated from his interview with us in 2013).

5.49. **Dr Coutts** confirmed that he first became aware of the reported concerns of some MDTCs in February 2012 when Mr Baker advised him that he was looking into some concerns that had been raised with him and he was getting advice from Mr Bowman.

5.50. Dr Coutts said that Mr Baker was quite "*low key*" about the matter when they discussed it together and that Mr Baker had not specifically asked to meet with him to discuss the matter.

5.51. Dr Coutts said he felt assured on hearing that two senior Directors (Mr Bowman and Mr Baker) were directly involved because one had a strong financial background and the other was an experienced HR professional who had been with the Trust for around seven years. Dr Coutts said he suggested to Mr Baker that he might also get some additional input from a clinician and identified a potential individual.

5.52. Dr Coutts said Mr Baker told him he would mention the matter to Ms Barnett, Deputy Chief Executive/Director of Operations, as the issues being raised fell within her portfolio of responsibilities; Dr Coutts said he advised Mr Baker she was not to directly involve herself in the preliminary investigation.

5.53. Dr Coutts said he heard nothing further from Mr Baker on the matter and presumed that had the preliminary investigation raised a matter of significance that Mr Baker or Mr Bowman would have discussed this with him. Dr Coutts said the matter only came to his attention again when The CQC Report emerged in 2013.

5.54. **Ms Barnett** confirmed that Mr Baker had alerted her to the preliminary investigation of the MDTC concerns and being told clearly by him that she could not get involved as it concerned staff from within her Directorate. Ms Barnett said she was concerned and surprised by the issues being raised and suggested to Mr Baker an individual that may be able to assist in investigating the concerns, however Mr Baker had felt that the person concerned was too directly associated with her.

5.55. Ms Barnett said shortly after the conversation with Mr Baker, Mr Jarman-Howe had approached her about the investigation and she had told him something to the effect "*to carry on as normal*" as she had no reason to believe that he was doing anything that was incorrect.

5.56. Ms Barnett said she heard nothing further from Mr Baker for some time and when they did speak about the matter, Mr Baker told her that the matter had been sorted and that there was nothing to worry about.

5.57. Ms Barnett said she had spoken briefly and not in any detail with Mr Agrippa about his preliminary investigation sometime after it had been completed and said that as a result a flowchart had been produced setting out the validation process. (We saw evidence of a validation flowchart).

5.58. Ms Barnett said she had also had a brief discussion with Mr Jarman-Howe on the outcome of the investigation in which she emphasised the need for transparency in his decision making but did not go any further given as she had been told the matter had been resolved by Mr Baker.

5.59. Ms Barnett also said she was extremely busy at this time and under internal and external pressure to ensure that the Trust improved its performance across a number of areas (including cancer performance); she was very pressured with demands for quick turnaround of information etc. by commissioners and Monitor for which she often needed detail from those directly reporting to her. She said this in turn created pressures for them also; however she said she always emphasised to her staff the need to do the right thing for patients and to ensure that the Trust met its quality and access standards

5.60. **Mr Jarman-Howe** said that the changes to the validation process were introduced by Ms Barnett and approved by the Performance Committee and involved both him and Ms Raeburn-Smith; the arrangements were included in the Trust's CWTSAP and overall validation was a small part of the plan and intended to ensure accurate reporting and enable root cause analysis of delays.

5.61. Mr Jarman-Howe highlighted several improvements which he considered had been primarily as a result of the outcome of the root cause analysis of breaches including improvements to the outpatient booking process, improvements in turnaround times for endoscopy, radiology and pathology. He said some of the ideas around this had been put to him by MDTCs, specifically **A** & **B**.

5.62. Mr Jarman-Howe said that although the responsibility for the validation process lay with him, he engaged with clinicians and over his tenure at the Trust increasingly sought to involve them in the process as part of increasing clinical accountability in the management of waiting times.

5.63. Mr Jarman-Howe said that his decisions on validation were supported by the CWTG, and advice from Ms Raeburn-Smith; he said both he and Ms Raeburn-Smith would review the breaches, referring to the patient notes and the CWTG, agree an amendment to the data where this appeared to be warranted and he would then record the agreed adjustment on the CWT. Mr Jarman-Howe said these adjustments applied to a relatively small number of records.

5.64. Mr Jarman-Howe said that he considered the CWTG was a "*best practice document and not a mandatory set of rules*", and that he felt the CWTG described common circumstances and how to deal with them but did (and does) not address all possible circumstances. He said he considered that some areas in the CWTG are left for local policies and identified other areas where he felt the CWTG may be potentially contradictory. Mr Jarman-Howe highlighted *Active Monitoring* as a case in point where he said:

- "*…it is not supposed to be used just to stop the clock" but it can be used where a longer period of thinking time is agreed*"

Mr Jarman- Howe provided detail of circumstances where he felt this might occur.

5.65. Mr Jarman-Howe set out particular examples where the responsibilities for a breach may be shared with another Trust where the care of a patient is shared between one or more Trusts, where he said there could sometimes be challenges between the Trusts concerned which resulted sometimes from differing local interpretations of the CWGT.

5.66. Mr Jarman-Howe described his relationship with the MDTCs as good and said he had regular meetings with them, talked with them frequently on an individual level, and particularly with **A** and **B.** He said as these were not formal meetings he may not have always recorded them in his diary. **A** reported that Mr Jarman-Howe's normal communication style was through emails or voice messages.

5.67. Mr Jarman-Howe said that at no time did he feel that **A** or **B** told or indicated to him that they felt "*pressured*" by him or by decisions he was making in regard to validation, although he acknowledged that he sometimes had a different view than they did on some aspects of the CWTG.

5.68. Mr Jarman-Howe said both **A** & **B** felt able to openly approach him; for example **B** approached him about some concerns they held in regard to another manager and their impending appraisal (which **B** confirmed) and he had also listened to and acted on ideas suggested by these two individuals which he felt showed that he was approachable and took on board their comments and suggestions, however it did not necessarily follow that he would agree with everything they suggested or raised with him.

5.69. Mr Jarman-Howe said he treated all MDTCs the same which was characterised in his view by a positive and constructive working relationship and he did not treat **A** or **B** any differently at any time. He was therefore surprised and concerned to learn the MDTCs had raised concerns about validation adjustments made by him with the informatics department in February 2012, and when Mr Baker told him about the preliminary investigation, he approached Ms Barnett to seek advice. Ms Barnett had said something to him to the effect that he should carry on as normal and await the outcome.

5.70. Mr Jarman-Howe also said he continued to engage and meet the MDTCs as normal during the investigation period (i.e. the preliminary investigation did not impact on their working relationship), although he did not discuss the particulars of the issues or cases that had been raised by them.

5.71. Mr Jarman-Howe said he thought the preliminary investigation seemed to take a long time between when he was first told about it by Mr Baker and when he met with Mr Baker on 23 February, however at the meeting Mr Baker discussed with him three cases that had been sent to him by Mr Agrippa. Mr Jarman-Howe said the three cases he was shown by Mr Baker came from one individual (**A**) and although he was not surprised by the identity of the individual, he thought this matter had resolved previously between them and he explained that as far as he was concerned this was a difference of opinion between them which he explained to Mr Baker.

5.72. Mr Jarman-Howe said Mr Baker did not show him Mr Agrippa's accompanying email of 9 February and that in so far as he was concerned at the time this was an individual matter being raised by **A**.

5.73. Mr Jarman-Howe said he took the three cases away to review further and wrote to Mr Baker later that same day to set out his rationale for his decision making in relation to each of the three cases raised. In the email he invited Mr Baker to establish a peer review of the three cases and said that he considered that in reaching his decisions he had:

- "*…simply applied more discretion in interpreting the guidance that the MDT co-ordinator* and "*the whole point of validation is that a senior person might come to a different conclusion".*

Mr Jarman-Howe also said in the email that two (external) audit reviews and other peer reviews had not identified any concerns in this area.

5.74. Mr Jarman-Howe said that he also spoke with Mr Bowman around the same time, possibly a day either side of the discussion with Mr Baker, and that he recalled raising concerns with Mr Bowman about the length of time the investigation had taken and specifically about the delay in notifying him of the concerns and in talking to him about the outcome of the preliminary investigation. Mr Jarman-Howe said he discussed with Mr Bowman the issues raised by the MDTC and recollected Mr Bowman being very supportive of him.

5.75. Mr Jarman-Howe said he also had a brief discussion with Ms Barnett after the discussion with Mr Baker and they had touched upon the issues arising out of the investigation; no concerns were raised with him by Ms Barnett about his validation or approach to staff.

5.76. Mr Jarman-Howe said that as far as he was concerned both Mr Baker and Ms Barnett had therefore not indicated there were any matters of significant concern that had arisen as a result and when he met with the MDTCs as a group in March he made some changes to the validation process to address some of their concerns.

5.77. Mr Jarman-Howe said that he and Ms Raeburn-Smith and Ms Barnett also met on a weekly basis to discuss progress on the PTL when issues of validation, interpretation of CWTG and potential breaches and individual patient pathways were discussed in detail between them.

5.78. Ms Barnett and Ms Raeburn-Smith dispute that the discussions between them included discussions about validation and CWTG and say the focus of the meeting was on unblocking potential breaches and identifying the resources and clinical activity to deliver this.

5.79. Ms West who sometimes attended on behalf of Mr Jarman-Howe said she also had no recollection of discussions about validation or CWTG at the meetings. Our review of the IT evidence suggested that these meetings were in any event established after the investigation period and were often cancelled.

5.80. Mr Jarman-Howe said that after his discussions with Mr Baker, Mr Bowman and Ms Barnett he considered that the matter had been closed and was unaware of any subsequent or ongoing concerns and felt that as a result of the outcome of those discussions and the preliminary investigation he was not doing anything that could be considered incorrect and continued as normal with the validation.

5.81. In his response to our consultation on our draft report, Mr Jarman-Howe said that in light of the information we had shared with him, he acknowledged that two individual MDTCs may have been concerned as a result of some of the changes he made during validation of their data which they disagreed with; however, he said they did not give him any indication of being "*pressured*", and he considered it was unreasonable to expect him to have insight into their feelings if they did not make that known to him and engaged with him openly on other matters.

5.82. Mr Jarman-Howe said that he never put the MDTCs in a position where he asked them to take responsibility for the validation changes he made, (the email evidence we saw confirmed this).

5.83. Mr Jarman-Howe said that there were no difficulties in his relationships with MDTCs and after the investigation he continued to engage as normal with them and he had often praised their work. We found an email (2011) from a service manager sent to one of the key individuals raising concerns that referenced Mr Jarman-Howe "*singing*" his praise of the individual to others. Mr Jarman-Howe also considered he had a positive exit interview with one of the key MDTCs raising concerns and had asked the individual to stay and said he would and had accepted some ideas for improvements from the individual concerned which he shared with the line manager concerned.

5.84. Mr Jarman-Howe said that whilst he could acknowledge, with the benefit of hindsight, that he could have provided more explanation of his decisions in some instances (particularly in regard to the two individuals expressing most concern), Mr Jarman-Howe said that the brevity of some of the responses to the two individuals was a factor of the wider pressures and heavy workload he was managing at the time.

5.85. Mr Jarman-Howe said he also believed he could demonstrate that there had been occasions where he had amended his decisions after discussion with MDTCs and that he was open to challenge but it did not always follow that he would necessarily agree with the challenge being made. We established evidence to this effect both with MDTCs and other colleagues in relation to validation.

5.86. Mr Jarman-Howe said he also accepted that he may, in a small number of cases, have been incorrect in his judgement in respect of validation, although he could not see (from the evidence we had shared with him from the Trust's review of the 30 cases identified in the CQC report), that this had adversely impacted on patient care apart from in one case.

5.87. In this case Mr Jarman-Howe said the patient had already experienced delays prior to his review and whilst with hindsight he regretted that he had not identified this at the time, he made the assumption at the time, that because the treatment had been recorded, the issue of the delay had already been effectively addressed but that he could now see this assumption was incorrect.

5.88. Mr Jarman-Howe said he had a busy portfolio of work and that he had been responsible for leading a number of initiatives to improve Cancer Services at the Trust. He had experienced a strong performance culture whilst at the Trust which he said at times also led to a tendency to micro-manage however he had never witnessed or experienced bullying by a senior manager and that he himself, had always acted in an open professional and approachable manner to those reporting to him or working with him.

5.89. **Ms Raeburn-Smith** said she had a busy and demanding role and had limited contact with the Cancer Division except for trying to support the patients through the pathway when she dealt with the relevant MDTC. Ms Raeburn-Smith said she had become involved in the validation process of the cancer data in 2011 at the request of Ms Barnett, although Mr Jarman-Howe was the "*gatekeeper of the data*".

5.90. Ms Raeburn-Smith said at the time was there was constant pressure to improve delivery of the Cancer standards being achieved by the Trust and to reduce the number of patient breaches; she generally felt under a lot pressure from Ms Barnett on a range of issues and would receive numerous calls during the day from her for information or actions to be completed, often by the end of the day, which she said was typical of Ms Barnett's general leadership style and approach.(See Ms Barnett's comments above).

5.91. Ms Raeburn-Smith said that her role in the validation process, was to give her professional opinion (Ms Raeburn-Smith has a clinical background) on the validity of completed pathways for Cancer patients within the Surgical Division following which a small number of validation adjustments may have been made by Mr Jarman-Howe. Ms Raeburn-Smith said she considered that overall she had more familiarity with CWGT than Mr Jarman-Howe, however she always kept a copy of the manual on her desk and referred to it during her sessions with Mr Jarman-Howe who also used the CWTG when validating

5.92. Ms Raeburn-Smith said she did not actually make the adjustments as she did not have access to the CWT system, the adjustments were made by Mr Jarman-Howe and she did not see the final entries he made and it was difficult for her to say if the actual entries made Mr Jarman-Howe were those they had discussed. The IT Department confirmed that Ms Raeburn-Smith did have access to the CWT but had never used it.

5.93. Ms Raeburn–Smith said that in regard to *active surveillance* she would be looking to ensure that not only had this been discussed with the patient but that they had agreed to this in the outpatient clinic with the consultant and she would look to the consultant letter to confirm this had been the case.

5.94. Ms Raeburn-Smith said she was not aware of any of the MDTC's concerns or of the preliminary investigation by Mr Agrippa; however she met with **A** immediately prior to them leaving the Trust to thank them for their work, when she said the individual also left some documents with her.

5.95. Ms Raeburn-Smith said she did not read the documents in detail, but on seeing some of the content which referred to data issues, she went to see Ms Barnett and mentioned the issues it contained to her. Ms Raeburn-Smith said that Ms Barnett told her the matter had previously been investigated and resolved. (Ms Barnett did not recollect this conversation between her and Ms Raeburn-Smith).

5.96. Ms Raeburn-Smith said that she did not retain the documents and did not consider the matter any further as a result. **A** said that they had not left or sent any documents to Ms Raeburn-Smith when they left the Trust.

5.97. **Ms West** confirmed that there was a strong focus on improving cancer performance over 2011/12 and that this was keenly felt by all in the division including the MDTCs who she said like her were very busy.

5.98. Ms West also said there were particular pressures at this time, on the urology pathway due to volume and the pathway design as well as volume pressure on upper and lower gastroenterology, and in consequence she said the specialities were experiencing a number of breaches around the 62 day pathway at this time.

5.99. Ms West said she had a constructive and professional working relationship with Mr Jarman-Howe and had supported him as far as she was able in building up his knowledge of cancer services and the related guidance; this had included advising him on the CWTG, although she did not recall him attending any of her training sessions. Ms West said she that overall she enjoyed working with him but had not found him easy to challenge as from her experience, he was not a particularly easy person to influence once he had made up his mind.

5.100. Ms West said that the MDTCs were a fairly unique and challenging group to manage with some individuals having strong personalities; although there had been difficulties with one individual (**B**), overall she felt had good relationships and felt that there was a good knowledge of the CWTG in the group with some individuals demonstrating a particularly sound knowledge and understanding, including **A** & **E**.

5.101. This positive relationship with Ms West and the MDTCs was confirmed by the MDTCs in their interviews with the exception of **A** who believed that Ms West was inconsistent in some of her decisions in 2011/12 (not confirmed by other MDTCs) and had been unfair in not allowing them to take leave at a particular time; and **B** who felt their relationship was untenable with Ms West.

5.102. Ms West said that **A** & **B** had spoken to her directly about the concerns they held about some of the changes that Mr Jarman-Howe was making during validation. Ms West told us that she held some similar concerns at the time, but having previously challenged him on some points and having now been largely removed from validation when he and Ms Raeburn-Smith took over did not feel she could take it any further and was unlikely to get support from Ms Barnett who she felt might consider she was trying to undermine Mr Jarman-Howe.

5.103. Ms West said that she suggested that **A**&**B** go directly to Mr Jarman-Howe with their concerns as she thought this might potentially influence Mr Jarman-Howe where she had not been able to. Ms West confirmed that she was subsequently copied into emails that **A** & **B** raised with Mr Jarman-Howe.

5.104. Ms West also said that after 10 January 2012 when Mr Jarman-Howe placed her on a personal performance review due to some performance issues in regard to poor performance relating to compliance with 2 week waits for routine breast referrals (one of her areas of responsibility), she felt "*vulnerable*" and concluded that that it was not in her best interests to challenge him directly.

5.105. Ms West said she had been asked to "*review*" patients herself by Mr Jarman-Howe but she did not make any changes unless they were in accordance with the CWTG and recollected a specific case where she said MJH requested to her to seek agreement to a pause on the pathway for a patient managed jointly with another Trust. She thought this was incorrect so she had made the call as asked but said she had not implemented Mr Jarman-Howe's request. (She provided details of this case to the investigation which was also included in the informatics information we received and supplied to Mr Jarman-Howe).

5.106. Ms West also told us that she had not been directly instructed to make an adjustment to the CWT however in the review of emails and specifically the email of 22 March 2012 we found evidence where Ms West had recorded an entry arising out of the request from Mr Jarman-Howe as "*amended on the instruction of MJH*".

5.107. Ms West said that she did not feel that Mr Jarman-Howe really gave any rationale for his validation changes although said his changes were normally supported by a comment in the CWT record; she was not sure if when challenged by others other than herself and the MDTCs who had shared their concerns with her, Mr Jarman-Howe had reverted any of his validation amendments.

5.108. Ms West said she was aware that the MDTCs had escalated matters to informatics and that Mr Jarman-Howe had been spoken to by Mr Baker and Mr Bowman but was not directly involved in Mr Agrippa's preliminary investigation.

5.109. Ms West said that she had joined the MDTC meeting with Mr Jarman-Howe but did not contribute significantly as she felt this was very much "*their*" (the MDTCs) meeting with Mr Jarman-Howe.

5.110. Ms West said she had a busy and demanding role and was located on the ECH site and although she was in regular contact with the CGH based MDTCs by email she did not see them every day. Ms West strongly denied that she had at any time instructed staff to amend records inappropriately. The evidence of the MDTC's supported this position.

6. Review of Evidence

6.1. There was a strong focus during 2011/12on improving performance and achievement of national cancer standards for delivering appropriate treatment time for patients at the Trust, which were included as a primary objective in Mr Jarman-Howe's personal objectives; two specialities, urology and gastroenterology faced particular challenges at this time due to volume and capacity pressures and in the case of urology the additional pressure of pathway design relating to timing of the MRI.

6.2. The review of this aspect of the urology pathway had been under internal discussion since 2010, however because of difficulties in establishing clinical engagement and commitment had not progressed; a trial of a revised pathway around the TRUS/MRI timing was implemented in early summer 2012, and was fully implemented in late 2012.

6.3. The Trust developed a CWTSAP and subsequently a CSRAP both of which were led by Mr Jarman-Howe, overseen by Ms Barnett and the Trust's Performance Committee. The plans were also known to and/or shared with the relevant commissioners and Monitor.

6.4. These plans included a number of initiatives designed to lead to service improvements of which new arrangements for the validation of cancer data formed a small part. The plans suggest that changes in validation process were driven by a need to achieve greater consistency in the process and in order to enable root cause analysis of the patient breaches in order to identify the reason for the breaches and develop plans to avoid future breaches.

6.5. The new system of validation introduced in early 2011, was led by Mr Jarman-Howe with input from Ms Raeburn-Smith; only Mr Jarman-Howe accessed the CWT and he was therefore responsible for the entries subsequent to the discussions between them.

6.6. Following validation, Mr Jarman-Howe sometimes wrote to MDTCs requesting an amendment. He normally copied Ms Raeburn-Smith in to the email and when the MDTC concerned responded she was also copied in, however because Ms Raeburn-Smith did not access the CWT she did not know what actions were subsequently taken on the CWT unless they were brought to her attention. The primary responsibility for the validation adjustments on the CWT lay with Mr Jarman-Howe.

6.7. We found one email (September 2011) where Mr Jarman-Howe indicated that he had undertaken a review along with Ms Raeburn-Smith, when in fact she was absent from work on the relevant date due to certificated sickness absence; we therefore concluded that Ms Raeburn-Smith may have on some occasions, been incorrectly attributed as having been consulted by Mr Jarman-Howe when in fact she had not.

6.8. There is no evidence to suggest that any MDTC directly raised such concerns with Ms Raeburn-Smith during the course of 2011/12 other than in the case of the disputed documents left by one of the three individual MDTCs when leaving the Trust in 2012, which the individual concerned denies they did. Having given consideration to other areas of inconsistency relating to this individual's evidence concerning with whom and where they left details of their concerns and others' accounts, we consider that on balance Ms Raeburn-Smith's account is likely to be more reliable on this point, and given this, we consider also that it is more likely that Ms Raeburn-Smith raised the matter with Ms Barnett and was advised the matter had been previously investigated and resolved.

6.9. The emails sent by Mr Jarman-Howe to MDTCs to make adjustments on the CWT post validation, were limited in number and primarily confined to urology in 2011 with some issues in early 2012 arising in the gastroenterology specialities. The emails from Mr Jarman-Howe were cordial requests to the individuals rather than instructions and there was no suggestion in any we saw or provided by the individuals to the informatics' team in 2012 that gave any indication of a direct instruction to the individuals by Mr Jarman-Howe to amend data, which in any event all interviewees confirmed had not been the case.

6.10. We also established that when **A** & **B** felt concerned by some of the changes and requests made by Mr Jarman-Howe during his validation of data, they felt able to refer those requests back to him for him to action. We found no evidence in the emails and none was reported by the individuals concerned to suggest that Mr Jarman-Howe on receipt of such emails subsequently placed pressure on the individual concerned to implement the request or in any way acted inappropriately towards them.

6.11. We also saw evidence which showed that on some occasions **A** or **B** would email Mr Jarman-Howe to express a concern about a change he had made on the CWT. When from the evidence we saw, Mr Jarman-Howe acknowledged these emails, which he normally did, he did not provide an explanation for his decision or follow up on the points they raised; sometimes he told the MDTC who had raised the concern to leave matters as they were and did not offer an explanation for that decision.

6.12. The evidence on the CWT suggested and Mr Jarman-Howe and the MDTCs confirmed, that he did not ask others including the MDTCs to take responsibility for decisions he made although as we have discussed above he did sometimes attribute Ms Raeburn-Smith as included in the discussion which as we set out below, may not always have been the case. We saw one case where Ms West acted on, and with a caveat, took responsibility for one action requested of her by Mr Jarman-Howe (see below).

6.13. There were some limited examples on the CWT records we reviewed which showed that **A & B** had made some entries on the CWT to say that the amendment they had seen had been made by Mr Jarman-Howe or that they were challenging his entry or disagreed with the amendment made by him on the CWT.

6.14. In one entry on the CWT made by Ms West, she had made the adjustment which said she had done so "*on the instruction of Mr Jarman-Howe*"; this related to the example that she highlighted to us and the Internal Auditor. In her interview Ms West confirmed that Mr Jarman-Howe asked rather than instructed, we concluded on balance that this entry could not be relied upon as evidence of an instruction to her by Mr Jarman-Howe.

6.15. There were some examples to show that Mr Jarman-Howe had responded to a direct challenge for example from **C** and in another case from a colleague Associate Director; after discussion, Mr Jarman-Howe had accepted the challenge and revoked the adjustments he had made. We considered that this demonstrated that Mr Jarman-Howe could be open to challenge and responsive to amending his view.

6.16. The email evidence we saw suggested that the majority of the concerns related to the urology specialty, concerned allocation of DTT dates, and specifically included some disagreement about when the date of *active surveillance* should be allocated as the effective treatment date; this was a particular issue of contention between them.

6.17. In context, the number of issues raised by **A** (which were nonetheless individually important) were limited in number when set against the overall number of patients being monitored on a weekly basis by **A**, which from information contained in training documents (attached to the exit interview documentation) was around five hundred in a week (including those tested as positive for cancer and the two hundred or so on the weekly PTL).

6.18. The internal preliminary investigation related to three cases all centred in some way, on *thinking time and active surveillance* from **A,** and following completion of the preliminary investigation when neither Mr Baker or Ms Barnett raised concerns with Mr Jarman-Howe about his approach or actions, Mr Jarman-Howe reasonably concluded that as a result he was acting correctly in his application of the guidance.

6.19. Mr Jarman-Howe's own evidence both to Mr Baker in his preliminary investigation and our investigation, indicated that he felt there was scope for discretion around the DTT on this point; the evidence of others and the advice we received on the CWTG, suggests that his interpretation was not generally consistent with his contemporary colleagues at the Trust and in consequence may have been incorrect on some occasions. Mr Jarman-Howe indicated to us that in regard to some of the cases we shared with him during our consultation on our report that he could accept that with the benefit of the information we shared with him, he may have been incorrect in his validation adjustments in some cases.

6.20. None of the evidence we received suggested that that the MDTCs or **A** in particular had described to Mr Jarman-Howe the impact of their actions on their individual feelings. However in the meeting on 27 March 2012 between him and the MDTCs, according to the email from **E** written after the meeting, there had been a full and frank exchange with him of their concerns which resulted in Mr Jarman-Howe accepting he may have in some cases been wrong and agreeing to some changes in his approach.

6.21. We found no evidence to show that **A** had indicated to Mr Jarman-Howe or any other manager that they felt "*pressured*" or had been "*pressured*" by him, although they had consistently represented their concerns about this issue to Mr Jarman-Howe during 2011 and 2012. Mr Jarman-Howe felt he had discussed the differing interpretations on this point with and **A,** and considered the matter had been resolved between them. The continued representations of **A** on this point right up until their departure from the Trust shows that this was not resolved between them and we found no evidence that indicated that Mr Jarman-Howe looked into why this might be the case either by engaging with **A** or taking other advice on the matter.

6.22. The MDTC concerns were initially confined to **A** & **B** but then more widely shared with other colleagues including in some email evidence we saw some colleagues based at ECH as well as those at CGH. We found no evidence to substantiate that Mr Jarman-Howe appreciated the extent of concerns held by the MDTCs prior to their emergence in February 2012.

6.23. The escalation of the shared MDTC concerns to informatics appears to have arisen primarily because of the way in which Mr Jarman-Howe handled **A's** persistent representation of their concerns and subsequently the way he handled **B's** representation on aligned points (and potentially the failure to listen to Ms West's representations on similar points to him). **A** shared their concerns with a colleague (**D**) who escalated the matter because they felt those concerns may be justified i.e. felt that Mr Jarman-Howe may not be correct in his application of some aspects of the CWTG during validation and needed further examination; there was no evidence to suggest this was a planned escalation and it seems it occurred more out of **A's** frustration that they could not get a reasonable recognition of the issues they were raising from Mr Jarman-Howe.

6.24. On balance we concluded, because of the reliance on the three cases, that the discussions between Mr Jarman-Howe and Mr Baker were unlikely to have reflected the full range of concerns held by the MDTCs to Mr Jarman-Howe at that time, although Mr Baker did suggest to Mr Jarman-Howe to meet with the MDTCs which Mr Jarman-Howe did not initiate as agreed.

6.25. On balance we consider that whilst Mr Jarman-Howe may have reasonably concluded that at this stage he was acting correctly in his application of the CWTG, we consider that not following up the suggestion that he should meet with the MDTCs indicated that he had not given meaningful consideration of the impact of his actions on the MDTCs in general, or **A** in particular.

6.26. When the concerns were initially raised with Mr Baker his subsequent action, notwithstanding his premise that this may be a staff communications issue, suggested he was sufficiently concerned by what he heard to take advice from Mr Bowman; Mr Bowman in turn was also sufficiently concerned to suggest the conduct of a preliminary investigation into the concerns and notification to Dr Coutts along with the exclusion of Ms Barnett from the initial considerations.

6.27. Dr Coutts, who says that the issues were presented in a "*low key*" manner to him, also heard sufficient at that time, to suggest the inclusion of clinical involvement in the preliminary investigation; Ms Barnett although not actively engaged also recognised the potential implications of the concerns.

6.28. Overall therefore we consider that Mr Agrippa's presentation of the issue to Mr Lehain and its subsequent escalation to Dr Coutts and the other executive colleagues' shows there was recognition amongst the colleagues concerned that the issue had the potential to be serious in nature and that in consequence Mr Baker was clearly advised to conduct a preliminary investigation and to include clinical input into advice; the latter of these which he did not do and offered no explanation for his decision not to do so.

6.29. The preliminary investigation was completed very promptly by Mr Agrippa although the cases he selected to submit all related in some way to the issue of "*thinking time*" and did not include a case which represented the concerns of either **B** or **C**. Mr Agrippa supported his selected cases with a clear recommendation in an email (attaching the three cases) to Mr Baker, Mr Bowman and Mr Lehain that the issues needed to be further investigated with suitably knowledgeable people, whilst reporting the degree of unease amongst the MDTCs and others about the issues.

6.30. The subsequent discussion between Mr Baker and Mr Agrippa about the preliminary investigation does not appear to have included any reference to the email and its recommendations; both parties report it as being brief and focussed on the hard copy of the three cases identified by Mr Agrippa that he had taken with him to the meeting.

6.31. Neither Mr Baker nor Mr Agrippa considered they had sufficient knowledge to really understand the detail of the issues that had been raised with them but no action was taken by Mr Baker to take clinical or more knowledgeable advice, to inform that discussion.

6.32. We consider it likely, that on balance, it was at this stage in the management of the preliminary investigation, that Mr Baker lost track of the original email sent to him by Mr Agrippa on 9 February, and relied on the hard copy of three cases alone that Mr Agrippa left with him after their meeting.

6.33. Mr Bowman and Mr Baker say they did not recall receiving or reading Mr Agrippa's email of 9 February. However the IT evidence confirmed that the email was received in their email account and we consider that it was incumbent on both individuals to have read this email which was marked "*Cancer Findings Confidential*" and flagged as of high importance; both had discussed the initial concerns and identified the need to instigate a preliminary investigation.

6.34. There is a disagreement between Mr Baker and Mr Bowman as to whether subsequent to the email of 9 February and Mr Baker's discussion with Mr Agrippa, a discussion between them took place; Mr Baker says they had a discussion about Mr Agrippa's findings and they agreed that Mr Baker should meet with Mr Jarman-Howe to discuss the cases, which Mr Bowman does not recollect.

6.35. We consider, on balance, taking account of Mr Bowman's own submission that he was having difficulty recollecting detail of events over such a long period of time and that the period concerned was difficult for him with considerable work pressures, it is more likely that Mr Baker's account is more reliable and that a conversation took place between them as Mr Baker reports although we consider that is more likely this was an informal discussion (and possibly brief) between them, in which it is more likely that Mr Baker represented his view based on the three cases he had discussed with Mr Agrippa..

6.36. Mr Baker considered that Mr Bowman was giving him professional HR advice and supporting him in the management of the concerns that had been raised with him, and that view was one that others with whom Mr Baker discussed the initial concerns also held to be the case; Mr Bowman does not accept this because he considers he was not involved beyond providing the initial advice to establish a preliminary investigation.

6.37. Having given consideration to Mr Bowman's role as the Trust's most senior HR professional (and with NHS experience, unlike Mr Baker), we consider there was a particular duty on Mr Bowman to support Mr Baker who had approached him initially for advice and to have informed himself as a result of the outcome of the preliminary investigation as set out in an email sent to him by Mr Agrippa before engaging any further with Mr Baker on the matter.

6.38. We also consider on balance that this was a pivotal discussion between two senior executives that set the course for the subsequent management of the Trust's response to the concerns raised by the staff.

6.39. The subsequent meeting between Mr Baker and Mr Jarman-Howe to discuss Mr Agrippa's preliminary investigation did not take place until 23 February when Mr Baker supplied Mr Jarman-Howe with a copy of the three cases that he and Mr Agrippa discussed and did not refer to Mr Agrippa's email of 9 February. Mr Jarman-Howe was therefore not fully aware of the concerns and responded only to the points the cases raised which appeared to come from one individual with whom he considered he had discussed some differing opinions on some areas of the CWTG.

6.40. In an email which Mr Jarman-Howe sent to Mr Baker later that same day Mr Jarman-Howe articulates in his analysis of two of the cases, his application of the DTT in regard to *active surveillance;* this was the nub **A's** concerns. We consider that Mr Baker was not sufficiently informed or aware of the details of the CWTG to have come to a conclusion without clinical or specialist knowledge /input as a result of his discussion with Mr Jarman-Howe, however he did so and concluded that the response reaffirmed his view that this was a matter of staff communications.

6.41. Significantly Mr Jarman-Howe invited Mr Baker to initiate a peer review of his actions in regard to the cases highlighted which Mr Baker did not follow up.

6.42. Mr Baker said he and Mr Bowman had a discussion after he had met with Mr Jarman-Howe (which Mr Bowman does not accept) and they agreed that the best course of action was for Mr Jarman-Howe to meet with the MDTC to listen to their concerns.

6.43. Again we concluded for the reasons we set out earlier, that this conversation was more likely than not to have taken place and noted additionally that Mr Baker included reference to this discussion in subsequent hand written note of the conversation with Mr Jarman-Howe on the same day. Mr Baker's note was compiled on 25 February, and briefly records the discussion with Mr Jarman-Howe and Mr Bowman. In the note he says he looked at the three cases supplied by Mr Agrippa from one member of staff with Mr Jarman-Howe and that after this spoke with Mr Bowman and they agreed that Mr Jarman-Howe should speak with the MDTCs; there is no reference in the note to the wider concerns alluded to by Mr Agrippa in his email of 9 February.

6.44. We considered that the note exposes further the weakness in Mr Agrippa's selection in his preliminary investigation of three cases from one individual and Mr Baker's failure to refer back to the accompanying email from Mr Agrippa.

6.45. Mr Baker did not take any subsequent action to follow up on the discussion with Mr Jarman-Howe.

6.46. Mr Baker and Ms Barnett agree that Mr Baker did not inform her of the outcome of the preliminary investigation other than in a passing comment some weeks after the issues first emerged; however Ms Barnett did have a discussion with Mr Agrippa shortly after Mr Agrippa had submitted his email of 9 February to Mr Baker and others, when Mr Agrippa informed Ms Barnett of the outcome of his preliminary investigation.

6.47. Ms Barnett and Mr Jarman-Howe also had a conversation shortly after completion of the preliminary investigation; both conversations appear to have been brief and in relation to the discussion with Mr Agrippa and Ms Barnett we could not establish if Mr Agrippa informed her of the detail of his recommendations in his email of 9 February or the on-going concerns.

6.48. However on balance we considered that the combination of the conversations with Mr Agrippa and Mr Jarman-Howe and the discussion with Mr Baker did not result in Ms Barnett exploring the concerns in any detail and as a result we consider that she did not fully inform herself of the detailed issues raised in one of her areas of responsibility.

6.49. There is a disputed account of the conversation between Mr Bowman and Mr Jarman-Howe which took place on or around 23 February, which whilst both agreed took place both have a different recollection of the detail. We concluded that, from either account this discussion did not cover the extent or scope of the MDTC concerns that had been indicated to Mr Bowman in Mr Agrippa's email of 9 February.

6.50. During February and March, Mr Agrippa continued to receive information about concerns held by the MDTCs, Ms West and **D** about some adjustments made by Mr Jarman-Howe. We found no evidence that the concerns which Mr Agrippa sent to either Mr Baker and Mr Bowman or Mr Baker and Mr Lehain were followed up or that Mr Agrippa took these issues to Ms Barnett for further review.

6.51. We consider however that the email sent by Mr Agrippa on 19 March to Mr Baker and Mr Lehain which reported the ongoing concerns and suggested the need to discuss the matter further and asked for their thoughts was significant and was not acted on by either Mr Baker or Mr Lehain. Mr Lehain says he was most likely to have discussed the email of with Mr Baker at the time but Mr Baker did not recollect the email or a conversation.

6.52. This email was received by Mr Lehain shortly after the Internal Auditor submitted a draft report to him on 14 March in which he highlighted that a small number of cases he had considered had shown some inconsistencies in some parts of the cancer data records and that as a result the Trust had incorrectly reported information against target.

6.53. Mr Lehain does not appear to have indicated or informed Mr Baker of the content of that report and when asked specifically about this advised that he had raised the fact that it was outstanding with Mr Baker but did not confirm that in so doing he had alerted Mr Baker to the issues it contained. Mr Baker did not receive this report and did not recollect it at all.

6.54. We consider that given his knowledge of the issues from the outset either the email or the Internal Audit report should have prompted Mr Lehain to raise the matters again with Mr Baker which the evidence suggests he did not do and which on balance we consider was remiss of him.

6.55. The draft Internal Auditors' Report was never completed and we could not identify that there was any clarity of ownership for the report or that the Audit Committee adequately followed up on the reasons why the report had never been completed.

6.56. The External Auditors report submitted to the Audit Committee in May 2012 drew a differing conclusion on the same indicator; we could not establish what discussions or considerations took place between the Internal and External Auditors in this regard. We could not evidence that the Audit Committee which was the Board Committee responsible for the oversight of both reports asked any questions about the relationship between the two reports. However as they were not sighted on any of the detail in the Internal Auditors report because of its draft status this would seem a reasonable position at that time.

6.57. The relevant non-executives, Mr Baker and the other executives did not recollect receiving reports about cancer performance/data; and whilst there were no specific reports to this effect, mention of the 62 day cancer standard and the data was included in both the 2012 and 2013 External Auditor Quality Reports. However neither raised specific concerns that would alert the non-executives to any underlying problem but it did strike us that this was an example where the governance in place at the time did not sufficiently ensure or encourage integration of different aspects of information across Committees.

6.58. From the end of March 2012 onwards, apart from **A** no on-going concerns were highlighted to us about Mr Jarman-Howe's validation decisions and on balance we concluded that it was most likely that the changes that Mr Jarman-Howe had indicated at that meeting had begun to be implemented and take effect, particularly in regard to informing MDTCs about changes he had or was intending to make.

6.59. The exception was in relation to **A**, who continued to express concerns to Mr Jarman-Howe about some validation issues concerning *active surveillance* and this continued until they left the Trust, which coincided more or less with the full introduction of the new MRI/TRUS urology pathway.

7. Conclusions

7.1. Overall whilst many of the issues were raised by **A**, there were also issues that were raised by **B** and **C** and were of concern to Ms West. To check this we looked at a number of cases ourselves in which we saw some changes that were "difficult to explain" against the CWTG and demonstrated that there were genuine and wider grounds for the MDTC concerns.

7.2. There is no evidence to support that there was at any time, an instruction to junior staff (or others) to manipulate data or make inappropriate adjustments to cancer data by Mr Jarman-Howe, Ms West or any other senior manager.

7.3. Mr Jarman-Howe made changes as part of routine validation when he sometimes took advice from Ms Raeburn-Smith; he was solely responsible for the final adjustment on the CWT as Ms Raeburn-Smith did have access to the CWT but had never used it.

7.4. Mr Jarman-Howe accepted personal responsibility for the revisions he made and at no time requested an MDTC or any other individual to take responsibility on his behalf. MDTCs' were able to and did reject some of the requests he made of them and there is no evidence that this held any subsequent adverse consequence for them in their relationship with Mr Jarman-Howe.

7.5. Mr Jarman- Howe did not adequately explain the rationale for his validation decisions to the MDTCs and in the case of **A** never resolved a longstanding difference of opinion on the application of *active surveillance* on which it was more likely that in the majority of cases (which are small in number) that **A,** rather than Mr Jarman-Howe was correct.

7.6. Mr Jarman-Howe's understanding on the application of the DTT for *active surveillance* was inconsistent with his wider contemporary colleagues and the generally accepted application within the CWTG.

7.7. There is no evidence to suggest that the issues which emerged in February 2012 were widely known in the Trust and specifically there is no evidence that the clinicians were aware of the concerns.

7.8. There is no case to answer for any individual, including Mr Jarman-Howe and Ms West, in respect of alleged bullying and harassment.

7.9. Mr Jarman-Howe failed to adequately and meaningfully engage with some of MDTCs in order to fully understand and consider their concerns and by so doing failed to demonstrate any insight or consideration of the impact of his actions upon them.

7.10. The MDTCs concerns emerged in the informatics department because having failed to get a satisfactory explanation from Mr Jarman-Howe, one MDTC discussed their concerns with a colleague in that department who, after receiving and considering some the information, felt it appropriate to escalate matters.

7.11. The preliminary investigation of these concerns was mismanaged from the outset by Mr Baker, because he failed to act on Dr Coutts' advice to seek clinical input and thereby ensure that the preliminary investigation (and consideration of its findings) involved appropriately qualified and experienced people.

7.12. The preliminary investigation was weak because it identified a limited example of the concerns being reported by the MDTCs and as a result may have contributed, in part, to persuading Mr Baker that this was a staff communications issue. This would have been a fundamental flaw had the cases not been supported by a clear recommendation for the matter to be further investigated by people with more direct experience and understanding of the issues.

7.13. Mr Baker as the commissioning executive and Mr Bowman as the HR professional from whom Mr Baker had sought advice, did not read, consider and discuss the email from Mr Agrippa which may, had they done so, have resulted in a more thorough and informed consideration of the issues being raised.

7.14. Mr Jarman-Howe was not fully aware of the extent of the MDTC concerns but equally failed to engage with them promptly once he had discussed matters with Mr Baker.

7.15. Mr Baker did not follow up on the actions agreed between him and Mr Jarman-Howe.

7.16. Neither Mr Baker nor Mr Lehain responded to the continued concerns Mr Agrippa informed them of, and specifically failed to respond to his email of 19 March 2012 which provided a significant indicator that matters had not been satisfactorily resolved around the staff concerns he had investigated and reported to them.

7.17. Mr Lehain did not highlight to Mr Baker the Internal Auditor's report submitted on 14 March 2012 which was an indicator that there were some issues around the cancer data which warranted further consideration.

7.18. The Internal Auditor's report submitted in March 2012was never completed and became almost obsolete once the External Auditor reported in May 2012 on the same area; The External Auditor's Report did not report any concerns with the cancer data they examined and there was therefore a conflict between the findings of both auditors.

7.19. The Audit Committee was not sighted on the Internal Auditors concerns equally they did not pursue any issues arising from the failure to complete the Internal Audit Report.

7.20. Ms Barnett as the Director responsible for Mr Jarman-Howe did not adequately explore the outcome and detail of Mr Agrippa's preliminary investigation with Mr Agrippa nor did she take any action to discuss with Mr Jarman-Howe or Ms West any of the detail of the issues raised.

7.21. The primary individuals involved in the management of the response of this matter are no longer in the employ of the Trust; we consider that it is not appropriate to consider disciplinary action for the two managers identified to us as still in the employ of the Trust as at September 2014.

8. The Emails - March 2013

8.1. Two separate emails were received in the corporate offices during the course of March 2013 which related to some of the issues which subsequently emerged in the CQC report and which we were asked to investigate. We have presented the evidence we established for email each in turn below.

8.2. The first email of 6 March sent by Mr Prentice to Dr Coutts and copied to Ms Shirtcliff arose following a confidential call from a clinician to Mr Prentice. The clinician concerned contacted Mr Prentice to alert him that he had received a call from an acquaintance who had advised him that an employee of the Trust was reported as have been attempting to contact the media concerning alleged mismanagement of cancer waiting times at the Trust.

8.3. The clinician told Mr Prentice he suspected that he knew the identity of the individual (although he did not directly name the individual) and gave some details to Mr Prentice which linked the identity to an MDTC working for Ms West.

8.4. The clinician reporting the matter to Mr Prentice had also told him (and confirmed the same in our interview with him) that this call was the first time he, and to the best of his knowledge that any clinician, had been made aware of concerns about data validation; (which in any event was not something the clinicians were directly involved in at the time).

8.5. Mr Prentice said he was surprised by the call as he would normally have expected to have heard directly from the media about such an issue but had no reason to doubt the integrity of the individual contacting him and shortly after taking the call sent an email to Dr Coutts which he also copied to Ms Shirtcliff who was at that time his line manager, advising of the information he had received

8.6. Dr Coutts said he read the email from Mr Prentice and sent it to Ms Barnett with a request for her to discuss it with him, but took no further action. Ms Barnett did not recall the email but said she was very busy at the time and thought that it had simply not registered with her.

8.7. Ms Shirtcliff said she "skim" read the email and from the information contained in it thought she might know the identity of the individual and thought it might be related to an issue around a particular employee (MDTC **B**) who was pursuing a complaint against a manager in the Cancer Services Division at the time (not Ms West or Mr Jarman-Howe) and which was being externally investigated. She responded to Mr Prentice by email copied to Dr Coutts later that day to indicate this. (The grievance was not connected to cancer data).

8.8. Having reported the matter to Dr Coutts and Ms Shirtcliff, Mr Prentice monitored the media but did not take any other proactive action, adopting a "*wait and see*" approach because he considered that the manner in which the story had emerged was unusual and inconsistent with the way the media normally handled such matters. Mr Prentice considered he would have had some soft intelligence about such a significant emerging issue, which he did not and this was the first time that any suggestion of the issue had come to his attention. Nothing further emerged and Mr Prentice said the matter never re-emerged as far as he was concerned.

8.9. Neither Ms Barnett nor Dr Coutts recollected having a discussion subsequent to receipt of the email.

8.10. Dr MacDonnell said that he recalled the email being mentioned in passing at either an executive meeting or the Trust's Issues Management Group, when Mr Baker had said it had previously been investigated and resolved. Mr Baker did not recollect any involvement in a discussion about the email.

8.11. No media interest emerged and nothing further was heard by Mr Prentice or the Trust.

8.12. On 26 March 2013 Dr Coutts received an email (copied to a union official) from MDTC **B**, which he said he read and responded to by email the same day to say he was taking the matter up with HR.

8.13. Dr Coutts said he subsequently had a conversation with Ms Shirtcliff (which Ms Shirtcliff confirmed) who told him the matter was being dealt by her team and that an external investigator and the employee's union were involved in an investigation into the employee's grievance. Dr Coutts said this conversation assured him that the matter was in hand and the appropriate people were involved; he stood back to let matters take their course.

8.14. Ms Shirtcliff said that although she and Dr Coutts had a conversation Dr Coutts did not send her the email he had received from the employee concerned. Ms Shirtcliff was not clear when this conversation occurred between them but thought it was most likely to have been on around the 26 March 2013 when Dr Coutts read the email.

8.15. A few days later (28 March 2013) the same employee wrote again to Dr Coutts who was on holiday at this time. Dr Coutts' secretary responded on his behalf and forwarded the email to Ms Shirtcliff whose team dealt with the issue that was being raised in regard to pay.

8.16. Dr Coutts said he read the email on his return but did not make any further enquires because as far as he was concerned the matter was with HR for resolution and investigation.

9. Review of the Evidence

9.1. The first email received on 6 March 2013, had little substance however it did suggest that a MDTC was raising concerns about the management of cancer data by the Trust. Mr Prentice and the clinician said that neither of them knew anything about such concerns before the issue was raised with the clinician by an external third party and then shared with Mr Prentice.

9.2. Mr Prentice alerted both his line manager Ms Shirtcliff and Dr Coutts the Chief Executive, who in turn alerted Ms Barnett. Given the limited information and the unusual circumstances in which the information had been relayed to him Mr Prentice determined that it was appropriate to wait and see and in the event nothing further arose.

9.3. Ms Shirtcliff considered there was sufficient in the information shared with her to reasonably conclude that the individual may be the same individual who was pursuing a complaint against one of their managers and advised the same to Mr Prentice and Dr Coutts. Ms Shirtcliff had no knowledge of the issues in February 2012 and the preliminary investigation conducted at that time.

9.4. Dr Coutts and Ms Barnett both knew of the previous investigation but both considered the matter had been resolved at the time and neither made an immediate connection with the previous events of 2012. Dr MacDonnell, the Trust Medical Director recollected a passing mention of the issue at a meeting in which those in attendance were told that the matter had previously been looked at and resolved by Mr Baker (although Mr Baker and others do not recollect the discussion); Dr MacDonnell could not be clear at which of the two meetings he mentioned this discussion took place and there will have been differing people at the meetings.

9.5. The email of 26 March which was sent to Dr Coutts (by **B**), is long covering 4 pages; on first reading it appears to relate primarily to a long running grievance about the individual employee's relationships with two different managers and the management of some HR matters. It also refers back to previous correspondence with Dr Coutts about some of these HR issues two years previous. The grievance was not connected to cancer data.

9.6. Some way into the email - page 3 - the employee alleged that a meeting with her new manager was really because the employee was under pressure to change patient data; on page 4 in the penultimate paragraph the email includes a sentence in which the employee alleges a colleague left the Trust because the employee concerned refused to change (cancer) data.

9.7. Dr Coutts read the email of 26 March 2013, however we consider he did not necessarily do so in detail and that as a busy Chief Executive it is more likely given the presentation of the issues on the first page or so of the document, which immediately strikes as an HR issue, he would have determined to refer the matter to HR for resolution.

9.8. Dr Coutts did not forward the email to Ms Shirtcliff however he discussed the email with Ms Shirtcliff and in that discussion was told of the arrangements for investigating the individuals concerns which included the involvement of a Trade Union Official and an experienced external investigator. From both accounts this occurred on and around 26 March.

9.9. The second email from the employee sent on 28 March focussed entirely on the need to get a response from him about pay and raised no other issues; this was sent by Dr Coutts secretary to Ms Shirtcliff and the pay issues were resolved by HR directly with the employee.

9.10. No other emails were received by Dr Coutts from the employee concerned.

9.11. A review of the investigation documents relating to the employee's grievance and complaints (which reported in May 2013) showed there was no mention at any time during the course of that investigation by the employee concerned, the trade union representative or the colleague who was identified in the email of 26 March in regard to cancer data or concerns about cancer data manipulation and specifically the employee did not report that their manager (which was neither Ms West or Mr Jarman-Howe) had put them under "*pressure to change patient data*", notwithstanding the grievance alleged bullying by the manager concerned.

9.12. The outcome of the external investigation of the grievance did not substantiate the allegations of bullying made by the employee concerned against their manager.

9.13. The individual involved did not report to our investigation any ongoing concerns about amendments to their data post March 2012.

10. Conclusions

10.1. We concluded that the response of Mr Prentice to the information he received highlighting a potential media issue and which he set out in the email of 6 March 2013, was appropriate and ensured a clear audit trail of the information and where it had been sent. In an ideal situation he or Dr Coutts may have given consideration to speaking face to face but we concluded that even if they had it is unlikely it would have significantly influenced their actions at that time

10.2. There was no basis for Ms Shirtcliff to make any connection with the preliminary investigation of the concerns of MDTCs in February 2012 as she had no knowledge of the issues.

10.3. Dr Coutts and Ms Barnett could and possibly should have made a link to the issues of February 2012 at the time, but we considered they were unlikely to have immediately done so because their focus at that time was on a number of wider issues challenging the Trust in regard to the Keogh and Francis reports. In any event we considered that even if they had made this link they were likely to be reassured by Mr Baker that the issue had been investigated and determined as a staff communication issue.

10.4. Although no one else could recollect the passing reference to the 6 March 2013 email in a meeting as described by Dr MacDonnell, we concluded that on balance his account was likely to be more accurate because at the time he heard this, he had no knowledge of the previous concerns or preliminary investigation and this served to reinforce our conclusion that the matter was likely to have been regarded as having no substance as we suggest above.

10.5. In regard to the email of 26 March 2013, we concluded that although Dr Coutts read and acknowledged this email we consider it is unlikely he read it in detail because from the accounts of the discussion between himself and Ms Shirtcliff, there was no mention of the specific comment alleging patient data manipulation and they reported that the matter discussed between them was the (long standing) employee HR grievance.

10.6. Dr Coutts did not forward the email to Ms Shirtcliff, which we considered was most likely due to oversight on his part and although this may have been ideal we concluded that it was unlikely to have materially impacted on the external investigation of the grievance as the employee concerned made no mention of these concerns in the course of that investigation. We concluded that the discussion between Ms Shirtcliff and Dr Coutts will have reflected on the particular historical difficulties associated with this employee and their history of previous grievances with managers and that as a result this is likely to have reaffirmed the issue as primarily a HR matter.

10.7. In turn we concluded that the existence of the email of 26 March 2013 was not identified to Mr Chin and Mr Fleetwood when they met with them in September 2013 as part of the internally commissioned fact finding review consequent to the emergence of the CQC concerns because the email had not struck Dr Coutts at the time as anything other than a HR issue and in the case of Ms Shirtcliff because she had never seen it.

10.8. The primary individuals involved in the management of the response of this matter are no longer in the employ of the Trust; we consider that it is not appropriate to consider disciplinary action for the two members of staff identified to us as still in the employ of the Trust as at September 2014.

11. The Whistleblowing Policy, Bullying & Harassment & Related Governance

11.1. As part of our investigation we were asked to give consideration to the effectiveness of the Trust's Whistleblowing Policy, its implementation and any wider issues around bullying and harassment that arose in the course of the investigation and we considered to be relevant. In addition we were also asked to consider related governance issues and how the Board could assure itself further in regard to staff concerns.

Whistleblowing Policy

11.2. We found little awareness of the Whistleblowing Policy during our detailed investigation of the MDTC concerns in 2011/12 amongst the MDTCs and little if any evidence that the policy was considered by the senior managers at the time as part of their investigation of those concerns, even though in January 2012 a weekly blog from Dr Coutts had highlighted the policy to staff.

11.3. We found a similar knowledge base when we interviewed staff in 2013/14 as part of our investigation with most saying that until the recent issues emerged subsequent to the CQC report in 2013, they had little awareness of and how to access this policy – although most knew where they could find details about it on the Trust intranet.

11.4. Local staff representatives described the policy as complex difficult to access and not adequately supported by training of managers and staff in how to report and manage staff concerns. They felt the process needed simplification and training – both of which we told were to be initiated during 2014.

11.5. During the investigation period and up until 2014, there were no clear processes that enabled the reporting of statistics and key trends in staff grievances and concerns systematically and regularly (apart from the national staff survey) to the executive team and relevant Board Committee/Board; this had led to a concern for local staff representatives that the matter was very much considered a HR issue and not a mainstream issue on the wider "dashboard" of performance indicators for the Trust .

Bullying and Harassment

11.6. The consistent report from our interviews was that staff and their representatives did not consider that there was a systemic culture of bullying in the Trust. For most interviewees the reports in the local media that suggested this was the case had distressed them significantly and we heard from the majority of interviewees that they and many of their colleagues simply did not recognise the culture being attributed to the Trust as consistent with their experience of working at the Trust.

11.7. However there was recognition by all interviewees that in a large organisation there are sometimes individual managers whose behaviours may be considered to be bullying in nature although overall, the conclusion of the staff representatives in particular, was that they felt this was probably consistent with any large organisation employing c 4,200 employees.

11.8. Staff representatives also highlighted the difficulties and fine line between performance management and perceptions by individuals that this was bullying particularly when a new manager came into role and set new and clear expectations in regard to performance which may not always be accepted by the employee even if they were reasonable. They felt this emphasised the need for joint development initiatives and consistency in the application of performance and capability procedures (which they identified may also need simplification and alignment with the bullying and harassment policy).

11.9. Alongside this however the interviewees and in particular the staff representatives, told us they considered that there were some parts of the Trust where staff had experienced bullying behaviour by an individual manager and considered this may not always have been quickly identified and remedied by the Trust. To support this they provided some historical evidence which we noted but determined it was not appropriate for us to investigate in detail although we undertook a cross reference with the HR professionals in their interviews (Mr Bowman and Ms Shirtcliff) who confirmed a shared awareness of some specific historical issues referenced by the staff representatives.

11.10. We also noted that the external review of bullying and harassment commissioned by the Trust in December 2013, reviewed six former cases which had been investigated by external investigators. The review concluded that the cases were not concentrated in any one area and involved a mix of staff grades and professions. It also noted that in five out of the six cases behavioural concerns or concerns with performance had not been appropriately addressed by managers and there had also been a lack of clarity in regard to lines of accountability and responsibility.

11.11. The report also identified examples where a new manager had encountered resistance to change initiatives which were translated by some staff as "*bullying*" and suggested that the Trust needed to reconsider its approach to managing performance so that it was more consistent and transparent, thereby reducing the suggestion of bullying.

11.12. Given these views and the context that had given rise to the MDTC concerns, we reviewed the staff survey results of 2012 and 2013 and in particular KF19 - the percentage of staff experiencing harassment bullying or abuse from staff in the past 12 months, KFI 21 - report good communications between senior managers and staff and KFI 22 - able to contribute towards improvements at work.

11.13. The indicators showed that Trust performance was worse than average against peer comparators and we felt suggested that there is an opportunity for improvement building on some of the staff representatives' suggestions.

Governance

11.14. Our observations and findings in regard to the specifics of governance in the cancer services division mirror the findings of the NHS England report "*The Immediate Review of Cancer Services at CHUFT*" published in December 2013 in regard to the shortcomings of the cancer governance structures, the lack of functionality and clarity in regard to clinical leadership, information governance and the role of the Cancer Committee. We do not propose to comment further other than to endorse those findings.

11.15. Some specific issues arose however during the investigation which we consider that in the spirit of improvement and learning it is appropriate to reflect in out report.

11.16. We noted that during the investigation period the composition of the Board did not reflect clinical or operational management experience of the NHS or related sectors, for example social care, in its non-executive membership; this is not an essential requirement in the non-executive composition of a NHS Trust Board however where possible we consider that the inclusion of such experience can be helpful in assisting the Board as a whole and in certain Committees of the Board to effectively challenge executives on key service indicators (even if they have non-executives with NHS Board experience) which can open up issues for other non-executives with differing experience to appropriately explore further. We felt that in the particular circumstances of the Trust where two of the senior Executive positions were held by people who had spent most of their working lives outside of the NHS this was a particularly important consideration in balancing the Board.

11.17. In support of this we consider that the Committee structures and governance also need to support and enable non-executives to integrate information to enable a balanced consideration of a variety of key indicators; from the evidence we considered during the course of the investigation we concluded that the Committee structures of the Trust and particularly those in place during the investigation period did not appear to promote an integrated discussion of aligned governance issues, with in some cases no clear flow of information from ward to Board, with the arrangements around risk management being reported as a significant area in need of review.

11.18. Earlier in the report we reported that we identified that the Audit Committee in particular may need to reflect on the processes it has in place to ensure clarity of executive ownership of auditors' reports and follow up on actions outstanding.

11.19. In the interviews with non-executives in particular but also for some executives there was a view that that the balance of the Board's business conducted in private and in public may benefit from some review to enable more business to be conducted in public. We consider that this may also be helpful to the Board in responding to a perception reported to us that for some stakeholders the Board may not proactively share information with stakeholders; we were specifically given some examples where stakeholders felt the Trust had been slow to respond to requests for information for example on risk, staffing levels and other governance information requested by staff side, full time union officials and governors.

11.20. During the course of our investigation we reviewed the appointment arrangements for Mr Baker which arose partly because he indicated that he felt his lack of NHS experience was material to his management of the preliminary investigation in February 2012 but also because we established that he had not been subject to any formal appointment procedure when he moved from his non-executive position on the Board to the position of Director of Finance (unlike Dr Coutts who made a similar transition at the Trust after an open national recruitment process).

11.21. It was explained that this had arisen because the Trust had unsuccessfully attempted to recruit substantively to the Director of Finance despite two open recruitment processes and that in consequence Mr Baker in discussion with Dr Coutts and subsequently Ms Irvine had agreed to undertake the role initially on an interim basis which was later made into a substantive appointment.

11.22. When we examined the detail of these arrangements we established that no formal interview had been held and that no job specific references had been taken up – the only references were those which related to his non-executive directorship appointment and which were taken up by a consultant and qualified as being "check" rather than full references.

11.23. The Trust held the view that because it was an interim appointment a process was not necessary and that in any event that had they followed a process the outcome would have been the same because of the previous unsuccessful recruitment exercises. Whilst we recognised the challenge we felt that the arrangements were inadequate and in particular failed to take account of clear advice, given to all NHS Trusts in the East of England in March 2010, following an investigation into an appointment of a chief executive that all chief executive and executive director appointments should be supported by a selection process even in circumstances where there is only one credible candidate.

11.24. We consider that the Trust may wish to reflect on their arrangements for appointment of executive directors specifically interim appointments to ensure that they are appropriate and robust for the future.

12. Lessons to be Learnt

12.1. The investigation has underlined the need for NHS organisations to establish an open and engaging working climate that encourages and supports staff to come forward with ideas and concerns and in which leaders respectfully consider and respond to employees consistent with the values of the NHS Constitution.

12.2. Key internal policies particularly those concerned with capability, performance management, bullying and harassment, grievance and whistleblowing should be simple, accessible and aligned to ensure congruence and proactively brought to the attention of staff and underpinned by training and development of those responsible for their implementation and for staff more widely.

12.3. Managers with line management responsibilities should take time to listen to and consider concerns being raised by staff and provide an opportunity for those concerns to be openly and constructively explored.

12.4. In the event of a persistent concern either from a group or individual Managers should be open to considering if they have fully understood the basis for that concern(s); if they have listened honestly and attentively to the concern and, have the humility to consider there may be an alternative view to their own and be open to seeking advice from others or reviewing their decision(s) with a colleague/mentor or their line manager.

12.5. Adequate orientation and induction and training of all staff involved in the management of cancer services should be established so that it is systematic and underpinned by clear principles which reflect the status, spirit and intent of national guidance and the scope for local interpretation which when applied should be subject to an agreed and transparent governance process.

12.6. When concerns are raised by staff, the preliminary investigation of those concerns should be undertaken by trained investigators and as necessary, supported by people with relevant expertise and knowledge.

12.7. Commissioning Officers for workplace investigations should ensure they have HR advice and that together they and the HR adviser, take time to review and consider the outcome of a preliminary (or full) investigation before they determine a course of action. Together they should agree and record their decision and rationale and ensure that those involved or who need to be informed are made aware of their decision.

12.8. Individuals who become aware of relevant or potentially relevant information either during or subsequent to investigation of staff concerns should make this known to the investigating officer/commissioning officer as appropriate.

12.9. The Chair of the Board should ensure that the conduct of Board business at all levels encourages and enables challenge and debate with an appropriate balance of experience and expertise; and through the Chief Executive and Committee Chair(s) respectively ensure that there is clarity about executive accountability for actions to be taken and robust systems to enable the Committee(s) to follow up and track progress.

12.10. Formal assessment and appointment processes should be followed for the appointment of interim executive directors.

Carole Taylor-Brown
Professor Pat Troop
September 2014