TRANSCRIPT OF “FILE ON 4” – “DANGEROUS HOSPITALS?”

CURRENT AFFAIRS GROUP

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NORTHAM: Last month a public inquiry chaired by Robert Francis QC reported on perhaps as many as twelve hundred unnecessary deaths at Stafford Hospital.

FRANCIS: This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety.

NORTHAM: But are other rogue hospitals yet to be discovered? The NHS now has fourteen hospital trusts under investigation for worryingly high mortality rates. A leading Government adviser says that twenty thousand of their patients suffered avoidable deaths over the past decade. Shouldn’t somebody have noticed? Somebody like the regulator, for example. Doctors and nurses tell us that official inspections often give glowing reports to suspect hospitals, they miss important failings and don’t hear from the right people. Have you, as a senior consultant here, ever been spoken to by a Care Quality Commission inspector?

BROOME: No, never.

NORTHAM: Would you have expected to be?

BROOME: Yes.
NORTHAM: And that’s never happened?

BROOME: No.

NORTHAM: Not even in the most recent inspection?

BROOME: No.

SIGNATURE TUNE

ACTUALITY IN BLACKPOOL

Alongside the zoo, in the seaside town of Blackpool, is a smart new complex of buildings mixed in with the traditional red brick hospital. Blackpool Victoria Hospital. It’s an impressive development. But how proud can local patients feel about the standard of treatment and care here? Blackpool is one of the fourteen hospital trusts under investigation by the top brass of the NHS because of its high mortality statistics. To put it bluntly, many more patients die here than the national average for their conditions across hospitals in England.

CHAPMAN: Mark was quite an active chap for his age. He had a cabin cruiser on the canal which he went out on most weekends. They had two springer spaniels which are quite active, excitable dogs, which they walked along the beach. He did all the DIY and the gardening – yeah, they were very young at heart.

NORTHAM: Hayley Chapman’s father-in-law, Mark Wells, went into Blackpool Hospital three years ago. He needed an ileostomy bag fitted following long and successful treatment for cancer in which his lower bowel had been removed. After his surgery Hayley was relieved that he seemed to be on the mend.

CHAPMAN: After his operation, he went into high dependency ward, where he had fantastic care and service, then they declared he was fit and well and as should be, moved him to the general ward to get his blood levels up and get the liver back to the right level and what have you, and that’s when Angela, his wife, started to notice blood in his bag.
NORTHAM: So there was blood in his ileostomy bag?

CHAPMAN: Yes.

NORTHAM: And there shouldn’t have been?

CHAPMAN: No. It didn’t look like what you’d think blood is. It was thick, tar-like, dark red, possibly black.

NORTHAM: And what did your mother in law do? What did his wife do?

CHAPMAN: She reported it to the junior nurses that were looking after him, at which point they just said, ‘Don’t worry, it’s nothing to worry about, we will look into this.’ And essentially what they did was, they just kept replacing the bags, it would fill up with blood again and then it got to the point where they kept giving him blood. That’s all they kept doing was replacing the bag and assured her nothing was wrong.

NORTHAM: The bleeding continued for five days until, a fortnight after he entered the hospital, Mark’s condition deteriorated so badly that his wife Angela was put on alert.

CHAPMAN: She literally received a phone call to say he had gone into arrest. She drove there and they said, ‘He’s died of a heart attack.’ But after the autopsy came through, it was revealed that he had a duodenal ulcer, which was obviously the cause of the blood.

NORTHAM: It was bleeding internally?

CHAPMAN: Yes. He was slowly bleeding internally. I would have thought that maybe he would have been sent off for a scan or someone would have looked at him and probably diagnosed that he had the duodenal ulcer and he would have been treated accordingly and would be here today.
Three weeks ago, the Health Service Ombudsman criticised the hospital’s treatment as significantly below standard, it ruled in favour of a complaint from Angela Wells, and concluded that the hospital’s failure had reduced Mark’s chances of survival. The hospital wrote to the family to apologise.

Those responsible for this lack of basic care and communication have been identified and severely reprimanded and steps have been taken to ensure they fully realise the appalling consequences of their failings.

The solicitors for the family, Pannone’s of Manchester, report an unprecedented rise in the number of medical cases coming to them in recent years. The firm’s partner dealing with clinical negligence, Gill Edwards, recognises some of the hospitals on the Government’s list for investigation.

Certainly in our law firm we receive 350 to 400 enquiries each month. We certainly see a pattern of certain hospitals cropping up again and again as potential defendants. And I have to say, when the fourteen hospitals were identified after the Mid Staffordshire inquiry, we weren’t surprised to see many of the hospitals who we regularly see as defendants in cases on that list, and Blackpool being one of them.

Blackpool Hospital’s management weren’t available for interview. In a statement, the Medical Director says its clinicians have been doing intensive work for several years to understand why it has a high mortality rate and to put improvements in place. The list of fourteen hospital trusts to be investigated was drawn up from data on deaths in hospital analysed by the leading national expert, Professor Sir Brian Jarman of Imperial College.

So I’ll put those there and then these are the numbers of admissions, you see? So what I need here is the year ...
NORTHAM: On his computer, Sir Brian stores monthly statistics from all hospitals in England - and elsewhere in the world - showing how many patients with each medical condition have died in hospital and comparing that with the national averages. Each hospital trust then receives a single score – its adjusted death rate for the year.

JARMAN: The red dots are the adjusted hospital death rate.

NORTHAM: And these lines that you’ve drawn across the graph here, what’s this hundred here?

JARMAN: The one hundred figure is the figure for England every year, so we actually adjust all the national data to make the national figure one hundred every year.

NORTHAM: Sir Brian showed us an example of a trust with death rates consistently above the national standard - North Cumbria University Hospitals Trust.

JARMAN: The adjusted hospital death rate for North Cumbria has been more than a hundred every year.

NORTHAM: So these two dots here, they’re almost 20% above the standard national figure.

JARMAN: Yes. Those two dots are 18% above the national figure.

NORTHAM: When you look at those dots, what do you think the conclusion should be from them?

JARMAN: My conclusion really for any hospital which has a significantly high adjusted death rate is that should be a trigger, a smoke alarm to indicate that they should be looking, drilling down to see if there is a problem.

ACTUALITY AT CUMBERLAND INFIRMARY
MAN: This is the acute medical admissions ward and it’s of particular interest as this is the real pressure point of the hospital in that ....

NORTHAM: The North Cumbria Trust runs hospitals in Carlisle and Whitehaven. It has a record of budget cuts and low morale.

MAN: ... peaks and troughs, but we do frequently have problems where we just don’t have enough staff and beds here, so the patients ....

NORTHAM: When the NHS recently surveyed hospitals across England, North Cumbria came out bottom of the list. Two-thirds of its staff said they would not recommend treatment there to family or friends. But concern over standards is not new. Four years ago, nurses in Carlisle became so alarmed that they compiled a substantial dossier of breaches which they submitted to the Royal College of Nursing.

DUNN: In 2009, the members were reporting things like ‘seriously unsafe staffing levels, inappropriate skill mix, lack of support from ward sisters and poor management practice and a general sense of feeling degraded, bullied and intimidated’.

NORTHAM: The Royal College’s northern operational manager, Estephanie Dunn, decided she had to approach the hospital’s management.

DUNN: One of the things that alarmed us the most was a dossier of issues in the A&E department, particularly about shortcomings and risk, overcrowding, delayed transfers to wards, inability to get patients out of the ambulances into the department for treatment, people being nursed in corridors. They were so serious and there were so many of them. I met with the Director of Nursing and we went through this, and her assurance to me at that time was that she would immediately investigate and they would do what was required to make sure the system was safe.

NORTHAM: And did that happen?
DUNN: From my understanding of what happened, there was a visit made to the A&E department and there, the staff felt that they were carpeted and told that they shouldn’t have given this information to me, they shouldn’t be whistle-blowing in this particular way and …

NORTHAM: Who told them that?

DUNN: The managers who went to see them. The staff were told not to write any more in the log that they kept. And they kept that really because of their increasing concerns about the lack of response to the things that they were reporting verbally.

NORTHAM: But they were told not to write any more things in the log?

DUNN: Not to write any more in that log.

NORTHAM: Did you ever get a proper response from the then management of the hospital?

DUNN: I think we got a number of assurances that really came to naught.

NORTHAM: When we approached other nurses and doctors linked to North Cumbria, we found them reluctant to speak openly for fear of reprisals - a fear the management says is groundless. But we were able to interview a serving doctor with strong concerns about the way deaths are investigated. To preserve anonymity, the interview has been re-voiced.

DOCTOR: Our results - patient care, outcomes at the end of treatment when patients go home, those figures are not really collected in a very serious manner.

NORTHAM: Why not?
DOCTOR: If you collect authentic figures, then there may be issues which make difficult reading for others. If they find areas are not safe for patients, then someone has to take action. Someone will be responsible and held to account and could even lose their jobs.

NORTHAM: But those figures you’re telling me are not actually kept and checked?

DOCTOR: That’s right. What we check are management figures - throughput and processes. How long do patients wait, how many patients are operated on. We rarely look at cases to see if things have gone wrong.

NORTHAM: Last September, North Cumbria Hospitals came under new management. The Chief Executive, Ann Farrer, told File On 4 she has provided an open forum for doctors and nurses to raise any concerns they have about standards of care. She acknowledges that this was not the norm in the past. Troubled by North Cumbria’s mortality figures, Mrs Farrer arranged a review of all deaths over twelve months. A team of clinicians examined eleven hundred cases where a patient died. In most they found no cause for concern. But in fifty or so, there were in the jargon “material issues which could have been done better”. We understand that in several cases significant harm to patients was identified. But Ann Farrer is keen to stress that this does not imply that the hospital was at fault.

FARRER: We’ve used an internationally based formula for looking at them and what they have indicated is that none of those patients died through any neglect of the hospital or any lack of care that was provided to the patient. What they identify is that there is scope for improvement in some of our systems of care and that’s what we’re setting out to improve.

NORTHAM: So on one mortality measure you’re 18% above the national standard and you’re telling me you’ve looked at eleven hundred deaths in the hospital over the last year and you haven’t found a single case where the hospital was at fault?

FARRER: That’s right.
NORTHAM: Do you realise that that sounds unconvincing?

FARRER: It is the facts from the review.

NORTHAM: But high mortality rates don’t raise questions only for the hospital trust. Where was the regulator? One of the striking things about recent years in North Cumbria is that while the death rate among patients has been well above the national average, successive inspection reports have failed to spot anything wrong in the two hospitals. The Care Quality Commission, CQC, declared in November 2011 that the Carlisle hospital was “meeting all the essential standards of quality and safety”. Last year it said the same about the Whitehaven hospital. It wasn’t until last August that it spotted problems in Carlisle, including lack of cleanliness, failings in safety, lack of support for staff and inadequate risk management. Staff have questioned with us how these things could have been missed before. Consultant surgeon Guy Broome, chair of the Medical Staff Committee, doubts whether the inspections were sufficiently thorough.

BROOME: The first visit they had to A&E, a year or so back when concerns were first raised, they came at seven in the morning, when you could almost guarantee there were no patients in the place, and they were told not to talk to the one and only A&E consultant who was in the department. We should have six consultants, in fact at that time we only had one, we had locums and what have you.

NORTHAM: And why did the CQC not talk to that consultant?

BROOME: I can’t answer that, but that was complete puzzlement to us lot as consultants and professionals.

NORTHAM: Did that seem to you an adequate way for an inspection to be carried out?

BROOME: No, completely inadequate.

NORTHAM: Have you, as a senior consultant here, ever been spoken to by a Care Quality Commission inspector?
BROOME: No never.

NORTHAM: Would you have expected to be?

BROOME: Yes.

NORTHAM: What would you expect them to ask you?

BROOME: Given the fact that I represent the consultants from a professional point of view, I would have thought I would have been one of the first people that they would ask me what was the consultants’ feeling, given the fact we were supporting the nurses as well, what’s actually going on on the ground, what are the real problems from working consultants on the shop floor, as it were, rather than hospital managers.

NORTHAM: And that’s never happened?

BROOME: No.

NORTHAM: Not even in most recent inspection?

BROOME: No.

NORTHAM: In what seems to be an era of new management, there’s also a fresh face at the top of the regulator, the Care Quality Commission. David Behan has been at the helm for six months and acknowledges that past criticisms by doctors and nurses may have some justification.

Let’s start with a point that is made to us in North Cumbrian. Doctors have complained to us that inspections in the past have been cursory, and in particular they’ve not been heard, they’ve not been approached and spoken to. Have inspections in the past been cursory?

BEHAN: Well, I think we concentrate on the wrong things in our inspections and in the future we need to speak to people that work in services, patients that have used services, carers. And I want us to focus on whether services are safe, how effective those services are, do they work and what are people’s experiences of services? We’ll also look at the leadership of hospitals.
NORTHAM: And when you say you focused on the wrong things in the past, before you were the Chief Executive, those doctors could be right then, could they, that they haven’t been talked to, important points in their hospitals have been missed in the inspections?

BEHAN: Well, historically and currently, when we inspect hospitals we will speak to staff ....

NORTHAM: And has that been adequately done in the past inspections?

BEHAN: I don’t think it has been adequately done in the past and we want to look at this in more detail and we’re determined that we will do this by focusing much more on the leadership and the experience of people that work in hospitals.

NORTHAM: The most pointed challenge to past CQC inspections comes from examining reports on a hospital which has loomed large in death rate tables over the past decade.

ACTUALITY WITH SIR BRIAN AND COMPUTER

JARMAN: I can plot them for you, so now I’ll just draw a graph and that’s it.

NORTHAM: Sir Brian Jarman, the leading statistician and Government advisor, showed us the record over the past decade of a centre which repeatedly has high death rates - George Eliot hospital in the Warwickshire town of Nuneaton.

JARMAN: It goes from 2001 to the last complete financial year, which ends at the end of March.

NORTHAM: So for the most recent year, it’s slightly under ...

JARMAN: It’s just above ....
NORTHAM: It’s just under 20% higher than the standard, the national standard.

JARMAN: That’s right, yes.

NORTHAM: And at its worst, in 2005/2006, it was 42% higher than the national standard. What do you make of this plot of data?

JARMAN: I would have thought that someone ought to have gone here and had a look.

NORTHAM: Has anyone been to Nuneaton to look at what’s going on in this hospital?

JARMAN: There’s not been an inquiry to my knowledge. I wouldn’t be at all surprised if the Care Quality Commission have been in there to look at it, but there’s not been an inquiry as at Mid Staffs, no.

NORTHAM: In fact, the CQC has been to Nuneaton and given good reports. In the past eighteen months, the Department of Health has produced quarterly mortality data of its own, counting not only all deaths in hospitals but also those within thirty days of discharge after treatment. In the first set of these statistics, in October 2011, George Eliot Hospital had the highest death rate in England. So how does the Chief Executive of the Care Quality Commission, David Behan, explain his inspectors’ reports? July 2011, you gave George Eliot Hospital a clean bill of health, meeting all essential standards of quality and safety. Four months later they came highest in the national statistics for having the worst death rate in England. Last November you gave them another clean bill of health while you were Chief Executive, and yet they’re still very high up the mortality rate statistics. How can your inspections not find out what’s going wrong there?

BEHAN: Well the first thing that I said when I arrived here is we’re going to change the way we inspect hospitals and we will do that.
NORTHAM: So are you saying that the November 2012 – four months ago – inspection of that hospital in Nuneaton is not reliable?

BEHAN: No I’m not saying that, because clearly in arriving at the judgement, people who carried out the inspection, my team spoke to members of the public, they spoke to staff that worked in those hospitals and the judgement that they’ve arrived at is based on that assessment.

NORTHAM: But they seem to have missed an extremely high mortality rate.

BEHAN: What I was going to say is, what this flags up is the importance of taking mortality rates alongside other information and actually challenging hospitals on the basis of their effectiveness.

NORTHAM: Do you think you’ve failed at Nuneaton in the past?

BEHAN: I think failure is too strong a word. Clearly, what we’ve done is raise concerns where we’ve found those concerns and if we’re not …

NORTHAM: But you gave it a clean bill of health.

BEHAN: And if we’ve not found those concerns, we’ve not raised them.

NORTHAM: File On 4 asked to visit the George Eliot Hospital and interview its Chief Executive. The hospital declined our request. In a statement, it says:

READER IN STUDIO: The Trust commissioned a comprehensive external review of its mortality rates in 2011. This review led to the implementation of a major strategy that has led to a gradual but significant improvement in the Trust’s mortality rate.
So the hospital’s management has recognised its problem with death rates, even if the regulator apparently hasn’t. Each year, the management of the Care Quality Commission are called to account in front of the House of Commons Health Select Committee. In January, the Committee published its judgment, noting with approval the approach of the CQC’s new management. But the chairman, Stephen Dorrell MP, concludes, somewhat ominously, that he’s not yet convinced that the organisation has successfully defined its core purpose.

It’s extraordinary actually when you think about it, isn’t it? This is an organisation which has now existed for over five years and we’re still discussing what is its core purpose. But the key purpose, the key reassurance that I think public and patients look for from the CQC is that if a hospital is delivering care to patients, it meets acceptable, fundamental standards, and that should be the prime focus of the work carried out by the CQC.

I don’t want to be too simplistic, but are you effectively saying the CQC has fallen down on the job?

That’s certainly the historical fact. I don’t think there’s any getting away from that, and that’s been acknowledged and is currently being addressed.

But from its birth in 2009, it was a troubled organisation. It merged three inspectorates into one and changed the way inspections were organised. Under the old Healthcare Commission there was a dedicated team of hospital inspectors, highly-trained and experienced in specialist areas. One of its infection control experts was Amanda Pollard, who turned whistle-blower at the Francis Inquiry on Mid-Staffordshire and revealed the change of direction brought in by the CQC.

We were all disbanded, we went off to our separate parts of the country and joined local teams. None of us would be specialists. There would be no infection control inspections of hospitals anymore. So I went into nursing homes and care homes and inspected.
NORTHAM: Well what about the people who replaced you inspecting hospitals then? Had they been trained to deal with hospitals?

POLLARD: No, not to my knowledge, certainly not in the area that I worked and there was certainly no national training programme for people to be able to have that body of training.

NORTHAM: It does sound like madness. What did you think at the time?

POLLARD: We couldn't quite believe it. We raised this to managers, we raised it when directors would come and visit us, but we really didn't get any adequate reply apart from the party line.

NORTHAM: Amanda Pollard’s experience could go some way to explaining the failure of the regulator, the CQC, to raise an early alarm about many of the hospitals now under investigation. So can the new Chief Executive of the organisation, David Behan, explain why a specialist team of hospital inspectors should have been broken up?

BEHAN: I can’t say what happened then. I’ve got to take Amanda Pollard’s word for it. What I’m absolutely clear that we’re going to do is we’re going to develop specialist inspections of hospitals. It will be led by a chief inspector, and every single hospital inspection that we carry out has a clinical expert, either a doctor or nurse as part of those inspection teams, and that’s a change that we’ve made over the past few months since I arrived. And the inspectors in CQC will begin to specialise in healthcare inspections, hospital inspections, adult social care, etc.

NORTHAM: It sounds a little bit like reinventing the wheel. How could anybody have thought that it was right that hospitals should be inspected by people who weren’t expert in inspecting hospitals?

BEHAN: Well I’m going to look forward and what I am saying to you is that we will change the way we inspect hospitals, and I that’s the right way for the public and the politicians and the professionals to have confidence in the judgements we arrive at about the quality of services.
NORTHAM: The list of fourteen hospitals under investigation reveals another area of doubt about the effectiveness of CQC inspections. The Commission’s website makes this claim: We check all hospitals in England to ensure that they are meeting national standards. Which might suggest that when a hospital fails to meet national standards, the CQC ensures that it puts matters right. But that isn’t always the case, particularly in a hospital which is also a Foundation Trust and so comes under another regulator as well - Monitor.

ACTUALITY IN BASILDON

NORTHAM: This huge sprawling collection of grey rectangular buildings looks like an industrial estate from the 1970s. In fact, it’s one of the most notorious hospitals in the country - Basildon University Hospital. Its record in recent years has been marked by allegations of poor treatment and care, a series of questions in Parliament and persistently high death rates. Time and again patients or their relatives have complained that conditions here amount to a substantial NHS scandal.

JUPP: She started to become really unwell, feeling really just, just uncomfortable. She was very hot, but she was cold to touch, very rapid breathing, felt very lethargic.

NORTHAM: The final fortnight of Kay Dejan’s life began with a broken kneecap after a fall. It was put back together by surgeons at Basildon Hospital using several staples. Kay’s sister, Clare Jupp, says all seemed to have gone well. But two weeks later, the family became very anxious about Kay and called in the doctor.

JUPP: The GP basically examined her, was unable to detect a blood pressure at all and was very, very concerned because he believed my sister was peripherally shutdown because her nails were sort of purple and blackening. He was very worried about the blood pressure, the fact that she was two weeks postoperative, he was worried maybe it could be septicaemia or a blood clot, so immediately said, ‘We need to get an ambulance.’
NORTHAM: And that was when, in Clare’s view, a succession of failures by the hospital reduced Kay’s chances of survival. She says that once Kay got to A&E, she had to wait more than an hour for triage. The possibility of sepsis could have raised serious concern. It’s a response to infection which can interfere with vital organs and ultimately lead to death. But Clare says no antibiotic was given for at least five hours, even as a precaution. And she complains that, as her sister’s condition failed to improve, she and her parents were left not knowing what was happening - until events suddenly turned drastic.

JUPP: We were standing outside and this loud over the speaker type announcement went out - cardiac arrest in resus - and all the doors started to fly open and doctors and trolleys just as you would see it on TV. And my mother and father and I just sort of stood there looking shocked and, as the doors opened, we could see the crash team were around my sister’s bed. And we were hysterical, I mean my sister had broken her leg two weeks before and she was now having a cardiac arrest. And, you know, for thirty to forty minutes we stood outside, no one would tell us anything. Later a doctor came out and said, ‘I need you to come into this side room,’ and that was the end.

NORTHAM: Kay’s death certificate records sepsis as her primary cause of death. Her sister Clare believes that Basildon Hospital could have done more to try to save her, particularly by giving an early antibiotic.

JUPP: The lesson we’ve learned is that we put too much faith in people to do their job properly and we were on that occasion severely let down. And had they have done more, we will never know, she could have been here today. What I know for sure is by giving no treatment, she had no chance. You try anything, you try anything and everything and I think they gave her nothing and I think she ultimately paid with her life.

NORTHAM: The hospital has told File On 4 that it does not accept that its treatment of Kay was poor. It points out that the Coroner recorded a narrative verdict and attributed no fault to the hospital over its care. But a letter to Clare Jupp from the Chief Executive does accept that Basildon Hospital failed to keep the family properly informed and offers:

READER IN STUDIO: Unreserved apologies for the areas where, with the benefit of hindsight, the treatment could have been managed differently.
NORTHAM: As for the missed chance to administer an early antibiotic, the Chief Executive says:

READER IN STUDIO: I wish to convey my sincere apologies that this opportunity was not taken and also that there is nothing that can now be done to alter your ongoing frustration and concern in relation to this point.

NORTHAM: One of the local MPs, the Conservative Jackie Doyle-Price, has taken up the case. She argues that it fits a pattern of low standards which have been repeatedly identified by the twin regulators - the CQC and Monitor. Identified, but not put right.

DOYLE-PRICE: We’ve had this whole series of inspections of the care regime at Basildon and we still find that it’s deficient, so there’s been a massive failure here on the part of the failure of the board to react to what was staring them in the face about poor care, but also regulatory failure, because no one’s been held to account for what’s gone wrong. Obviously, the CQC is the care regulator, Monitor is responsible for governance and for some reason nobody’s been held to account effectively and really enabled that change in performance. I’ve had regular discussions with Monitor about the issues at Basildon. It’s fair to say that, you know, we discussed the findings of the CQC, we had a very robust discussion about them.

NORTHAM: What does ‘robust’ mean?

DOYLE-PRICE: Well I was impatient …

NORTHAM: It normally means someone ends up with bruises!

DOYLE-PRICE: Well, I was certainly impatient that Monitor hadn’t played a more active role in trying to sort things out at Basildon. Their response was that actually things weren’t as bad as in 2009, so there was no reason to intervene, because things were getting better, even though they were still poor, but that isn’t good enough for me. My constituents deserve the best standards of care and they trust the regulatory system to help deliver it, and for me that was a failure.
NORTHAM: In a statement to File On 4, the foundation hospitals regulator, Monitor, says it intervened in Basildon four years ago because of concern about mortality rates and the care of patients in A&E. It says it still has concerns about clinical quality and will hold the hospital trust board to account for fixing them. As for the Care Quality Commission, the Chief Executive, David Behan, accepts that Basildon has failed again and again to meet proper standards.

BEHAN: I think Basildon raises some really important issues. The key issue is that they put one thing right and something else raises a concern and we require them to take action. But if we were to close a service at Basildon, where would the people that currently use that service go? If it just squeezes them on to the next hospital or the next system, that will raise important issues.

NORTHAM: That’s a pretty grim answer that, isn’t it? Saying you recognise that things aren’t going right at Basildon, that the hospital may, in some respects, be extremely substandard, but you don’t want to do anything about it because that would mean the patients had to go somewhere else.

BEHAN: But with respect that’s not what I said. I said our role is to ensure that Basildon can improve and that we’re committed to making Basildon improve.

NORTHAM: Why doesn’t it improve and stay improved then?

BEHAN: The improvement that will take place will not take place by what regulators do. Improvement takes place by what the leaders and boards of hospitals do. You cannot regulate quality into services. Quality exists in services because of the leadership of the hospital, the board, the doctor leadership, the nurse leadership ensures that quality is in those services.

NORTHAM: Well, what’s the point of all your reports then, saying you find these problems at the hospital – one gets better and another gets worse, then that gets better and another gets worse. What’s the point of that if you’re saying you can’t regulate quality into the hospital?
So what’s the role of a regulator? The role of the regulator is to check that those services are being provided to that, and where we find that the services aren’t, we identify for them improvements which need to take place. And our ultimate sanction, if those improvements don’t take place quickly enough, is to take regulatory action. Ultimately that may mean closing a service.

But that sanction, as David Behan acknowledges, is fraught with difficulties which make the CQC exceedingly reluctant to use it. So the main guarantor of proper standards in English hospitals has in recent years lost sight of its core purpose, it disbanded its specialist inspection teams, and has given glowing reports to hospitals with exceptionally high death rates. In some cases, even where it has identified serious problems, it’s been unable to ensure sustained improvement. Perhaps we shouldn’t be surprised that fourteen hospital trusts are currently under investigation by Sir Bruce Keogh, the Medical Director of the NHS. The question for the Health Minister, Dr Dan Poulter, is why it should take a special review team to find out whether too many patients have died. How is it possible that the regulator has permitted persistent high mortality rates? I mean, in some of these hospitals it’s ten years.

I think you have rightly pointed out the CQC has had a challenging history. It wasn’t, I believe, fit for purpose when it was originally set up.

‘Challenging’ is one of those polite words when people mean disastrous.

Well, it wasn’t fit for purpose when it was originally set up, that was very clear and that’s why, when we came into Government, we made it a priority to provide extra resources and extra direction of the CQC and beef up the inspection regime.

Is it your impression that, as he goes through these fourteen hospitals, the Medical Director of the NHS is going to find another Mid-Staffordshire lurking amongst them?

Well, we certainly hope not. We were concerned enough by the fact there were two years of a concerning mortality rate at fourteen hospitals and we felt that had to be investigated.
NORTHAM: And you’re not able to tell me that there might not be another or even more than one?

POULTER: Well, our concern is that we have to make sure that there are not other pockets of bad care in the NHS, and that’s what we have to make sure of, and it would be wrong of us not look into potential other triggers that could indicate that care is not good in some hospitals.

SIGNATURE TUNE