Transcript of Radio Ombudsman #6

James Titcombe, OBE, Patient Safety Campaigner: Making the NHS safer for patients

Rob Behrens: Okay, good morning everybody and welcome to Radio Ombudsman. All our guests are special, but this morning we have a very special guest and it's James Titcombe. It's very good to see you James, thanks for coming.

James Titcombe: Great to be here, thank you.

Rob Behrens: Now, it's a tradition on Radio Ombudsman that our guests tell us a bit about where they were born and brought up, and what values are associated with that. Could we begin by hearing something about that from you, please?

James Titcombe: Yes, sure. I was born in the Midlands in a little village called Cosby where I was brought up. My dad was a teacher, so he was a science teacher and my mum was a housewife for many years. She later became a teacher. Two older sisters and I had a very happy, kind of, childhood. Lots of education around in the house, home taught a lot about science and yes, a very happy, happy childhood.

Rob Behrens: Good, so you eventually went to work in project management in the nuclear industry. How did you get there?

James Titcombe: I studied engineering at Leeds and when I graduated, I got a job with a big engineering construction organisation. That took

me around many different parts of the world actually, so I worked in China and Vietnam a lot. When our first child was born, Emily, back in 2005, the life of travel was getting a bit tiresome and I wanted to settle down. I got an opportunity to work at Sellafield which is a big nuclear site in Cumbria. From 2005 onwards I worked there, first as a commissioning engineer and then later as a project manager.

Rob Behrens: What were the big issues, particularly around safety, that you took from that experience?

James Titcombe: I mean from day one really the safety culture was really, really embedded from the induction. I remember turning up at Sellafield, having the safety induction and hearing very, very powerful stories of people who have died at work and the lessons from that.

The whole culture, the culture of reporting, the culture of actually, it's professional to raise concerns and raise issues, and this whole ethos of taking all reasonable practical steps to reduce harm. There was no, kind of, set level where you reach a certain standard of safety and that's okay, it was always striving, 'Actually, what's the very safest way we can do this?' That was the kind of culture that I worked in for a long time.

Rob Behrens: And a decade ago you suffered an appalling and avoidable tragedy with the loss of your baby son. In the midst of this tragedy, you were let down by a number of number of National Health Service organisations including the Health Service Ombudsman. How did you deal with this at the time when the

temptation for many people would be to take time out just to grieve?

James Titcombe: Yes, and I think that is probably what I wanted to do, it's what my family wanted me to do, but the problem was I couldn't accept the answers that I was given. Firstly, you know, the local organisation, the way they responded, I just didn't accept that that was the case. The investigations that were carried out were poor, they didn't establish the truth and it was almost as if every time I pushed for answers, the walls came up, it became more and more defensive.

Eventually, I'd managed to lift the stone and what I found led to more questions and more concerns. That really is the way it's carried on. It's not been a conscious choice, but things have transpired so that I've had to carry on asking those questions. It's been quite an incredible 10 years. When I look back, I can hardly believe how the system responded and all the failures that have been uncovered.

Rob Behrens: You had a lot of doors closed to you, did you have a support network that enabled you to keep going?

James Titcombe: Definitely, yes. That came from other families, other families at Morecambe Bay and other families who had a similar harm. Family - very, very important, very, very supportive family, I have to mention them. And a few, kind of, almost insiders if you like - people in the system who were very, very supportive, and that's made a huge difference, I think.

Rob Behrens: Now, coming to our organisation, the Health Service Ombudsman, your interaction with us was extended over four or five years. Without commenting on the personalities, could you characterise the way in which you were treated and ultimately let down?

James Titcombe: Yes, I think there was, to start with, an overreliance on what the organisations were saying and a more dismissive approach perhaps to my concerns. A real lack of curiosity and scrutiny. Fundamentally, the logic within which the Ombudsman responded was a flawed logic. It was saying, 'Although we accept there are problems with the way Joshua's care has been investigated, we don't think there would be a worthwhile outcome in looking at it because things like medical records have gone missing, or because we think other organisations will have an oversight of the changes that are needed.'

At the end of the day, I think what happened there was mutual assurance and nobody actually looked at these serious issues that needed looking at. That led to, I think, risks going on for longer than they needed to.

Rob Behrens: The term, 'no worthwhile outcome,' has come back to me from a number of complainants in the last year who never forget it. What did it mean to you?

James Titcombe: It was an incredible statement to read in the assessment papers for Joshua's case. Yes, it's infuriating because obviously from my perspective and with hindsight there would have been an incredibly worthwhile outcome. That would have

been in identifying very serious issues that would have led to action being taken to help protect other mothers and babies. Yes, absolutely appalling and of course how can you make a judgement about whether something is worthwhile before you've tried? Yes, very inappropriate language I think.

Rob Behrens: I think one of the cultural issues for the Ombudsman was the assumption in its operations, up to that point, was that they could and should do deal with a very small number of cases, perhaps 400 a year, that they thought they could produce some positive results which would have an impact on the Health Service. That didn't take account of the many more cases where there were avoidable deaths and things to investigate. Your experience really brought that home, that you can't just confine it to a small number of cases, you have to think more widely than that.

James Titcombe: I mean really, Rob, thinking about this, and this has been my… I was very confused after Joshua died as to why I was dealing with a complaints process, OK? For me, this was about safety and it should have been a separate process. For me, in the future, what I'd like to see really is fewer and fewer cases of serious patient safety events having to come through the complaints system.

I think actually they should be recognised as serious patient safety events. They should be investigated with candour. Those investigations should be very high quality. They should involve the family. And actually if they're not done adequately, it shouldn't be for the complaints system to resolve that. The commissioners, the local systems should be quality assuring those investigations. In an ideal world, I would like to see fewer

and fewer patient safety events makes their way through to the complaints system. I think that would help with this problem that we have.

Rob Behrens: You're a champion of HSIB and the idea that an institution will take responsibility for modelling investigations into patient safety across the Health Service, are you?

James Titcombe: Yes, absolutely. I mean after Joshua died, and actually after babies that died several years before Joshua, had there been an investigation that said, 'Look, let's establish why this happened. What went wrong, what do we need to do to fix that?' Then I'm fairly convinced that Joshua would actually still be alive.

That shouldn't be a complaints process. If something happens on a construction site or in a nuclear industry and it's a safety investigation, you don't expect the family to raise a complaint about that. You expect there to be a thorough independent investigation that answers those questions. That's the way we should routinely be responding to these types of tragedies.

Rob Behrens: Do you think the Bill as it currently stands provides enough resource to HSIB to be able to do what you just said you wanted it to do?

James Titcombe: I think you're never going to have in health care a central organisation like HSIB that is going to be able to investigate independently every case of something going wrong. I think HSIB have an ambition to investigate around 30 systematic

issues in healthcare a year. The exception being maternity which perhaps we'll mention later, but the first line in the vast majority in these cases, the responsibility is going to be with the local organisation.

I think there is as huge task ahead, actually to professionalise that framework for local organisations to do those investigations. I think over the next few years I'd really like to see accredited training for investigators, a proper standards framework and proper quality assurance so that those investigations are happening locally to very high standards.

Rob Behrens: The accreditation will come from HSIB, will it?

James Titcombe: That is certainly one option yes, but what a step forward it would be. At the moment we've had so many reports saying huge variations. When the Each Baby Counts report looked at babies that had died in 2015, 25% of those investigations were too poor for the Each Baby Counts team to establish whether there were failures in care or not. Any step forward from that is going to be positive progress.

Any framework that actually says, 'These are the minimum standards. The people that do that the investigation need to be properly trained, these are the components of a good investigation that we're going to demand in these cases'. That would be a huge step forward.

Rob Behrens: My understanding from seeing what you've written and what you answer now is, is you want a clear separation although a link between patient safety and complaints on…

James Titcombe: Yes.

Rob Behrens: You don't see PHSO as being redundant in my understanding of what you're saying.

James Titcombe: No, not at all. I think in an ideal world, as things improve, as local investigations get better and better, you will naturally see less people feeling that their patient safety events that they've been involved with need to end up with a complaint to you. There will be circumstances where they do and it's perfectly right at the end of this process that people come to you and you will be the arbitrator of that process. In an ideal world, those serious patient safety events will be fewer and fewer that end up at your door.

Rob Behrens: I would agree. I would see us as being the last report of patient safety where it didn't work in the HSIB environment. In addition, there are lots of complaints that we receive that aren't about patient safety, they're about service delivery.

James Titcombe: Absolutely, and that's, for me, the real value of the Ombudsman should be. That's where the focus should be, that's what the complaints process should be about. I think it's a sign actually that we've had a poor, poor safety system in healthcare that so many people with a serious patient safety event who have suffered end up having to go through the complaints system as a way of getting answers.

Rob Behrens: Okay, so at my pre-appointment hearing last year, I told MPs about the profound learning that I took from how this office had handled your case. What do you think are the key lessons that the Ombudsman should take away from the way in which they dealt with you?

James Titcombe: There are many, many lessons. Fundamentally, the issues I was bringing to the Ombudsman's attention was: 'Look, this terrible thing has happened to my son. I don't believe that the local organisation has investigated it properly. If they haven't investigated it properly, how are they going to learn?' Yes, at that time, the Ombudsman was the only organisation I could go to, so I think a more rapid assessment process that simply looked at that fact: 'Has this been investigated properly or not?'

Had you done that, I think it was evident that the answer was no and a remedy…we talk about this language of remedy. The remedy I wanted was for there to be a proper investigation and for there to be learning. That investigation wouldn't necessarily have had to come, in my view, from the Ombudsman. It might have been a recommendation that the local organisation went away and did that proper investigation. That's one of the lessons I think - early taking a view of whether this has been handled properly or not.

There are many others. There was too much reliance on what the local organisation was saying. There was a lack of joined up working with other organisations, there was confusion and yes, there was a failure really, to get to grips with the issues that I was raising about Joshua's care.

Rob Behrens: One of the key things for an Ombudsman is to be independent of the bodies in jurisdiction. What you've described is unsatisfactory where there is an overreliance on what organisations are saying. That's interesting. Part of it, as you say, the word you chose was 'a lack of curiosity.' That's very important. You can't train for curiosity, but you can inspire it and you can incite it.

There are also issues about technical competence which trusts can hide behind as a way of putting people off looking further. It's about how you train people to deal with that as well as a mindset and a determination to look at it.

James Titcombe: I absolutely agree, yes,

Rob Behrens: Okay, now you've campaigned for a long time. Your campaign led to the investigation by Dr Bill Kirkup and his report was a damning condemnation of how things had occurred at the hospital. But, more than three years on from that investigation, it seems that there has been a lot of change. Not only in the hospital, but in the wider service. Is that accurate? Would you say that was true?

James Titcombe: Yes, that's absolutely true and from a family affected by these events, I've been keeping a very close eye on the Kirkup recommendations. Not all of them have progressed as fast as I would have liked to see, but actually looking back now, first of all, the local hospital has made incredible changes that I could talk about for a long time.

But nationally, yes there has been some really important stuff. There was the National Maternity Review which, although I

wasn't completely happy with every aspect of it, did result in this workstream to focussing on safety. Big focus on multi-disciplinary training and Tim Draycott's work at Southmead and the PROMPT [Practical Obstetric Multiprofessional Training] idea, obstetric emergency training, multi-disciplinary training, work…organisations like Baby Lifeline monitoring. Huge focus on multi-disciplinary work and safety in that regard.

Of course, we've seen the supervisory system which was one of the subjects of one of the Ombudsman's reports that there was a conflict in local supervisory investigations in maternity cases and the Serious Untoward Incident Framework. That system has been completely changed now which is good news.

Of course, the biggest change is we do now have HSIB and from April 2019, the cases that meet the Each Baby Counts criteria which would include Joshua - this is term babies with brain damage or term babies who are stillborn or die in the early neonatal period - will all be investigated independently by HSIB. One of the big lessons from Morecambe Bay was that we are simply not learning from these events. I'm really optimistic that that programme of work through HSIB will really result in some major changes in safety in maternity.

Rob Behrens: This work is unfinished and it's still ongoing. Only a week ago, we had the report into the Nursing and Midwifery Council which was hugely critical of the cover-up of issues that you had raised with them about fitness to practice. It's not a simple issue. Could you say something about leadership in this respect? A lot of people raise this. You can't have meaningful change unless you have leaders prepared to take responsibility for delivering this. How have you found the leadership issue in the Health Service?

James Titcombe: Very, very, very, very important and it makes an absolutely huge difference. The example I can give you is in 2013, major critical report about CQC's handing in Morecambe Bay. It was called the Grant Thornton Report. The report accused the CQC of a cover up. What really struck me about that was just how frank the new leadership team were, so this was David Prior and David Behan, about that.

I remember being quite shocked listening to David Prior on the news saying somethings that I would be worried about saying. He was explicit about the failures in the organisation. There was confidence that they really had diagnosed what the cultural issues were and they weren't hiding away from it.

Actually, those chaps, the two Davids, David Behan and David Prior, they came up to Cumbria. I remember this very powerful meeting they had with some of the families affected by Morecombe Bay. They were going around asking the families their stories and really listening. What became apparent was that they were families there whose babies had died avoidably after CQC gave the green light on the maternity unit at Furness General Hospital. I think their eyes were wet, there weren't many dry eyes.

I remember David Prior very clearly acknowledging, we have to be clear that had we not missed these opportunities, your baby might have survived. I think if you have that level of understanding, that level of ability to hold your hands up and accept what's gone wrong, it can perhaps provide a foundation from which to make positive change. It does come down to good leadership.

Rob Behrens: David Behan is very interesting. I mean, he was a guest of Radio Ombudsman [ADD LINK TO PODCAST] and one of the things that I take away from what he said was that he brought to the task, a background in social work which is very unusual for a senior Health Service person. It shows that having the experience of being on the ground is very important in understanding and relating to people.

Just moving it on a bit, I mean, you then went to work for CQC which many people thought was a brave thing to do. What was that experience like?

James Titcombe: Well, I mean, at the time, of course I was still working at Sellafield. I was enjoying my job, but more and more of my focus had been on getting to grips with Joshua, learning about patient safety. I became a little bit enthusiastic about patient safety and about the contrast between the culture I was used to working in and what I'd learned about the healthcare system.

It was actually at the meeting when the two Davids met families at Morecambe Bay. I stayed behind after that meeting and had a long conversation with them and reflected some of the culture and ways of working I was used to in the nuclear industry. This suggestion came, 'Why not come and do some temporary work with CQC?'

To me, that was a great opportunity to influence things. I did a temporary six months work, really enjoyed it, really enjoyed working with the people and then was interviewed for a permanent role at CQC which I very much enjoyed. No regrets at all, it was a really, really exciting time for me and a time when I think we made some positive changes and made a difference.

Rob Behrens: We're moving towards the end, but I want to use the time as best as I can. Tell us about your career after leaving CQC.

James Titcombe: Yes, it was actually at the launch of my book. We were very lucky that the book launch was sponsored by a company called Datix. Datix, as many people will know, are patient safety software, incident reporting systems and I had a very good conversation with them. Yes, a mutual kind of, agreement that I might come and do some work with Datix which was fantastic, you know, developing new software with them.

More recently, one of the founders of Datix, a chap called Jonathon Hazan approached me with the idea, why don't we set up our own patient safety organisation? For the past 12 months really, I've been working with Jonathon and we've been growing a small team of people. We're thinking about how could we do something different?

It's a very exciting time. We've just launched our new organisation. We're just in the process of applying for charity status and we're planning some really exciting work around sharing learning, around culture change and hopefully that's where I'm going to be working for the foreseeable future.

Rob Behrens: You're far too modest to promote you own book, but it is a classic account. It's required reading for anyone who's interested, not only in patient safety, but in what Ombudsmen have to do. It's published by Anderson Wallace Publishing, it's called *Joshua's Story: Uncovering the Morecambe Bay NHS Scandal*. It's a brilliant book. How long did it take you to write that?

James Titcombe: Well, I suppose in essence, I was writing it ever since Joshua died. Hard, hard work and probably a year of deciding I'm going to write the book to actually finishing it. I have to mention, my good friend Helen Hughes who was prompting me very regularly and giving me encouragement. Yes, it's been a rewarding thing to do and I'm very glad that I managed to get the book published.

Rob Behrens: I want to ask two final questions, if I may. We've talked about HSIB. We've talked about how patient safety, partly by your own personal efforts, has come up the agenda of the Health Service, it's recognised by the Secretary of State and so on. Do you see any causes for concern about the future of patient safety in a situation where the Health Service is desperate for resource?

James Titcombe: Yes, I think you've hit the nail on the head. I think the risks to this are very much around workforce, resources and cost and we've seen this being a huge pressure. I saw David Behan talking about an expected decline in standards possibly next year. The government, at the moment, is focussing on a long-term plan.

My personal view is if the NHS needs more money as a taxpayer, I'd be very happy to fund that. So of course, those are huge issues and we've got to the basics right. We've got to have the right number of staff on the wards. The last few years, I don't know whether I'm in the minority or not but I think political leadership has been very important that we've actually had that focus on patient safety. I think if that changed, I'd be very nervous about whether we could slip backwards.

The most fundamental thing for me, Rob, is that we, as in the nuclear industry safety is professionalised, I think in healthcare over the next few years we've got to see patient safety as being professionalised. It should be the pinnacle of peoples' careers and recognised, and a whole framework around the profession of patient safety. If we get those things right, we will head in the right direction.

Rob Behrens: Okay, thank you. Now, you're recognised as a resilient and influential campaigner and your work has been recognised in the Honours List, but what is disturbing is that you've also experienced substantial and entirely unacceptable abuse from lots of people. From disaffected nurses and midwives, but other people as well. How do you cope with that?

James Titcombe: Yes, I mean in context it's important to say that the vast majority of feedback I get, and interactions, are lovely and positive but there has been this, kind of, darker side. There are few reasons, I think locally there have been people who have obviously been affected by the investigation and there are one or two really unpleasant things that happened. You know, almost stalking type of behaviour. It's upsetting and horrible. The only way I think to deal with that is to ignore it and to not feed it.

The other area of criticism is the Morecambe Bay report had some findings that not everybody agreed with. There was the finding around the focus on normal birth and inappropriate focus on normal birth, and there are elements I think within the midwifery community that find that a very difficult area of discussion.

Yes, I think it's almost those things. Criticism is fine, disagreement's fine, but I think the thing I found difficult is the personal attacks. I guess it can't stop you. I have to stand up for what I believe is right and I'll continue to do that. But yes, it's been an unfortunate aspect of the last few years, without a doubt.

Rob Behrens: Well, you are a role model for resilience and principled campaigning. Just as a very final question, there are perhaps 300 people who work for the Ombudsman. Most of them are young graduates, out of university a couple of years, fashioning their careers. What advice would you give to them following your experience?

James Titcombe: I think first and foremost actually, every person in the Ombudsman has a fantastic chance through their role to make a real difference to people and don't lose sight of that, really. The work that you do day in, day out can make a massive difference to families.

Ultimately, if you get these decisions right it can save lives as well, so keep that in mind and keep those values at the core of what you're doing day in, day out.

Rob Behrens: James Titcombe, thank you very much indeed.

James Titcombe: Thank you, Rob.