A Collapse in the Culture of Care
The Stafford Hospital Inquiries

Professor Brian Edwards

“How could all this happen and we not see it”.

2005-2009
Professor Brian Edwards is a former Dean of the School for Health and Related Research at the University of Sheffield where his chair was Healthcare Development or as he has described it; “How to make medicine work…consistently well”.

Prior to this he had had a long and distinguished career at all levels in NHS Management including Chief Executive of two NHS regions.

For some years he chaired the Regional General Managers group in England which acted as the primary managerial interface between the NHS and the Department of Health. In the regions he managed financial discipline and a focus on patients went hand in hand.

He led one of the earliest attempts to introduce ideas about service excellence and patient focus into the NHS. He was President of the Institute of Health Services Management and of the European Hospital Federation [HOPE].

He was the first Chair of the patient empowerment group within the Department of Health and led a major review of Volunteering in the NHS.

He became Chairman of one of the largest mental health trusts in the country.

He remains in great demand as a speaker and writer on health policy.
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The full text of the Mid Staffordshire NHS Foundation Trust Public Enquiry is to be found here.
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KEY EVENTS TIME LINE


1993
New Stafford Hospital commissioned.

2002
Local Authority Oversight and Health Scrutiny process commences.

2001
Jan – First Annual Dr Foster guide shows that Stafford Hospital had a higher than expected HSMR at 108.

2003
Jan - Community Health Councils replaced by the Commission for Public and Private Involvement in Health and local Public and Patient Involvement Forums.

May – David Nicholson appointed Chief Executive of Birmingham and Black Country SHA and from 2006 all the SHAs in the West Midlands

July - Commission for Health Improvement [CHI] raises Mid Staffordshire NHS Trust from two stars to three stars.

2004
Apr - Healthcare Commission [HCC] replaces CHI.

July - Trust loses all its stars based upon its performance in 2003/4.

Oct - Toni Brisby appointed as Chair of the Trust

2005

June - David O’Neil resigns as Chief Executive of the Trust and is replaced by Martin Yeates in September.

July - HCC award the Trust one star.
Dec - Trust is advised by David Nicholson that it is two years away from foundation status.

2006
Jan – West Midlands Specialist Commissioning Group warn the Trust that its services for critically ill children present an immediate risk to clinical safety.

Jan - Local Press claim that town hospital was in a squalid mess.
Mar - Trust decides to reduce costs by reducing staff by 170 posts.

May – Trust appoints Karren Morrey as Chief Operating Officer.

May – HCC tell Trust that it has serious concerns about the accident and emergency service. 
June - David Nicholson moves to London SHA and within four months is appointed Chief Executive of the NHS..

July - Cynthia Bower takes over as Chief Executive of the West Midlands SHA.

Sep - Dr Val Suarez becomes Medical Director of the Trust.

Oct - South Staffordshire PCT created by merging four former PCTs.
Oct - Trust assessed as Fair/Fair in 2005/6 Annual Health Check

Dec - Helen Moss takes over from Jan Harry as Director of Nursing.

Dec - Monitor and Trust have Board to Board meeting.

2007

Jan - HCC Hygiene Code Inspection at Mid Staffordshire is positive.

April- Dr Foster Good Hospital Guide shows Trust had a higher than expected mortality ratio [127] and that the West Midlands SHA had six of the ten highest in England.

Jun- SHA commission team from Birmingham University to review mortality data.

Jun - Monitor begins the review of the Stafford Trust application for foundation status.

July – Dr Foster Unit sends Trust a series of mortality alerts.

Oct- HCC grade Trust as Good/Fair in Annual Health Check.

Oct- First Royal College of Surgeons Report.

Dec – Monitor/Trust Board to Board meeting

2008

Jan - Cure the NHS created by Julie Bailey following the death of her mother.

Feb-Trust granted foundation trust status

Feb- Julie Bailey writes to every member of the District oversight and scrutiny committee expressing her concern about care at the hospital

Mar-Trust considers nursing skill mix review and agrees 50 extra nurses.

Mar- HCC launches investigation at Mid Staffordshire Trust
Aug-CURE hold candle lit protest at hospital

Sep-Heart of England Team review A and E services at Trust.

Sep – LINks starts to operate

Oct-PCT makes unannounced hygiene check at Trust. Full compliance with mandatory duties reported.

Oct- HCC rate Trust Good/Good in Annual Health Check.


2009


Mar-Sun newspaper leads with headline “Chaos kills upto 1200 in one hospital”

Mar-Chair [Brisby] and Chief Executive [Yeates] of the Trust resign.

Mar- Interim Chair [David Stone] and Chief Executive [Eric Morton] appointed by Monitor.

Mar- National Quality Board meets for the first time.

Apr- Commission for Quality Care [CQC] takes over from HCC.

Apr - Dr Manjit Obhrai takes up his duties as Medical Director of Trust.

Apr-Alan Johnson Secretary of State and the Chief Nursing Officer visit Stafford and meet CURE at the Breaks Café.

Apr-Reports by Prof George Alberti and Dr Colin Thome published

Apr-David Cameron, Leader of the Opposition visits Stafford to meet CURE.

May-CURE present their report “Turning the NHS the right way up” to Alan Johnson and Andrew Lansley.

Jun- Andy Burnham appointed Secretary of State for Health

Jun-CURE give evidence to Health Select Committee who remain unconvinced of case for a public inquiry.

July – Second Royal College of Surgeons Report presented to Trust.

July - Independent Inquiry [First Inquiry] announced by Andy Burnham.

Aug-Antony Sumara takes over as Chief Executive at the Trust.

Sep-Julie Hendry takes over as Director of Nursing
Sep - CURE publish “Turning the NHS the right way up again; starting with Stafford Hospital.”

Oct - Ken Lownds makes a presentation to the Conservative Conference.

Nov - First inquiry begins oral hearings.

Nov - Helen Moss resigns as Director of Nursing.

2010

Feb - First Francis report is published [HC-375-1]

May - General Election and Coalition government Con/Lib formed

Jun - Andrew Lansley announces that the second inquiry would be a public inquiry under the Inquiries Act 2005.

Nov - First day of oral evidence at the second inquiry in Stafford.

2011

Sep – Lynn Hill-Tout appointed as Chief Executive of the Trust.

Dec – Oral evidence to Public Inquiry ends

2012

Feb - Prof John Caldwell appointed Chair of the Trust

2013

Chapter One

The First Inquiries; The hospitals

Stafford District General Hospital has been the focus of a number of Inquiries in recent years over and above the normal inspection regimes that apply to all hospitals in the NHS. It is a relatively new hospital commissioned in 1983 with around 350 beds and is situated on the outskirts of Stafford. It provides a standard range of acute services as well as a maternity unit delivering 2000 babies a year and an accident and emergency service visited by around 75,000 patients each year. The Trust also manages Cannock Chase Hospital which is a modern centre for musculoskeletal and rheumatology but also provides specialist services for the elderly and a minor injuries unit. Between them the hospitals serve a local population of around 320,000.

Both hospitals form the Mid Staffordshire NHS Foundation Trust.

This is a standard NHS hospital described by many witnesses as unremarkable and unexceptional. Yet beneath the surface some parts of the hospital were profoundly dysfunctional and in the words of Robert Francis QC the lawyer who had led the major inquiries offered an “appalling experience” to many patients.

So what went wrong and why did nobody in the Trust blow the whistle? Was everybody experiencing organisational blindness? Why did it take so long for the higher tiers of the NHS and the independent regulatory bodies to spot and correct the problems? These questions have been at the heart of the first and second Inquiries.

First Signs

The first significant signs that things were not well at the hospital emerge in January 2006 when the local press published a story under the headline “Town hospital in squalid state”. The story came from a member of the local Patient and Public Involvement Forum [PPI] Mr. Terence Deighton, a man with a background in product safety, risk management and health and safety. His first contacts with the hospital had been focused on telephone services for patients and particularly the cleanliness of the phones provided by a private company. The phones were not cleaned between patient uses. He started to ask questions about cleanliness generally and brought his analytical experience to the fore by commenting on the criteria used to assess cleanliness in the hospital as a whole. He also commented on the lack of training for cleaning staff. His critical comments were not welcomed by his PPI colleagues and he fell out with the Chair. The PPI was in his view like an “old pals network” which included the hospital. The PPI Forum was, he claimed, always reluctant to discuss press reports about poor care. That was the duty of others. Most PPI members thought that the hospital was fine and that their job was to support its development.
In January 2006 Terrence Deighton and two colleagues made a formal visit to the hospital to look at, amongst other things, cleanliness. He selected the Accident and Emergency Department for review whilst his colleagues visited the wards. The chairs in the waiting area were dirty and smeared with congealed blood. The carpet in the children’s area was filthy. The floors were equally dirty and the lavatories disgusting. The emergency assessment area had a bowl with scum in it and a bin overflowing with paper. He thought that the receptionists were effectively acting as triage nurses and observed that doctors were moving from one patient to another without washing their hands.

The modern matron who had accompanied him claimed to be as alarmed as he was at what they had found.

He wanted to summon the Chief Executive to come and see the problem for himself, but his colleagues, the chair and vice chair of the PPI, refused and insisted on following the protocol that had been agreed with the Trust for handling complaints and problems.

He resigned and a few days later went to the local press. The Stafford News Letter and Express and Star gave his story a lot of prominence.

Shortly after the story had appeared in the press the hospital got a local solicitor to write to him to the effect that as he was no longer a member of the PPI, if he set foot in the hospital again “appropriate action would be taken”. Despite the threats he continued his campaign through the PALS and complaints system. Eventually he got to meet the chair and chief executive of the Trust but they did not appear to want to listen..... he was a troublemaker. He had a similar experience with the local Overview and Scrutiny committee and his local MPs.

He was briefly appointed as Chair of the Stafford LiNks but resigned before the first meeting because of a lack of clarity about its purpose and aims. He was clearly not an easy man to deal with and was regarded by the chair of the PPI forum as a maverick. Difficult as he was he appears to have been right. Later attempts to draw him in to help the hospital never really worked.

Amongst those who were also reading the critical local press reports was Robin Bastin a retired university lecturer who had had a bad experience at Mid Staffordshire with the treatment of his daughter in 2005. He made contact with Terence Deighton and decided to join the PPI. It was a bit like the Women’s Institute he thought. As a group they did not want to rock the hospital’s boat. They were, in his view, more like the League of Hospital Friends than a patient pressure group.

He began to take a close interest in hospital acquired infection at the hospital and doubted the reassurances he had received that the problems were just the result of a winter vomiting bug. He was alarmed when he read in the minutes of the Hospital Infection Committee [sent to him by mistake] that in 2006 there had been 420 cases of C.Difficile which sounded to him very much like an epidemic. After talking to Terence Deighton he decided to leak the report to the press because he was sure that the PPIF would not want to discuss his concerns. Then, as he put it, the trouble began. The Forum accused him of breaching the code of conduct and the Chair told him that he would not be allowed to have any contact with the hospital in the future. The forum cancelled a planned unannounced visit to the hospital as all the adverse publicity was causing problems for the Trust. Robin Bastin was effectively forced to resign.
He continued his campaign in a personal capacity with the Healthcare Commission who shared with him their growing concern about the high infection rates at the hospital and the manner in which the problem was being managed. The HCC told him that one of the problems was the absence of an isolation ward. Patients with infection were being shipped out to Cannock Chase Hospital he was told.

Like Terrence Deighton he joined the Stafford LINks, the successor organisation to PPI but found it full of the old guard from the former organisation. It was in his judgement just a bureaucratic talking shop dominated by the County Council.

In this capacity he met Ben Bradshaw the minister for health who congratulated him on being a whistle blower about infection control.

Rod Hammerton the Chair of the PPIF clearly had problems with his two mavericks and came under some pressure from the Chair of the Trust to make them behave. Matters came to a head at one meeting when Terence Deakin accused him of being more concerned to foster his personal relationships with the hospital[both he and his wife had been patients] than fulfilling his role as chair of the PPIF. Eventually he effectively sacked them. Despite his evidence that relationships with the Trust became more difficult after they secured foundation status he became a public governor. He resigned after the HCC report which he found shocking. He simply could not understand how he had not known about the problems and had to conclude that there were particular individuals who had blocked information and prevented him from seeing the full picture. If he had listened more closely to his two mavericks the picture might have become clearer sooner!

But the Trusts problems with what they must have regarded as the awkward squad were nothing compared with what was to follow.

**Julie Bailey and Cure the NHS [CURE]**

Julie Bailey created CURE in January 2008 following the death of her mother Bella in Stafford General Hospital. For the eight weeks preceding the death she and her family had cared, as best they could, for her mother on the ward. It had been a bad and dispiriting experience during which they saw things that it was hard to believe could happen to vulnerable adults.

Patients were basically left to fend for themselves. Few of the staff seemed to care.

Half the staffs on ward eleven were older more established staff known as “the rough ones”. “You could hear them dragging the weak out of their beds saying nothing if working alone. If working with another carer they talked over the patient. Once they had dragged them out of bed they left them sitting in a chair uncovered until breakfast at 9am. Some patients were left in those chairs until 11.0 at night.”
Patient Story

An 86 year old patient was referred to Stafford Hospital by her GP in September 2007 complaining of recurring vomiting. Accompanied by her daughter she was taken to the emergency assessment unit [EAU] where the staff were caring but her mother who was hard of hearing struggled with the number of junior doctors who were constantly in and out of the unit. She had to explain her mother’s symptoms a number of times and felt that there was a lack of co-ordination between nursing and clinical care. After three days in the EAU her mother was taken by a porter to ward 10; a mistake as she was supposed to go to ward 11. She was left unattended for some time until later that evening she was transferred to ward 11, a ward described by the daughter as one in utter chaos. The chaos intensified at night when patients wandered around and approached other patients. Buzzers were constantly going off and it was extremely difficult to locate staff. She described weekends as “complete madness” when there were even fewer nursing staff available and no doctor on the ward. The patient was taken to another ward for a gastroscopy but without the oxygen supply she needed. The porter said he was in a hurry so she was moved without it.

Following the procedure there was a delay in bringing the patient back to ward 11 whilst nursing staff disputed whose responsibility it was to collect her. On her return to the ward the patient was not connected to her oxygen supply. She collapsed in a chair and her family struggled to find anyone to help. A doctor was finally found and several minutes later asked the daughter to sign a Do Not Resuscitate Order as her prognosis was very poor. The family were shocked and vowed never to leave the patient alone in the hospital again. Over the weeks her condition improved and a date was set for her discharge from hospital. One evening the patient needed help getting back into bed. A healthcare assistant attempted to lift her on her own and dropped her. The patient’s head hit the bedframe and she fell unconscious. It was not until two days later that the patient was assessed by a doctor who demonstrated little concern or interest.

The daughter became increasingly concerned and when she raised her concerns with a nurse she was given a medical book to look through and see if she could identify her mother’s symptoms. She saw immediately that the symptoms were indicative of heart failure. It took four days for her mother to be seen by a respiratory specialist who confirmed that the problem was her heart. Several days later the family were told that the patient needed a blood transfusion which would be done very slowly along with the drug frusemide which would eliminate the majority of any risks. The transfusion took place two days later in the evening but not slowly as had been promised. The daughter looked at the patients drug chart and realised that the extra frusemide had not been given. Don’t moan said the sister...because I have had no break today. The night nurse had put her hands on her hips saying that she was in charge of the ward and would decide when a doctor was to be called. The standard dose of frusemide was given at 4am but no record could be found of the extra dose being given.

The next day the patient died.

When asked to describe the nursing culture on ward 11 the daughter said “They were bullies. They bullied the other staff and they bullied the patients. There was no word for it; particularly in the two weeks when mum was dying, effectively they were calling out for the toilet and they would just walk past “

Source; First Independent Inquiry. February 2010.

Julie Bailey, who had a background in social care, made a formal complaint and wrote to both the local newspaper and the Health Care Commission. Calls and letters flooded in from patients and relatives who had had similar experiences. The Trust had apologised to many of those who wrote in but it was judged as a familiar excuse by the patient group that was growing around Julie Bailey at
her café in Stafford. She and her group talked to MPs, the Local Authority Oversight Committee and anybody else who would listen to their arguments about the need for change at the hospital. In October 2008 whilst the HCC team were investigating the Trust, CURE was joined by Ken Lowndes who offered his expertise and political contacts.

He and his family had had extensive contact with the University Hospital at Stoke over many years and he had been actively involved in the Stoke PPI and had been chairman since 2005. He had been involved in safety in the construction industry and had extensive political connections. He wrote to Anne Keene who was then the Parliamentary under Secretary of State for Health, and a former nurse, about the sorry state of care at Stafford Hospital. “This was not why I worked so hard to get you elected”, he challenged. How could this happen? “He also wrote to William Moyes, the Executive Chairman of Monitor the foundation trust regulator, asking him to come to Stafford and help make a fresh start after the Board and senior executives had been cleared out.

Between them Julie Bailey and Ken Lowndes started to work on the local MPs with some success with Bill Cash M.P being particularly helpful. They kept in very close touch with the local newspapers. After the HCC report had been published AVMA got in touch with Julie Bailey and offered their support and helped organise a public meeting in Stafford attended by over 100 members of the public and addressed by all three local MPs.

They also reviewed 24 cases referred to them by CURE and helped a number of families through the independent case note review process. CURE was building a powerful set of partners which included the Patients Association and its new president Richard Branson.

Over time CURE became a tight self-supporting group which campaigned vigorously for change at the hospital and for an independent inquiry. They produced a survival guide for patients and in May 2009 they presented their report “Turning the NHS the right way up” to both Alan Johnson the Secretary of State and his Conservative opposite number Andrew Lansley.

Ken Lowndes spoke at the Conservative Party conference in October 2009 about Stafford hospital and CURE’s plans for the future of the NHS.

The Trust and a number of other NHS organisations tried to build a relationship with CURE but none had any real success. They were refused membership of the Staffordshire branch of LINks. To many they were regarded as the enemy. As well as engaging very successfully with the national media they held silent demonstrations outside the hospital to light candles and kept up the pressure through the local media. They built a wall of shame upon which the names of many Trust staff appeared. They had become a very powerfully lobbying group.

The chair of the Trust told the first inquiry that they were a self selected group and their views were not representative of the wider community. The Trust governors were discouraged from talking to CURE because they were protestors. Cure were eventually invited to attend the AGM of the Trust when the families were each given three minutes to tell their story. Some Trust governors were reported to be in tears. After a short break the meeting continued with its formal business as if nothing had happened. Nobody really listened said CURE.
In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for a nurse, Nurse, Nurse, and it just went on and on. Then very often it would be two people calling at the same time and then you could hear them crying, like shouting nurse louder and then you would hear them just crying, just sobbing, they would just sob and you presumed that they had wet the bed.

The daughter of a patient in ward 11

The Trust never got the measure of this powerful group. They regarded CURE as hostile and negative and deliberately getting in the way of those who were trying to turn the Trust around. This view appears to have been shared by some of those in the higher realms of the NHS.

CURE did not want reassuring words or sympathy; they wanted the management of the hospital to be as angry as they were about what had happened. They wanted action now and the heads of those judged to be responsible. Only Anthony Sumara, who took over as Chief Executive in the summer of 2009, seemed to understand this. Eventually the principle goal of CURE became the establishment of a national public inquiry. There was little the Trust could do to convince them that the service was improving. The battleground had shifted to London.

The Healthcare Commission Report

During the summer and autumn of 2007 the Healthcare Commission became aware of apparently high mortality rates for specific conditions or operations at the Trust. The Dr Foster hospital guide published in April 2007 showed that the Trust had a hospital standardised mortality ratio of 127 for 2005/6, in other words more deaths than expected. The Trust investigated but put most of its energy into challenging the data and in this they got some support from the Strategic Health Authority who commissioned their own review of the Dr Foster analysis. The HCC were not satisfied with the Trust response and in March 2008 launched their own investigation focusing particularly on patients admitted as emergencies.

We got there about 10 O’clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn’t got a stitch of clothing on. I mean she would have been horrified. She was completely naked and if I said covered in faeces it was everywhere. It was in her hair, her, eyes, her nails and on all the cot sides so she had obviously been trying to lift herself up and move about as the bed was covered and it was literally everywhere and was dried. It would have been there a long time. It was not new.

A patient in the Emergency Admission Unit

The report took a year to produce, which was of itself a matter for serious criticism by some who argued that a quicker report would have enabled corrective action to have been started much sooner than it did. The investigation team was led by Dr Heather Wood who had read medicine at Trinity, Dublin but practiced only briefly before taking up a teaching post in anatomy and pathology at the University of Surrey. She later became a Director of Commissioning for the Isle of Wight Health Authority. She and her team’s principal finding were;
Many patients and relatives thought that nursing care was poor. The Trust was in the worst 20% in England for overall standards of care. Patients complained that when patients rang the call bell because they were in pain or needed to go to the toilet it was often not answered. Tablets or nutritional supplements were not given on time, if at all, and doses of medication were missed. Patients were left sometimes for hours in wet or soiled sheets putting them at increased risk of infection and pressure sores. Wards, bathrooms and commodes were not always clean. Nurses often failed to conduct observations and identify that the condition of a patient was deteriorating, or that they did not do anything with the results.

Mortality was higher than expected for emergency admissions but not for elective admissions. Between 2005/6 and 2007/8 the Trust SMR for patients admitted as emergencies varied between 127 and 145. There was only a 5% chance that these high rates were a statistical aberration. The Trust had concentrated on clinical coding as the explanation for poor outcomes and there was a reluctance to acknowledge, or even consider, that the care of patients was poor.

There were systematic problems across the Trust’s system of emergency care with deficiencies at virtually every stage. The Accident and Emergency Department was understaffed and poorly equipped. There were too few Consultant Medical staff in the specialty. Junior doctors were not adequately supervised and often put under pressure to make decisions quickly in order to avoid breaches of the national target for all patients to be seen and moved from A and E within four hours. The Emergency Admission Unit was busy and frequently chaotic. Communication between nurses and patients and nurses and doctors was poor.

The general surgeons did not work well together and there were few agreed protocols in surgery. There were not enough doctors on duty out of hours and the most senior surgical doctor after 9pm at night could be quite inexperienced. The Trust did not always comply with deep vein thrombosis national guidance.

The Trust had a weak system of clinical governance and performed poorly on clinical audit. The Board seemed to be insulated from the reality of poor care.

In order to stabilise its finances the Trust set itself a target for savings of £10m which represented 8% of its turnover and involved the removal of at least 150 posts. They did not properly assess the consequences of this decision. A badly managed reorganisation of the wards and a reduction in beds meant that the care of patients was compromised. The top priority of the Trust Board was Foundation status.

The HCC did report some changes since it had begun its investigation and gave the Trust credit for improvements in the prevention and control of infection.

When the HCC report was published in March 2009 [just as the HCC was closing down to be replaced by the Care Quality Commission] it caused a storm.

Ministers had had some days’ notice that a highly critical report was to be published and it was discussed in some detail at a meeting held with Alan Johnson the then Secretary of State and his senior officials. It was at this meeting that he asked for the statement in the draft final report that
there had been between 400 and 1200 excess deaths be deleted on the grounds that it was speculation based upon a statistical analysis and could not be linked to actual deaths. Despite this action the numbers were leaked to the media. “The killing fields of the NHS” was one of the worst headlines. The Sun led with “Chaos kills up to 1200 in one hospital.”

In his statement to the House of Commons Alan Johnson talked about astonishing failures at every level. The standards of care at the hospital were, he said, appalling. He demanded a case by case review of patients who had died, which was eventually commissioned by the PCT rather than the Trust.

The Department of Health asked two members of its senior clinical staff to visit Staffordshire and undertake two rapid reviews. They did this in April 2009 and reported at the end of that month. Dr David Colin Thome the National Director for Primary Care agreed with Sir Ian Kennedy who had described events in Mid Staffordshire as “A story of appalling standards of care and chaotic systems for looking after patients”. He placed the prime accountability firmly on the shoulders of the Board and its professional staff but indicated that the PCT and the SHA also had a role to play. The Trust had demonstrated a closed culture. He advised more engagement with patients and the public, the commissioning of NHS care by outcomes, effective clinical governance and proper clinical leadership. Professor Sir George Alberti who had been sent in to look at emergency care broadly confirmed these findings but reported that the accident and emergency department was now providing safe, good quality care.

These reports were both damning and at the same time reassuring about the corrective action that had been taken. However they did not convince CURE who continued to campaign for an independent Inquiry. Dr David Colin-Thome was well received by CURE...he listened to us carefully they said. They found Professor George Alberti more difficult as they thought that he did not engage with them properly.

CURE and the Patients Association then launched a national petition calling for a truly independent Inquiry. The signatories included Nick Clegg the leader of the Liberal Party and future deputy Prime Minister.

Alan Johnson met with CURE at the Breaks café shortly after the HCC report was published with Christine Beasley the Chief Nursing Officer from the Department of Health and followed this up with a meeting at his office in London. It did not go well particularly as Mario Dunn his political advisor suggested that CURE should stop criticising the staff and the hospital and move on. David Cameron visited the café in April 2009 and promised his support for a public inquiry. “We need to make sure that this can never happen again” he told the press. Stafford was now at the centre of a political storm.

The new Care Quality Commission who had taken over the regulatory role from HCC in April 2009 undertook a stock take of what had happened at the Trust in the transition and whilst acknowledging that there had been some progress reported that there was much more to do.

The Secretary of State would have removed the Trust’s foundation status but found he did not have the power to do so.
The Chair and Chief Executive of the Trust, who thought that the evidence base for the HCC findings was very dubious, resigned shortly after the HCC report was published much to the dismay of the staff and the surprise of CURE who had had no advance notice. After some serious hassling between the Department and Health and Monitor, the Foundation Trust regulator, an interim Chair David Stone and acting Chief Executive Eric Morton were appointed. They were only in post for four months whilst permanent new appointments were made.

In July 2009 the patient groups secured a major victory when Andy Burnham the new Labour Secretary of State announced a further independent inquiry to be chaired by Robert Francis QC. It fell short of a full public Inquiry and whilst evidence would be taken on a confidential basis a summary of the evidence would be made public as would the final report.

He wanted the inquiry completed quickly so as not to impede those staff who were charged with making improvements at the hospital. The Inquiry were not asked to consider or determine whether there were failings in individual cases or to seek to apportion blame for any such failings.

The Inquiry would proceed in a manner that encouraged cooperation, openness and frankness. The inquiry was seen by the politicians as a means of rebuilding confidence and restoring trust in the hospital. There was a strong sense at the top of the NHS that the problems in Stafford were now clear and what was needed was action to resolve them.

The First Independent Inquiry

Robert Francis QC started his first inquiry in September 2009. He actively sought to encourage the participation of local people, staff, former staff and members of the Trust.

He accepted written statements from national bodies before a month of oral hearings. Hundreds of those who contacted the inquiry reported that they or their relatives had not received the standard of care to be expected from a modern hospital in Great Britain.

Counsel for the Inquiry listed the typical examples;

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<td>1</td>
<td>Patients being left unattended for so long that they soiled their bedding and in some cases being told to defecate in their beds; then left in soiled beds; soiled bedding not properly cleaned; in one case the patient’s wife was handed the sheets to clean.</td>
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<td>2</td>
<td>Patients left on commodes for extended periods.</td>
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<td>Patients left unwashed</td>
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<td>Catheter bags left un-emptied</td>
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<td>Call bells and calls for help left unanswered despite obvious need for assistance.</td>
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<td>Patients left without food and water, generally because they were unable to help themselves; a common theme is that visitors had to feed their relatives and others on the ward.</td>
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<td>Extremely poor hygiene</td>
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<td>Medication not administered or properly recorded</td>
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<td>9</td>
<td>Lack of information about or knowledge of patients condition by ward staff</td>
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<td>10</td>
<td>No provision of pain relief</td>
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<td>11</td>
<td>No adequate or proper control of infections such as Clostridium Difficile</td>
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<tr>
<td>12</td>
<td>Patients left unattended for extended periods in A and E or discharged or transferred inappropriately</td>
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Lack of adequate heating
Failure to notice or respond to deteriorating conditions
Failure to take account of or manage the risk of falling or to inform family of falls.
Failure to listen to, take seriously and respond to concerns of relatives.
Inadequate equipment

Two striking features of the negative comments were how many there were about basic nursing care and that the majority related to elderly patients.

A patient story

“Sadly the care on ward 10 at Stafford General Hospital left much to be desired with a pervading lack of respect for the care of elderly patients manifested by a disinterest and neglect, and an alarming lack of awareness in the nursing staff of the side effects of a stroke. A series of specific issues are then set out including her mother being threatened with eviction from the ward following an emotional request to speak with a doctor, poor cleanliness on the ward including urine on the floor and leaving her father and the patient next to him sitting in their own excrement for one and a half hours.”

Not all Bad

Throughout the various inquiries there have been those who have argued that the problems related only to part of hospital. When the Inquiry team sought patient views 26% of the responses were positive. Many described their care and treatment variously as first class, excellent, exemplary, very good and second to none.

A patient story

“My father ..... was admitted in April 2005 with heart failure. He was admitted again in 2006 and then in November 2006 following a heart attack. On each occasion he received excellent care from the nursing staff and the cardiac team. He has a good quality of life thanks to the team at Stafford Hospital. During his stay we did not see any of the neglect portrayed in the media. My mother was an impatient in November 2007. She was admitted after a fall at her home and had broken her hip. We have nothing but praise and thanks for the hospital staff. The hospital described in the media is not the one I and my family saw.”

This could suggest that the drop in standards was episodic and related to particular staff when they were on duty. However some problems like the pressure to discharge patient from wards to accommodate the patient intake from A and E were systematic and the responsibility of the hospital’s managers as were the overall levels of staffing. But was this a hospital with system wide problems or a good hospital with a few poor areas?
Wards 6, 7, 8, 10, 11, 12 the Emergency Assessment Unit and A and E.

The Culture of the Trust

The culture of the Trust was not in the view of Robert Francis conducive to providing good care for patients. Even Martin Yeates acknowledged this describing the culture as very inwardly focus and complacent…. resistant to change, innovation and development, accepting of poor standards and with relatively low professional esteem.

Although some staff were singled out for praise by patients concerns were expressed about the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients and the marked indifference they showed to visitors. A forceful style of management was perceived by some as bullying. A failure to meet targets could lead to the sack. The Consultant body largely dissociated itself from management and adopted a fatalistic approach to management issues and plans. Staff morale was low. Staff were worried about coming forward with concerns. It was a closed community and the Board conducted much of its business in private. Poor performance and sometimes misconduct was ignored in filed in the too difficult box.

A patient story

...he said I need to go to the toilet...he said she seemed to be quite angry that he wanted to go to the toilet. She flounced out and went to get a bottle. It took a long time and he said I am really sorry but I have done it. With that she exploded. She threw the urinal onto the bed and pushed his trolley up against where he was with his dinner. She went out and we never saw her again.

The organisation was in his view in denial about its shortcomings.

In submitting his report to the Secretary of State, Robert Francis argued that the evidence he had uncovered should surely put to rest the views, still harboured by some, that the Health Commission’s Report painted an unfair picture of how the Trust was performing. There can no longer be any excuse he said for denying the enormity of what had occurred.

As well as detailing the evidence and presenting the patient stories in graphic detail, he made 18 recommendations;

<table>
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<tr>
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<th>The Trust must make its visible first priority the delivery of a high class standard of care to all its patients by putting their needs first. It should NOT provide a service in areas where it cannot achieve such a standard.</th>
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<tr>
<td>2</td>
<td>The Trust should lose its Foundation status.</td>
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<td>3</td>
<td>The Trust should link better with other NHS Trusts</td>
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<td>4</td>
<td>Professional training programmes for all staff should be reviewed and ensure that high class standards of service are valued.</td>
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<td>5</td>
<td>Clinical audit processes improved and made a requirement for all relevant staff.</td>
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<td>6</td>
<td>Radical improvements to the Trust complaints procedure</td>
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<td>7</td>
<td>Trust policies, procedure and practice regarding professional oversight and discipline should be reviewed.</td>
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<td>8</td>
<td>The whistleblowing procedures should work</td>
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<td>9</td>
<td>An Independent body should set professional standards for Executive and Non-Executive Directors and be given powers of disciplinary sanction.</td>
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<td>10</td>
<td>The management and leadership of the nursing staff should be renewed.</td>
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<td>11</td>
<td>The Board should review its management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust.</td>
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<tr>
<td>12</td>
<td>The Trust should review its record keeping procedures and regularly audit the standards of performance.</td>
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<tr>
<td>13</td>
<td>All wards admitting elderly acutely ill patients should have multidisciplinary meetings. All nursing staff should have</td>
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He rejected the advice of some that the hospital be closed.

The media reaction to his report was predictable. Far from being a healing process it had ignited a storm of political and public outrage.

Management and its problems

Toni Brisby was appointed Chair of the Trust in October 2004 and was briefed by the Chair of the SHA that the Trust was becoming a problem. It’s finances were spiralling out of control, there was a poor relationship amongst consultant medical staff, the Board committee structure was byzantine and there were lots of old fashioned practices amongst doctors and nurses.

The Chair thought the hospital was trapped in a time warp. It had lost all its stars in 2004 primarily because of patient waiting breaches and financial overspends. It recovered the following year to secure a Fair for the quality of its patient care which was the lowest entry point for foundation status.

Within her first year Toni Brisby had moved the Chief Executive on and replaced him with Martin Yeates and she had also engineered the departure of Jan Harry an unpopular Director of Nursing who some regarded as a bully. One sister told the Inquiry that Harry did not provide good clinical leadership. Her senior staff were told to solve their own problems. She was focused on strategy.

Brisby was described by some witnesses as a strong leader with a clear vision who was much admired by her colleagues. She told the first inquiry about the problems at the Trust but the remedial action to resolve them was slow and often ineffective.

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<tr>
<th>Appointed</th>
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<tbody>
<tr>
<td>October 2004</td>
<td>March 2009</td>
<td>Chair</td>
<td>Toni Brisby</td>
</tr>
<tr>
<td>July 2009</td>
<td>January 2012</td>
<td>Chair</td>
<td>Sir Stephen Moss</td>
</tr>
<tr>
<td>February 2012</td>
<td></td>
<td>Chair</td>
<td>Prof John Caldwell</td>
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The Mid Staffordshire Trust faced most of the same sort of problems as any other NHS Trust at the time. Patient demand was largely unrestrained but they were expected to operate within a fixed annual budget with only marginal flexibility from one financial year to another.

The hospital also had to accumulate a surplus to succeed in an application to be a foundation Trust. The pressure to balance the books and become a foundation trust dominated the managerial agenda for a considerable period of time. Martin Yeates and his Board colleagues genuinely
believed that the application process itself would assist the organisation in improving its management and governance.

How Mid Staffordshire came to be approved as a foundation trust in February 2008, just before the HCC report was published, was a major focus of the second inquiry. How much did Monitor know before approval was granted? Why did Martin Yeates or the SHA not ring and say we have a problem coming up with a highly critical HCC report?

When it was granted foundation status the Trust announced that it was now in the premier league which was startlingly at odds with the newspaper headlines only a month later.

The first foundation trusts had been launched in 2004 and represented, according to the Department of Health, a profound change in the history of the NHS and the way in which hospital services were managed and provided. They were independent legal entities [public benefit corporations] and were set free from central government control and were no longer performance managed by the Department of Health or by Strategic Health Authorities.

As self-standing, self-governing organisations they were free to determine their own future within rules set for them by Monitor their regulator. They could raise capital from both the public and private sectors and retain financial surpluses for reinvestment. Securing foundation status was usually a testing process involving preliminary screening and Board to Board meetings with the Strategic Health Authority, the blessing of the Secretary of State and a formal review by Monitor which was particularly focused on their business plans and financial health.

Over time the labour government [and later the Coalition Government] saw every NHS Trust converting to foundation status. Each Foundation Trust had a managing board and a board of governors drawn from the local community and staff.

Strategically the Stafford hospital was surrounded by larger hospitals in Stoke on Trent, Wolverhampton and Birmingham who between them provided most of the specialist care for Staffordshire.

However the hospital and its doctors had ambitions to provide some of the more sophisticated care themselves both on economic grounds and in order to lift their professional prestige. This was not an uncommon ambition at the time amongst hospital trusts like Mid Staffordshire.

In the words of Toni Brisby the Chair they wanted “to be not just an ordinary DGH but an outstanding one”. The last thing they wanted to do was restrict or close services down whatever pressure they were under. As a Trust they were wary of partnership arrangements with the larger hospitals. Relationships with General Practice had been scratchy for years with one group of GPs calling for the resignation of David O'Neil, when he was the Trust Chief Executive, The challenge was brushed aside but he did eventually “move on” in 2005 to a post in another NHS region.
**A Patient Story**

*When we went back the next day [she] was a different woman. Whereas in Stafford she had been slumped all over the place, in Stoke she had been washed, her hair was brushed and she was sitting up. You would think that there was a well a different woman, without a doubt.*

**Financial problems**

The Board was unsurprisingly preoccupied with the financial health at the Trust. When they ran into real trouble between 2003 and 2006 the external pressure to sort this problem out was great. Toni Brisby told the Francis Inquiry that on the occasion of a Board to Board meeting with the SHA in December 2005 David Nicholson and Antony Sumara who were leading the questioning process on behalf of the SHA kept leaving the room to take telephone calls about problems in North Staffordshire which led to that Trust Board being sacked that very afternoon. “If you don’t break even you get removed “she explained.

The Trust had been facing financial problems since 2003/4 when it took a loan from the SHA of £1.5 million [brokerage as it was called in the NHS]. A further overspend occurred in 2004/5 and the brokerage was increased to £1.8 million. A deal was struck with the SHA that this would be repaid in 2006/7 and 2007/8. The Trust made a small surplus in 2005/6 on a turnover of £113 million.

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<th>Appointed</th>
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<th>Post</th>
<th>Name</th>
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<tr>
<td>1987</td>
<td>June 2008</td>
<td>Director of Finance and Deputy Chief Executive</td>
<td>John Newsham</td>
<td>Retired</td>
</tr>
<tr>
<td>July 2008</td>
<td>April 2010</td>
<td>Director of Finance and Deputy Chief Executive</td>
<td>Michael Gill</td>
<td>Resigned</td>
</tr>
<tr>
<td>October 2010</td>
<td>June 2012</td>
<td>Interim Director of Finance and Performance</td>
<td>Darren Cattell</td>
<td></td>
</tr>
<tr>
<td>July 2012</td>
<td></td>
<td>Director of Finance and Performance</td>
<td>A.Cummins</td>
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But the national situation had worsened and things got even tougher as the Primary Care Trust from whom most of the Trusts income was derived announced that it was planning to reduce the amount of money it paid the Trust by 2-3% in the financial year 2006/7. The Trust calculated that if in addition to this they were required to repay the brokerage then they had a £10 million problem.

In fact this was probably overegged a little in order to accumulate a small surplus that would support their bid for foundation status which despite being a marginal case succeeded in February 2008 just as the first concerns about the Trust’s mortality rates were emerging into the public domain.

Vacancies had been scrutinised since 2004 in the search for low priority posts and in order to generate one off savings as a result of delays in filling posts. By January 2005 the management team decided to take out 180 posts but nothing much happened so that in March 2006 the decision was taken to take out 170 posts of which 52 would be in nursing.

It was a centrally imposed decision with little, if any, clinical buy-in.
Many witnesses to both inquiries reported uncertainty about staffing numbers. Some explained that the cuts were not real as they represented the removal of vacant posts but you then had to factor in the locum, agency and bank staff that had filled these gaps as well as sickness and absence rates.

The numbers were still unclear as late as September 2009 when a new Director of Human Resources was appointed. The first Francis Inquiry wanted to see the risk assessment associated with the decision to reduce staff but none could be found by the new team that took over after the HCC report had been published. “So one can assume it didn’t happen”. Antony Sumara the new Chief Executive told the Inquiry. What did happen was that a significant number of posts were lost. A long running independent staffing review which reported in March 2008 said that the Trust needed to increase its nursing numbers by 121. The Board did react but slowly…it still had to balance its books.

The first Francis inquiry was very critical of the Board for allowing such a sizeable reduction in nursing numbers without undertaking a full risk assessment. But what alternatives were available to the Board? Short term, non-recurrent, savings would only move the problem forward not resolve it. They could have vigorously attacked non staffing costs, reduced management costs, closed non vital clinical services that were not covering their costs, outsourced those services whose costs could not be reduced in house, sought cost saving partnerships with other Trusts and demanded greater productivity from their medical workforce and perhaps reduced their numbers.

They could have closed a ward or two and spread the nursing staff more equitably across those that remained open. Given the pressure on acute medicine and the beds for the elderly the hospitals surgical bed capacity would most likely have been the prime target. This would almost certainly have been resisted by the surgeons and might have affected the Trusts income from the PCT which was related to the number of patients treated.

There was no easy way out of the problem but taking out high turnover vacancies was quick and effective if one was not overly concerned about the consequences. If the Trust had acted earlier the management team would have had more time for a measured response. As the first inquiry put it “changes made or demanded in haste can be inimical to good patient care.”

According to some witnesses the Trust never took up the offer of a loan from the SHA. That would have looked weak. They had to demonstrate that they could manage their own affairs.

The absence of clinical “buy-in “to the cost reduction programme, much criticised by the first Inquiry, is a deeply embedded problem in the NHS. Hospital consultants will always want to argue the case for more money rather than contemplate cuts, particularly if it involves bed reductions. As one consultant said in his evidence “the Trust was never adequately funded”.

The best that management can usually expect in these circumstances from its clinical community is acquiescence and a grudging respect for making the right decisions however tough they might be. In Stafford there was no concerted pressure from the medical staff about the planned cuts and the senior nurses at the Trust were firmly embedded in the management team and made no waves at all. Toni Brisby told the Inquiry that the Director of Nursing [Jan Harry] had assured her that the changes would not be detrimental to patient safety.
In their first year as a Foundation Trust in 2008/9 the hospital managed a surplus of £750,000 which amounted to around 0.5% of a turnover which had by then risen to £144m. In reality this was just clever book keeping and ignored an underlying deficit of £3m which had been rolled forward. They had dealt with the immediate financial crisis but at a cost to their patients. By March 2009 the PCT was able to tell CURE that there had been a net increase in the number of nursing staff of 101 since January 2008. But the relief was only temporary as two years later a new Chief Executive was dealing with another financial crisis this time sized at over £18 million. In order to meet the now clear quality gap the Trust had by this stage employed over 100 additional staff. The Department of Health covered the cracks with a grant as the first inquiry was in process. The Department and the PCT were still covering the cracks in 2012/13. The fundamental flaws in the Trust business plan had still not been resolved.

<table>
<thead>
<tr>
<th>Year</th>
<th>Financial Situation</th>
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<tr>
<td>2001/2</td>
<td>Break even</td>
</tr>
<tr>
<td>2002/3</td>
<td>Break even</td>
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<tr>
<td>2003/4</td>
<td>Trust borrows £1.5m to balance the books</td>
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<tr>
<td>2004/5</td>
<td>Brokerage increased to £1.8m</td>
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<tr>
<td>2005/6</td>
<td>Small surplus</td>
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<tr>
<td>2006/7</td>
<td>Surplus of £1.26m</td>
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<tr>
<td>2007/8</td>
<td>Surplus of £883,000</td>
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<tr>
<td>2008/9</td>
<td>Surplus of £1.7m [Not a true surplus but due to technical reasons]</td>
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<tr>
<td>2009/10</td>
<td>Overspend of £4.75m [Underlying deficit of £9.2m]</td>
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<tr>
<td>2010/11</td>
<td>Overspend of £13.8m [Underlying deficit of £15.7m]</td>
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<tr>
<td>2011/12</td>
<td>Overspend of £19.9m</td>
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Ward Reconfigurations

An emergency assessment unit where patients could be examined prior to transfer to one of the main wards had been created in the summer of 2004 and appeared to work tolerably well but was in the view of many witnesses grossly understaffed.

In 2006 the Trust decided to reconfigure its acute wards. Instead of wards the hospital would have separate clinical floors for medicine and surgery. Clinical skills and resource would be allocated to patients with the highest dependency. It was an idea that had evolved following a visit to the USA by a number of the Trust’s senior staff. It was presented as a forward looking scheme that would focus skills and expertise around the sickest patients and improve the patient’s journey. However it was also part of the financial recovery plan and was forecast to produce savings of around £325,000.

The creation of the surgical floor was implemented in 2006 although it appears from the evidence to the first inquiry that real concerns by some senior clinical staff were swept under the carpet. The business case now promised savings of £594,000. In practice the ward area was chaotic according to one of the leading surgeons.

The creation of two medical floors [three if the floor at Cannock Chase Hospital was included] followed but seemed to generate more problems than it was designed to solve. Toni Brisby the chair described the whole programme as “a really bad idea”. The Chair of the consultants committee told the inquiry that whilst the changes were well intentioned they were not very well thought out in terms of what would work and they were deeply unpopular. There is some dispute
about who pushed this idea but its proponents must have included senior members of the nursing team. The first inquiry actually gave up trying to bottom this issue on the grounds that it would have taken a disproportionate amount of resource and time to do so. Whoever was to blame the changes impacted badly on patient care.

There had also been a row about the need to create an isolation ward as one means of combating MRSA. The Trust claimed it had no money for the alterations and asked the PCT [who had no spare cash either] to pay. Within the hospital nobody wanted to give up any of their beds. Nothing happened, it was put in the too difficult box.

**Mortality.**

Although the financial problems at the Trust could have been handled better the crucial mistake that triggered the first inquiry was the attitude the management team adopted to the early reports and alerts about comparatively high mortality at the Trust. All the HCC knew before they triggered their inquiry was that the Trust appeared to be outside the expected range at 127 with 100 being what might reasonably have been expected.

Martin Yeates and his team argued that this was due to problems in recording and coding information about patients and the Board appeared to have accepted this judgement. It was a bad call although there were some clinicians at the Trust who had also expressed major doubts about the accuracy of the data. There was a problem with the data as well as some academic controversy about the relationship between mortality data and the quality of care. A two twin approach of challenging the data but at the same time looking at the evidence in case it was signalling real problems would have been more sensible. It might also have persuaded the HCC to help in a constructive way in the search for the truth as they had done at other Trusts with high mortality scores.

The Trust however stuck to their guns...the problem was with the data and the coding. Even a small acknowledgement that the data might indeed indicate a problem might have got in the way of the foundation bid on which the Executive team was so focused. The public perception of the hospital was profoundly damaged when the newspapers ran with stories about a thousand unavoidable deaths.

The first Inquiry spent a lot of time reviewing the mortality data relating to the Trust and set out an explanation of the statistics and how they were collected and interpreted in a substantial appendix to the main report. The conclusion was that there was strong enough evidence to suggest that the figures mandated a serious investigation of the standards of care being delivered [and particularly emergency care] rather than reliance on the contention that they had been caused by coding errors. Professor Brian Jarman later demonstrated that Dr. Foster data going back as far as 1998/9 showed up problems at the Trust which continued in the following years. The Department of Health had looked at mortality data following the Bristol Inquiry and concluded that the early warning signs about Bristol could be detected in the data. Sadly the Department never followed up this potentially important lead.

This issue would be gone over in even greater detail in the second inquiry.
Complaints

Complaint handling by the Trust was negative and defensive and the cause of much of the dissatisfaction displayed by patients and relatives. In the first instance it was delegated to staff in the area giving rise to the complaint. Unsurprisingly the responses were often defensive or incomplete. All the Board received was a thematic report with none of the detail. The NHS Ombudsman in her evidence described the NHS Complaints system as dreadful.

Doctors

The doctors at Mid Staffordshire were not an easy group. They did not have a close relationship with the Board and it’s managers or with each other. They lived in a local world of their own, reluctant and at times unwilling to accept national guidelines. The Consultant body were, as a number of witnesses put it, very old fashioned in their attitudes. Consultants thought they should each have clinical freedom to do what they thought best for their patients. As the Consultant with the lead for implementing NICE guidelines put it “the evidence that, for example clinical autonomy and clinical freedom are necessarily safe and in the best interests of patients, just doesn’t exist. If you are going to practice evidence based medicine you have to change your practice to fit the evidence not change the evidence to fit your practice”.

A former Chair of the Medical Staff Committee said in his evidence “The Trust has always been looking over its shoulder at neighbouring hospitals and thinking…. are we about to be gobbled up? There has always been a certain paranoia about what is happening in Stoke. It is all too easy to become isolated on one’s patch and think that everything is going swimmingly because you don’t have a benchmark against which you can compare yourself.”

There were a few Consultants who consistently expressed concerns about problems at the Trust[perhaps 4 or 5].They claimed that they were told by their clinical peers to get back in their box, shut up and do as they had been told. Some of them had very personal agendas which weakened the impact of their pressure on managers. The disheartening response they claimed they always received was that the Trust had no extra money for change and development and that matters were going to get worse. Their mind set and that of many others at the Trust was that growth and improvement was only possible with more cash. Change had to be an add on to the status quo.

One Consultant put his perception rather graphically to the inquiry, “If you complained you were seen as being awkward”. It was he explained “a very hostile environment where you had to watch your back in case a mistake [which did happen] was used as the excuse for destroying your career”. There were arguments about the distribution of local clinical excellence points [which led to higher pay] amongst the Consultant staff. Very few Consultants in Stafford had higher distinction awards which had rung a very faint alarm bell at the regional headquarters.

Personal appraisal systems for Consultant staff were weak and in any case according to the medical director were designed to encourage and support doctors rather than weed out bad apples.

Surgery had been a problem for some years. Concerns had been expressed on a number of occasions by one surgeon about the performance of one of his colleagues. Interpersonal relationships within the surgical community were poor. Meetings of the surgical division were unpleasant affairs.
Matters had become so fraught that some theatre staff refused to work with one surgeon against whom there were allegations of assault. Medical cover at nights and weekends was fragile at best.

Dr Valerie Suarez a pathologist who had assumed the role of Medical Director in early 2007 became so concerned about the performance of one of the two colorectal surgeons that shortly after her appointment she sought advice from the Royal College of Surgeons who agreed to undertake an inquiry.

The inquiry was focused on both colorectal surgeons although the greatest concern was about the more junior of the two who was referred to in the public evidence as Surgeon X. The review was asked to look specifically at laparoscopic cholecystectomies [removal of gall bladder]. Both surgeons continued working whilst the review was undertaken although the more junior of the two agreed to stop laparoscopic procedures until the investigation had been concluded .The Royal College reported in October 2007 but the final report was not formally presented until April 2008 as the College had first to deal with the objections of one of the surgeons to its content. Amendments were agreed but they did not materially affect the recommendations. Feelings were obviously running high in the consultant community and one of the physicians described the first report as another example of blatant racial discrimination.

Although the college reviewers found no evidence suggesting a higher than expected mortality rate they did express concerns about the attitude and insight of one of the surgeons and described a dysfunctional relationship between this surgeon and his colleague as well as ineffective leadership within the department of surgery. It recommended that the general surgical department be revitalised with strong leadership, that an additional colorectal surgeon be appointed with laparoscopic experience and that an occupational psychologist be recruited to see if relationships could be improved within the surgical division. The junior surgeon should be offered mentoring to improve his skills.

It was not a very helpful report as, in the view of Dr Suarez, “a lot of judgements had been made without the evidence to back them up”. It was not strong enough for the Medical Director to take decisive action...it was “too soft” and offered a “ false reassurance”. The occupational psychologist made little impact although the surgeon who was the source of most concern did agree to undertake a seconment for mentoring. He eventually came back to the Trust and continued with his colorectal surgery.

After the report had been presented to the Trust the surgical director asked the College, directly, whether colorectal surgery ought to be undertaken by a specialist rather than a general surgeon. The advice was clear... it needed a specialist.

In the meantime there was a serious untoward incident in March 2009 relating to the treatment of a patient with bowl cancer by Surgeon X. A multidisciplinary team had discussed the case and agreed that the patient should have chemotherapy or palliative radiation treatment and a colostomy. Instead the surgeon had performed an abdominal perineal resection and the patient died two hours after the procedure. An independent review reported that “this is either a weak clinician giving in to unrealistic patient expectation or a lack of clinical insight. But it certainly shows a complete disregard for nationally accepted best practice of MDT working and a complete disrespect of other professional advice. This lady had advanced disease. On the information supplied to me, palliation
with radiotherapy following a dysfunctional stoma seems to be the treatment of choice. An unacceptable surgical treatment was offered and performed with a disastrous outcome and this appears to have been the decision and action of one clinician with complete disregard for national evidence and local professional MDT opinion. This is 1970’s medicine being practiced in 2009."

This incident and other concerns prompted the Trust to ask the Royal College of Surgeons to come back in 2009 with pretty much the same terms of reference but this time they were asked to include a detailed case note review [40 cases; eight per surgeon with half chosen by the surgeon and half by the Trust]. The review was led by a senior member of the College council and involved three eminent surgeons.

When the report was presented to the Trust in July 2009 it pulled no punches. The general surgical department was the most dysfunctional the review team had ever encountered. “Its members are polarised and this caused problems for nursing and support staff and crucially put patient safety at risk”.

The case note review had found significant concerns with the cases of four of the five surgeons. These included poor judgement and decision taking; lack of current knowledge and sub-optimal post-operative care. Care was in some cases, in the view of the review team, “grossly negligent” and they were appalled at the mismanagement of one case in particular. “The mortality from gall bladder removal was 10-15 times the expected rate. All surgeons bar one were advised to stop undertaking laparoscopic gall bladder removals until they had completed the national training programme.

If matters could not be improved the surgical unit should in the view of the College reviewers be closed. A catastrophic step for the Trust to take. One of the surgeons at least did not accept the criticism in the report which he said was biased. The inquiry team would have none of it. Although our reports are supposed to be advisory, on this occasion, we are telling you what you have to do, explained Mr Robert Greatorex the review leader.

Although the report was supposed to confidential to the Trust in an unusual and somewhat irregular step its contents were reported to the Medical Director of the NHS in the light of the unacceptably high mortality rate. He in turn raised the concerns with the new Medical Director of the Trust who immediately stopped laparoscopic cholecystectomies being performed at the Trust and removed one of the surgeons concerned from clinical practice.

Arguments about the accuracy of the report between the College and the surgeons continued well into 2010, particularly when the GMC eventually got a copy. As late as 2012 the Trust was again in trouble again with its surgical breast service and dysfunctional relationships.

But the problems were not limited to surgery. A number of physicians had expressed their concern about what they regarded as dangerously low levels of staffing to deal with acute medical emergencies. The public inquiry heard evidence from a gastroenterologist who had a lengthy dispute with both his clinical colleagues and managers about a range of issues including a lack of secretarial support and the absence of nurses when he did a ward round. There were he said a number of senior doctors at the Trust who had a vested interest in protecting each other which meant
sometimes protecting people who were not quite up to scratch in terms of their clinical competence. You had to be a member of the club.

He was briefly suspended by Dr Suarez [on her last day in the Medical Director post] after an alleged dispute with nursing staff only to be reinstated a few days later by her successor Dr Manjit Obhrai. As he had on previous occasions when his conduct had been called into question he alleged harassment, victimisation and discrimination.

Another physician told the inquiries that he was constantly complaining about secretarial support and nurse and junior doctor staffing levels. He tended to channel his complaints through his clinical directors but claimed to get little support. Those doctors involved in management would have nothing to do with his dissent. He had been particularly concerned when managers had decided that staff shortage would no longer be included as a trigger event for incident reporting.

When he had complained to the Director of Nursing about nurse staffing levels he had been sent away with a flea in his ear and an email had been circulated to all his colleagues saying that he had had the temerity to tell the Director of Nursing how to manage her nurses.

With the benefit of hindsight one can see some validity in some of the complaints made by these consultants. Perhaps because of their attitude and the aggressive way in which they made their point they were kept at a distance. They presented problems but no solutions. Managers, senior nurses and even senior colleagues in medicine, found it difficult to build a productive relationship with them. The gastroenterologist was offered a package to leave the Trust by Martin Yeates which he rejected in outrage.

Between 2009-2011 eleven doctors from the Mid Staffordshire Trust had been referred to the National Clinical Assessment Service which was often a precursor to disciplinary action.

There were, at the time covered by the inquiries, over 80 consultants at the hospital. The majority got on with their clinical practice in a responsible manner and played little part in hospital politics. But they all had a duty to report colleagues whose performance or conduct might be impacting badly on patient care. Keeping one’s head down was no longer professionally acceptable. When mistakes happened they needed to be acknowledged so that corrective action could be taken. To err is normal; to cover up a mistake and thereby negate the learning process is unacceptable.

But what could an individual consultant do about a dysfunctional and divided clinical community without finding themselves ostracised by colleagues? The whole system was heavily dependent on strong, effective and respected leadership which was lacking.

Clinical governance was very difficult to implement and there was a lot of resistance to clinical guidelines and protocols. Old fashioned medicine left individual consultants to plan and organise care for their patients.

Clinical audit was seriously under developed at the Trust and the Trust did not normally participate in national audits run by specialist societies. There was little pressure to do something about it as it would have required some degree of investment. Perhaps because of this the first and second inquiries spent a lot of time looking at clinical audit processes and the handling of serious untoward incident reports which was both inadequate and poor.
But the duty to be honest and frank about accidents and mistakes goes much further than the medical and nursing professions and applies to the Trust itself and their legal staff. A particular case in Mid Staffordshire involving a patient who died after a mountain biking accident is one of many quoted by AvMA, one of the core participants to the second inquiry, in support of a statutory duty of candour. In the particular case a critical internal report on the death prepared for a coroner’s inquiry was not given to either the coroner or the patients parents.

Inevitably the role played by the Medical Directors of the Trust came under close scrutiny as he/she might have been expected to spot and deal with problems associated with clinical quality before anybody else.

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<td>2003</td>
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<td>Dr John Gibson</td>
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<td>September 2006</td>
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<td>Medical Director</td>
<td>Dr Val Suarez</td>
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<td>April 2009</td>
<td>August 2011</td>
<td>Medical Director</td>
<td>Dr Manjit Obhrai</td>
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<td>2011</td>
<td></td>
<td>Medical Director</td>
<td>Dr Robert Courteney-Harris</td>
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There were three doctors in the post during the period covered by the inquiry. John Gibson retired in the summer of 2006 to be succeeded early in 2007 by Valerie Suarez a pathologist who combined the role with some residual clinical commitments [20%]. She was in post for two years until Manjit Obhrai took over in April 2009 shortly after the HCC had reported. He had been appointed from outside the Trust.

Dr. Suarez saw the role change during her period in office evolving from effectively the spokesman for the consultants to managing the professional performance of the doctors employed by the Trust. She found the role very onerous and demanding. Dr Obhrai a gynaecologist by background told the inquiry how demanding managing clinical performance was as “it puts you at risk of being a bully”. You can be accused of being a racist but you have a duty of care to your patients and you have to make it clear to colleagues what their professional duties are and how the organisation will hold them to account. It was he who removed Surgeon X from clinical practice on the evening after the second Royal College of Surgeons report landed on his desk.

Even after the HCC report there remained a high level of denial in the organisation. This is just an ordinary DGH like many others many of the doctors said in private. It was, thought Manjit Obhrai, quite frightening. He took the lead in shutting the Clinical Decision Unit because nobody seemed to own the patients. It reopened some months later as a surgical assessment unit led by a Consultant. With Antony Sumara he set about improving the clinical audit and clinical governance processes, the handling of incident reports and improving the communication between managers and the clinical community. At last the clinical community had a leader and an environment in which he could demand change.

**Nursing**

Poor nursing care on some of the wards at Mid Staffordshire Hospital was the focus of most of the patient’s stories. The HCC report described the care of patients as unacceptable. “Patients and relatives told us that when patients rang the call bell because they were in pain or needed to go to the toilet, it was often not answered, or not answered in time.”
Families claimed that tablets or nutritional supplements were not given on time, if at all, and doses of medication were missed. Some relatives claimed that patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of infection and pressure sores.

Wards, bathrooms and commodes were not always clean. CURE the patient group went so far as publishing a survival guide for patients.

In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, “Nurse, nurse”, and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting “Nurse” louder and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. Then after they would sob, they seemed then to shout again for the nurse and then it would go quiet.....

The daughter of a patient in Ward 11 September 2007

Alan Johnson the then Secretary of State described the standards of care at the hospital as appalling, an adjective used widely by others. In her evidence to the first inquiry a former Director of Nursing [1998-2006] claimed not to have been aware of the concerns about the level of care. “I cannot believe that some of those nurses would have allowed that level of care to happen in their clinical areas....If things had been that bad, I think it is highly unlikely that it would have gone unnoticed by me or by my staff”.

But it had. Senior nurses were either too far from the ward areas to notice or they were preoccupied with other matters. They were however quick to rebut criticism.

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<td>2002</td>
<td>Director of Nursing and Quality</td>
<td>Jan Harry</td>
</tr>
<tr>
<td>2002</td>
<td>July 2006</td>
<td>Director of Clinical Standards and Chief Nurse</td>
<td>Jan Harry</td>
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<tr>
<td>December 2006</td>
<td>October 2009</td>
<td>Director of Nursing and Governance</td>
<td>Helen Moss</td>
</tr>
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<td>November 2009</td>
<td>June 2010</td>
<td>Interim Director of Nursing</td>
<td>Julie Hendry</td>
</tr>
<tr>
<td>June 2010</td>
<td></td>
<td>Director of Nursing and Midwifery</td>
<td>Colin Ovington</td>
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The experiment with two clinical floors in the hospital, which had the support of senior nurses, had not helped deliver good care as it had diluted the proportion of qualified staff [from 60/40 to 40/60] and scattered patients over a wide area. One Consultant claimed that his patients who needed specialist care could be found in up to five different clinical areas.. The hospital reverted back to a more traditional ward arrangement after the HCC report.

Reducing the number of nurses in response to a financial crisis was blamed by many for the stress under which nurses performed their duties. But the problems were rooted in culture as well as work intensity.

....The nurses never spoke. They did not know how to behave socially They would carry on conversations over your head but never once acknowledge you. You were an absolute pain...I used to get there every morning at about 9.15 and always asked if it was convenient to go on the ward and
stay with my husband. I sat... held his hand and wiped his face and his hands and washed his mouth,, just there to comfort him and do whatever I could.... they did not hide the fact that they did not like me being there.

A Relative

Helen Moss had been appointed Director of Nursing in 2006 having served in her previous post as deputy Director of Nursing at University Hospital Birmingham. Stafford should have been an excellent next step in a promising career.

She had had to work hard to gain the acceptance of the nurses in Stafford. Her first impressions were of a nursing workforce that was quite stagnant. Many of the nurses had worked at the hospital for a long time. When she asked how things were she was told they were fine. However her own ward visits told a different story. Basic nursing skills and care seemed to be missing on many of the wards. She commissioned an independent nurse staffing review which took a year to complete. When it finally reported it found a shortfall in nursing numbers of 121 WTEs but also reported some uncertainty about whether this number of nurses could be recruited even if funds were made available.

There was not enough staff to deal with the type of patient you needed to deal with, to provide everything a patient would need. You were just skimming the surface and that is not how I was trained.

A nurse in evidence

Helen Moss's role included much of the Trust’s quality agenda which clearly took up much of her time and energy. She understood that there were problems in nursing but almost certainly missed judged their depth. She was not the dragon matron some thought that the Trust needed. She did not according to her Chief Executive [Sumara] “display any sense of remorse...more an anger that we had attracted that sort of attention.”

She left the Trust and the NHS altogether in November 2009. She got some credit from her medical colleagues who in evidence gave her credit for bringing new ideas to the Trust and placing a structure around clinical governance. The NMC found that she had no case to answer when they later reviewed her conduct.

Having read the HCC report, Peter Carter the General Secretary of the Royal College of Nursing, was clear that there were parts of the hospital which were providing a very, very poor if not in some areas a disgraceful standard of care.

He was somewhat embarrassed by a visit he had made to the Trust in June 2008 after which he had send them a polite note saying how impressed he had been with the standard of nursing care. He later explained that hospitals had microclimates with good and bad areas. He had obviously been shown the good.
An inquest into the death of Mrs Gillian Astbury who died after falling into a diabetic coma at Stafford General hospital concluded with a verdict of death by neglect. She had been admitted to hospital with a fall but she was insulin dependent and staff failed to adhere to her diabetic plan. Some nurses did not know that Mrs Astbury was a diabetic, others said that they were too busy to check. Insulin was not administered on the day before her death despite being prescribed by doctors. The jury decided that the standard of nursing fell well below the professional code of conduct. A police investigation was launched after Mrs Astbury’s death but the Crown Prosecution Service ruled that there was insufficient evidence to bring charges.

The argument that all was not bad in nursing at the hospital keeps reoccurring in the Mid Staffordshire story. As it was put to Peter Carter by a large meeting of nurses “We feel the whole hospital has been traduced here and yet many of us provided excellent nursing care. We are now being castigated but we submitted incident reports but they were filed in the wastepaper bin”. It was soul destroying another nurse told the Inquiry to be the butt of constant public criticism.

How was it, the second inquiry asked, that such unacceptable standards of nursing became tolerated? Why was it that basic things like fluid balance and observation charts were kept so poorly? Why did the nurses as a body say nothing? Didn’t they notice that standards had slipped badly or were they afraid to speak up?

It was not just one ward. It was a number of wards and clinical areas. The accumulation of pressure from acute admissions, over a long period of time, might form part of the explanation. If this is the case why did the senior members of the profession not call a halt and demand action before the quality of care collapsed altogether.

‘I will never understand that’, responded the interim Director of Nursing, who had been appointed in November 2009. Nurses in Stafford were taught complex electrocardiogram packages but training in essentials such as slips, trips and falls training was inadequate. Was the transfer of nurse training to the higher education sector the root cause of the problem; were modern nurses now “too posh to wash?” Peter Carter resisted this but acknowledged that all was not well. Nursing was not a job you could learn in a classroom. There was no substitute for working on wards and departments and with people he claimed. Like many witnesses Sir Stephen Moss, himself a nurse, argued for the return of the State Enrolled Nurse whose expertise and focus was basic nursing care.

There was clearly a major job to be done in transforming nursing in Stafford and deeper national problems which could only be resolved by the profession itself, no doubt after some prodding from government. An initiative entitled Compassion in Practice was launched by the CNO in December 2012 just before Francis reported. It made a promising start by acknowledging that that poor care of the sort found in Stafford was a betrayal of all that nursing stood for. The NMC has announced its plans to revalidate nurses in much the same way as the GMC does for nurses.

“I think nursing did lose its way”. Chief Nursing Officer for England.

**Accident and Emergency**

Staffing the Accident and Emergency Department had always been a problem but matters reached crisis point in early 2006 when one of the two Consultants was killed in a climbing accident. It proved
impossible to recruit a full time replacement. There was little Consultant cover at all during the
night. It was decided to fill the gap by the appointment of acute general physicians.

Although this was against the professional advice given by an expert team from the Heart of England
Trust in Birmingham, it was judged locally to be acceptable as the majority of patients were
admitted with an acute medical problem.

Nobody seemed unduly alarmed at this, as a covering option, until such time as consultants in
accident and emergency became available. The College of Emergency Medicine would not have
supported this move as in their view the skills and competencies in acute medicine and emergency
medicine whilst complementary were not interchangeable. But the problems in this department
went much deeper than staff shortages. A trainee doctor arriving in Stafford in October described
the department as an absolute disaster. There was he said a culture of bullying and harassment
towards staff, particularly nurses. There was no evidence of an aspiration to provide high quality
care. There were clashes of ego, ethos and basic philosophy. There was no significant medical
leadership or vision of what good looked like. With senior clinical staff constantly fighting each other
the pressure was passed laterally by nurses onto junior doctors when they wanted to get patients
moved on to meet targets.

The effect of all this was, according to the same junior doctor, that the staff of the department
became immune to the pain of their patients.

The Board did discuss the possible closure of its accident and emergency service but decided that it
had to be kept open at all cost and all times. To ask for respite from other hospitals would have been
regarded as a major setback.

An injection of General Practitioners into A and E to divert inappropriate cases worked for a while
until the funding was withdrawn by the PCT. It was too expensive. It had never had the full and
enthusiastic support of the hospital.

National targets such as the 4 hour rule [patients had to be seen diagnosed and treated or admitted
within four hours] caused major problems in the Trust as managers attempted to force adherence.
There was convincing evidence that some senior staff fiddled the numbers.

A whistle blowers story.

A former staff nurse in the A and E and had blown the whistle on what was happening to
patients and their records. Breach times where, she said, routinely massaged, the pressure
to do this coming from the two sisters who ran the department with a rod of iron. They were
bullies and engendered a culture of blame and scapegoating. Training was offered only to
the chosen few who were the Sister’s favourites. She had made 50-100 entries in the incident
log but never got any feedback. In order to avoid a breach the length of the waiting time
would be falsified on notes and computer records. Our witness went along with this if the
delay was only a few minutes, waiting for a porter, but not when it became 30 minutes. One
of the sisters had told the receptionist to change our witness’s entry. Sometimes she went
home in tears but she was afraid to speak out. Staff were afraid that the A and E might close if it had too many breaches.

In October 2007 she finally spoke out after a day when there had been so many breaches that they could no longer be hidden. Both sisters were suspended. The floodgates opened and a lot of other people also began to complain about poor practice and a bullying culture within the A and E. A group of junior doctors wrote a joint statement but were told it would not look good on their record and so retracted it.

Around the time that the HCC came into the Trust one of the two remaining A and E consultants decided to leave. The department was then staffed by one consultant, three acute physicians and some locums.

The HCC team expressed their concerns to the Trust. Help was sought from the major hospital in Stoke who provided a Consultant on a temporary basis. Discussions about joint appointments in the future came to nothing but the Trust did manage eventually to make two new appointments. To complicate matters one of the Consultants was then suspended and his conduct reported to the General Medical Council. Maintaining a twenty four hour high quality accident and emergency service was a very testing challenge indeed[and has continued to be so] despite the fact that the Trust did not routinely deal with major trauma which was diverted by ambulance control rooms to one of the larger hospitals in the region.

There never seemed to be time to properly triage patients. The emergency admission ward acquired the nickname Beirut. The President of the College of Emergency Medicine told the inquiry that Mid Staffordshire was not at all unique. Emergency care in the UK was not consistently safe.

Accident and Emergency services at Mid Staffordshire had improved sharply with the appointment of three new consultants early in 2009 and the President had been impressed by the enthusiasm and commitment of the new team. Sadly he reflected that the improvement was short lived as two of the new Consultants had now left and in his view the level of support and investment had not been sustained. The Army flew in some specialist staff but this could only ever provide short term support. The department was eventually closed at nights and weekends on safety grounds whilst a public debate on the future was launched.

The ethical dilemma for the Board was very testing. Do you keep an unsafe service open or close it and expose patients to the risks associated with longer travel times and a long term diminution in the core service provided to the community as the hospital became focused on non-emergency care?

Chief Executives

Martin Yeates came to the Trust first as an interim Chief Executive in 2005 but was quickly confirmed into the substantive post. He came from Wolverhampton with a mixed reputation. To some he was an excellent fixer who got results but to others he was a Rottweiler in pursuit of targets. His Chair thought he was very good at his job. He made a good early start with both his Board and local general practitioners. He made a series of visits to local general practices leading one GP to report that he came across as a dynamic and impressive individual. Another Consultant told the public
inquiry that he thought that Martin Yeates had been fed anodyne and sanitised reports of what was actually going on. “I never found him anything less than pleasant, accommodating and thoughtful and prepared to take action to make services safer.” The Department of Health thought he had a “can do” attitude. Francis took a different view. Yeates was he said the most dangerous of leaders; one who was persuasive but ineffective.

He did not appear before either the first or the second inquiries citing health grounds, the detail of which was ruled confidential by Robert Francis. He did however provide a written statement. His solicitor claimed on his behalf that he had turned a failing organisation around, brought it back into financial balance and provided it with a credible way forward.

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<td>David O’Neil</td>
<td>Relocated within NHS</td>
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<td>John Newsham</td>
<td>Returned to Finance post</td>
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<td>September 2005</td>
<td>November 2005</td>
<td>Acting Chief Executive</td>
<td>Martin Yeates</td>
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<td>September 2011</td>
<td>Chief Executive</td>
<td>Lyn Hill-Tout</td>
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Despite some progress in targeted areas including reducing infection rates and getting the books balanced the first Francis Inquiry uncovered numerous examples of poor care in the Accident and Emergency Department, Emergency Admissions Unit and some of the wards during Yeate’s period in office. When CURE eventually got to tell the story of some of the patients to the Trust Board the non-executive directors were shocked and appalled as were many of the senior staff of the hospital “How could this happen they asked themselves.

One reason problems remained undetected was the abolition of the Board complaints review committee on the grounds that it took too much time at Board meetings. The Board never knew about the number of incident reports relating to three of the wards with the greatest problems [wards10,11,12].

The Board and the senior management team were blind to what was happening in some parts of their organisation. According to the HCC the Trust did not have a grip in operational areas with no effective system for the admission and management of patients admitted as emergencies.

“...and I still to this day do not understand why we were not aware of these issues and I find it astonishing that nothing was said to us, that none of these investigating or scrutinising bodies found even a glimmer of evidence of these issues and that in our informal contacts with doctors and nurses
round the hospital nobody ever said anything about these issues. I just find it astonishing and have no explanation for it.”

A Non-Executive Director

When the highly critical HCC report was finally published Toni Brisby the Chair of the Trust fell on her sword as demanded by the Chair of Monitor. Two of her non-executive colleagues also resigned. She was firmly of the view that the evidence base for the HCC report was “really dubious” and the outcome had been really damaging.

Martin Yeates resigned shortly afterwards having failed to secure a deal that would have transferred him to another post within the NHS. An independent review conducted by Peter Garland a retired Department of Health official concluded that there was a case to answer in disciplinary proceedings for potentially serious failings in leadership. In the event a negotiated settlement proved to be the cheapest and quickest way of securing his departure and his retirement from the NHS.

One of the non-executive directors described Yeates as follows in his evidence to the First Francis Inquiry:

“Martin was an interesting character. By then he had been completely vilified in the press. He had actually done some quite good stuff for the hospital because I have seen him working. For example he got hold of infection control: infection control went down seriously and he was quite driven like that. He was a man who worked very hard. But at the end of the day he was missing stuff. He was either missing it— and you ask why a chief executive is missing serious failings like this. It is difficult to know whether he—whether the system was not pushing things to him and was it failings of other executives or was it getting to Martin and Martin didn’t like the idea of his hospital not doing very well and therefore was keeping the lid on certain things. Either way it is a serious failing as a Chief Executive not to have spotted these things and brought them to the Boards attention and therefore he had to go. But he wasn’t all bad.”

Two short term interim appointments were made after a serious row between the Department of Health and Monitor about who should make the appointments given that the hospital remained a Foundation Trust. In the event Monitor found an interim chair, David Stone from Sheffield, and accepted a suggestion from the Department of Health that Eric Morton from Chesterfield act as interim Chief Executive. Both worked on a part-time basis in a difficult climate as the staff of the hospital had been angry at the way their former chair and chief executive had been sacked and CURE were suspicious.

They found a hospital still in denial. Eric Morton pulled no punches at his first meeting with the Consultants. When they asked him for his first impressions he told them that they ought to be ashamed of themselves for allowing matters to have got so bad. It was like the Emperor’s clothes. Everybody knew things were poor but nobody would say as much.
The new team got off to a difficult start with CURE the patient group by trying to lift the morale of the staff and putting the bad press behind them as they tried to build a better future. Eric Morton’s claims that the Trust now had a “committed and dedicated staff” was strongly disputed by CURE. Things are as bad as ever Julie Bailey claimed. We are still having to intervene in cases of patients being neglected and we are so deluged with new cases that we have had to limit those we could help. We have, she claimed, opened a real can of worms. What CURE actually wanted was a public inquiry as in their view the problems had still not been solved whatever the new team at the Trust said.

Between them David Stone and Eric Morton held the hospital together and weathered the media storm for about 5 months whilst the search proceeded for permanent replacements.

In July 2009 Sir Stephen Moss [a former senior nurse] was appointed as Chair and Antony Sumara became Chief Executive. Sumara, had, in a regional capacity, been present at earlier discussions with the Trust about their financial problems and had developed a reputation as a straight talking trouble shooter. He was as he put it “from the stop the buggers bleeding model of leadership”. One of the members of CURE who had known him when he was send into North Staffordshire to resolve their financial problems spoke highly of him and lobbied for his appointment.

He managed to strike up a relationship with Julie Bailey and CURE. He understood that they did not want mealy mouthed assurances that everything was now fine. They wanted those in charge of the hospital to be as mad as they were about what had happened. They wanted those judged to be to blame held to account. Majit Obhria who had been appointed medical director at about the same time had been strongly dissuaded from talking to CURE but he did and with Antony Sumara built a reasonably constructive relationship with the leading figures.

Sumara found the hospital to be in a mess and many staff in denial. On arrival he was told that 139 staff had been recruited. The truth was that half of these were agency staff working at inflated costs without a contract. Rather than chair his first meeting of the executive team he had sat back and observed…. well for five minutes he told the inquiry. It was immediately evident that they were not focused on the really important issues confronting the Trust. The executive team still did not grasp the seriousness of the situation they were in.

There were plenty of explanations which shifted the blame to others. The PCT had underfunded the Trust, the SHA had set too many targets and patient expectations were unrealistically high. He spoke personally to over 200 relatives which at times had him in tears. There would be no quick fix he judged. The Board began to meet in public with patient concerns at the top of the agenda. The Board now got to see SUI’s and hear about complaints. Clinical governance and audit was sharply improved as were staff communications.

Finance was no longer top of the agenda...at least for a while. Cash was no longer the principle goal by which they were measured. Quality had jumped the managerial queue. But, even an experienced manager like Sumara found driving change hard going with Inquiries, Regulators and the Department of Health all over him and a largely hostile press.

But Antony Sumara was a turnaround specialist and not in it for the long haul. He moved on two years later by which time he thought the Trust was providing safer care. He emerges from this story
well but did not solve all the Trusts problems. He did listen to the patient groups and respected the work that CURE had done to get the problems into the public arena.

He was succeeded in the summer of 2011 by Lynn Hill-Tout an experienced Chief Executive from the Swindon Trust. Sir Stephen Moss retired early in 2012. In a period of seven years the Trust had had three chairs and five Chief Executives.

Looking back one can see the problems building. The hospital had a poor managerial infrastructure and an inexperienced Chief Executive. Counting staff numbers was a major challenge. The attitude to complaints was negative and defensive. The complaints review process that involved non-executive directors was dismantled as it took up too much time at Board meetings. Critics were too easily labelled as troublemakers. Clinical audit systems were underdeveloped. Government targets were pursued with single minded aggression. A weak management team bluffed their way out of challenges rather than dealt with them. Target fiddling in places like A and E was quietly ignored.

Nurses were quiescent when poor care was exposed in A and E and on some of the wards. It simply cannot have been a well hidden mystery. The medical staff rarely found a common purpose or a shared set of objectives with management. They found plenty to argue about amongst themselves. Nobody blew the whistle loud enough for it to be heard by those who had the power to intervene.

She told me that her mother had been diagnosed with bone cancer and subsequently underwent chemotherapy. In the summer of 2006 she began to have trouble with mobility and had a fall and was admitted to Stafford hospital. On her transfer to ward 2 from A and E her family requested that she be placed in an isolation bay due to her suppressed immune system because of chemotherapy. However nurse informed that this would not be necessary and there was not the capacity even if required. After a few days the patient acquired Clostridium difficile. The family were not told of this and only became aware of it by reading their mothers medical notes which were kept at the end of the bed. The patient experienced severe diarrhoea and the daughter could find nobody to help clean her mother. In the end she got some rubber gloves and stared to clean her mother herself. At that point one of the nurses said; your Mum is highly contagious and you should not be cleaning her. Her mother’s blood stained swabs were often left on the cabinet beside her bed. After her mother had died and been transferred to a chapel of rest the family were told that they could not spend time with her as the hospital had advised that the body was highly infectious and had to be buried in a sealed body bag.[They were later told that this form of isolation had been unnecessary]. The daughter told the Inquiry “My Mum was my soul mate and my best friend, she was the kindest gentlest woman you could ever meet who spent her life looking after and caring for others. I was so proud that she was my Mum.

My Mum died aged 67 in a hospital that had forgotten its duty of care.

A Daughters evidence
Pressure for the second inquiry

One of the recommendation of the first Francis inquiry was that the government should order a second inquiry to examine the operation of commissioning, supervisory and regulatory bodies with the objective of learning lessons about how failing hospitals could be identified in the future.

After the May general election in 2010 David Cameron and Andrew Lansley delivered on their promise to commission the second inquiry as a public inquiry despite some “institutional resistance” within the Department of Health.
Chapter Two

The Lawyers

First Inquiry

In July 2009 Andy Burnham the Secretary of State for Health announced the appointment of Robert Francis QC as chair of the first inquiry to investigate complaints relating to care provided by the Mid Staffordshire NHS Trust between 2005 and March 2009. It was to be focused on the Trust and its two hospitals and not extended to include an investigation of the role played by the relevant primary care trusts and strategic health authority or the various regulators or oversight authorities.

The inquiry was to be held in private under the rules laid down by an NHS Act despite pressure from CURE and others for it to be constituted as a public inquiry under the Inquiries Act 2005. The Royal College of Nursing and others had argued that taking evidence in private would encourage staff to come forward more readily and in this they were supported by the Health Select Committee.

The Chair of the first and the second inquiries was Robert Francis QC who had practiced as a barrister since 1973 and was a specialist in medical legal issues including clinical negligence claims in which he acted for both claimants and defendants. He appeared as a barrister at the Bristol Royal Infirmary Inquiry, the Royal Liverpool Children’s Hospital Inquiry and the Neale Inquiry. He regularly appeared before the General Medical Council and dealt with difficult ethical issues in medical treatment. He was assisted in the first inquiry by Keith Morton QC as Counsel to the inquiry and he in his turn had the support of Benjamin Hay and Joanne Hughes. The secretary to the first inquiry was William Vineall.

Robert Francis handled the inquiries with a deft touch and occasional humour, often intervening during the course of evidence to put his own questions to witnesses. He treated the patient groups with great sensitivity.

Second Inquiry

The second Inquiry was established in June 2010 by the Secretary of State Andrew Lansley under the Inquiries Act 2005. It was to be a public inquiry and the chair was charged with securing reasonable access for the public and publishing statements and a transcript of the evidence on the Inquiry web site. He had the power to compel people to give evidence and require the production of evidence. He could, and did, issue directives which ensured that the names or clinical history of individuals were kept confidential.

The Inquiries Act specifically provides that the Inquiry is not to rule and has no power to determine any person’s criminal or civil liability. It was an Inquiry not a trial.

The terms of Reference were as follows;

To examine the operation, commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March
2009 and examine why problems at the Trust were not identified sooner; and appropriate action taken. To identify the lessons to be learned.

Prior to attending the inquiry to give oral evidence, which was taken under oath, each witness made a formal statement in writing which was circulated in advance to all core participants. It was an inquisitorial exercise and not a forum for adversarial litigation tactics. A list of witnesses is set out in Appendix One.

The hearings were held in the Council offices in Stafford. The Inquiry team and core participants and other legal representatives were in one large room. The public and press were in an adjacent room with an open room divider which allowed them to see and hear the proceedings. The public room also had monitors displaying the simultaneous translation of the proceedings and any documents produced for witnesses.

All questions to witnesses were channelled through the Inquiry Counsel. The lawyer representing a witness had a right to ask their client questions to clarify their evidence at the end of the questioning process.

Counsel to the second Inquiry was Tom Kark QC who was called to the Bar in 1982 and whose specialist area was medical regulation although he was also an expert in white collar crime and had represented the Serious Organised Crime Agency in a number of major cases. He too appeared regularly before the General Medical Council. His low key but insistent questioning drew much out of nervous witnesses.

His first junior Counsel was Ben Fitzgerald who had specialised in Fraud and Regulatory cases and public inquiries. He had prior experience as a researcher for BBC Newsnight and Breakfast News. There are two other junior Counsel, Joanna Hughes who had been involved in the first Francis inquiry and Tom Baker whose experience included the General Dental Council and the Nursing and Midwifery Council.

The Solicitor to the Inquiry was Peter Watkin-Jones who had led teams on a number of public inquiries, including the Shipman Inquiry. He had been supported by Luisa Gibbons, Catherine Henney and Sara Garner. Secretary to the Inquiry was Alan Robson a senior civil servant from the Department of Health. His job immediately prior to the Inquiry had been a Deputy Director for Elective Care and Diagnostics. The Chair had designated the following as core participants;

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Solicitor</th>
<th>Counsel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cure the NHS</td>
<td>Derek Miller</td>
<td>Jeremy Hyam, Kate Beattie</td>
</tr>
<tr>
<td>AvMA and Patients Association</td>
<td>Adam Chapman</td>
<td>Peter Skelton</td>
</tr>
<tr>
<td>Mid Staffordshire NHS Foundation Trust</td>
<td>Andrew Vernon</td>
<td>Katie Price, Nick Mullany</td>
</tr>
<tr>
<td>South Staffordshire PCT</td>
<td>Nick Parsons</td>
<td>Rachel Langdale QC, Rob Harland</td>
</tr>
<tr>
<td>West Midlands SHA</td>
<td>Alan Mowat</td>
<td>Sally Smith QC, Christopher Mellor</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Sue Pickering, Philip Elvey</td>
<td>Gerard Clarke</td>
</tr>
<tr>
<td>Monitor</td>
<td>Richard Caird</td>
<td>Karon Monaghan</td>
</tr>
<tr>
<td>Organisation</td>
<td>Legal Representative(s)</td>
<td>Chair's Decision</td>
</tr>
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<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>Care Quality Commission and HCC</td>
<td>Carlton Sadler, Katrina McCrory</td>
<td>Debra Powell [CQC]</td>
</tr>
<tr>
<td>Health Protection Agency</td>
<td>Stirling Harcus</td>
<td>Paul Spencer</td>
</tr>
<tr>
<td>National Patient Safety Agency</td>
<td>Janice Barber</td>
<td>None</td>
</tr>
<tr>
<td>NHS Litigation Authority</td>
<td>John Riddell</td>
<td>None</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

All the core participants were legally represented at hearings and entitled to make an application to the Chair for their legal expenses to be met [as could witnesses]. They could also make opening and closing statements to the Inquiry and in exceptional circumstances and with the permission of the chair ask questions of witnesses during oral evidence.

The inquiry had a relatively relaxed atmosphere with Counsel, the press and patient groups mixing together in the adjacent entry and coffee room. For the most part the public [predominantly members of CURE or future witnesses], listened in silence to the oral evidence. The local press attended every day with the nationals and other media making only occasional appearances. The relationship between the local press and the patient groups was very close and comments about the veracity of witnesses were often shared during breaks.
**Salmon Letters**

Any person who was the subject of criticism in the Inquiry report was issued with a warning letter and given the opportunity to respond. [Rule 13 of Inquiry Rules 2006]. Many were sent in September and October 2012 and a number of recipients including the Department of Health are understood to have asked for an extended time scale for their response.

**Advisors /Assessors**

Robert Francis was assisted at the first inquiry by a team of experts;

- Professor David Black. Consultant Physician in Geriatric Medicine.
- Tricia Hart. Director of Nursing and Patient Safety.
- Tony Allen, Lawyer and Mediation specialist
- Mary Bakers. Former Chief Executive of Parkinson’s Disease Society
- Peter Hutton, Professor of Anaesthesia.
- David Richardson, Foundation Trust chair.

Professor Black, Tricia Hart and Peter Hutton were joined by Sir Adrian Montague a lawyer with extensive commercial experience, at the second inquiry.

Quite late in the day and after the Salmon letters had gone out a further team of external advisors were appointed to assist the Chairman in framing his final conclusions and recommendations.

- Dr Judith Smith, Nuffield Trust.
- Professor Peter Homa, Chief Executive. Nottingham University Hospitals Trust.
- Sir Cyril Chantler, Former Dean of Guy’s, Kings College and St Thomas’s Hospitals Medical School.
- Nigel Edwards. Kings Fund and former Head of Policy at the NHS Confederation.

**Cost**

The Inquiry team itself had a staff of over 50 if you include the dozen pupil barristers. The total cost of the public inquiry was of the order of £14 million.
Chapter Three
The Mid Staffordshire Public Inquiry Day by Day

Each day of the inquiry was reported on nhsManagers.net by the author who was acting as a special correspondent.

Days 1-4 were taken up with opening statements by Counsel to the inquiry and the core participants.

Day 5

History

A day spent working through the history of the NHS with two experts. A very dry day for the relatives although the audience, who are located in a side room, are still spellbound by the simultaneous text rolling down their monitors.

The Inquiry tracked through the myriad of NHS reorganisations stopping occasionally to check accountabilities and the pace of change from an administered to a managed organisation. The target regime had a good outing and the P45 issues for Chief Executives were exposed and explained. “The NHS has never been short of ideas and whilst this renewal in innovation is a real strength the latest big idea can also exercise a form of tyranny over Boards and organisational agendas”. Accountability and quality were regularly probed.

The role of the Secretary of State was examined and produced a comment from the chair “On the other hand you have a Secretary of State who in reality can tell anybody in the system what to do through guidance but on the other hand because of legal structures can separate himself from that because actually the system says that for instance that the Chief Executive of a PCT takes the decision.” This appeared to be just a sighting shot for future questions.

Later in the day the Inquiry turned to whistle blowing, the duty of doctors to report potential harm to patients, patient safety and ethical issues such as the duty of candour by professionals.

With many months to go the Inquiry team is going to have to work hard to avoid being smothered by explanations of an extraordinarily complex and constantly changing bureaucracy. The tempting prospect of an exploration of commissioning structures and processes on day six is unlikely to bring in the crowds.
Day 6

I cannot go there.

More historical background about the development of the NHS. Interesting exchanges with expert witnesses about the respective roles of Chairs and Chief Executives and questions as to whether a Medical Director could say to his Board “I cannot go there because my professional code of conduct will not allow me to”.

The role of Non-Executive Directors was examined. The hours spent explaining the development of commissioning was positively tedious until it got to patient safety and the overlapping monitoring roles of a PCT and Monitor.

Exploring these issues was complex and was effectively ended by the expert witness who responded to a question as follows “I am scratching my head. It is just getting late”. A very human touch!

Day 7

Patient safety

A teach-in on patient safety. In a comment on Stafford the expert witness explained that whilst the particular tragedies were huge and the extent of the harm was great, the specifics of what people did and didn’t do were familiar problems in healthcare as were the contributing factors.

The inquiry should look for system faults rather than spent all their times hunting down individuals to blame. Were faults reported to the National Patient Safety Authority passed onto to CQC the inquiry team wanted to know?

Later in the day George Orwell got a mention in the context of the responsibilities of busy professional staff. Before I did this [washing up] I used to wonder why the poor did not rise up in rebellion. I realise now they have no time!

All very interesting and technical designed to outline the problem of safety in health care. Of interest to professionals and lawyers but I doubt it convinced those in the public gallery.

Day 8

Regulatory Landscape

A day focused on the regulatory landscape which led into stars, earned autonomy, annual health checks and self-certification. The Bristol and Shipman Inquiries got an outing as both had had something to say about the regulation of health professionals.

The expert view that the problem in England was a problem of enforcement rather than detection was noted with interest. God forbid anyone would suggest that the professional regulators should
be merged with CQC said the expert witness which prompted the Chair to respond.... now there is a thought!

With I suspect a twinkle in his eye. Much more of this to come later I am sure.

Days 9 -14

Patient Stories

Days now of evidence from patients and relatives, both in person and by statement. But, before they began, some testing legal issues had to be resolved. What were the rights of individuals named in witness statements? Did they have a right to come before the Inquiry and respond? Should the Chair place restriction orders on the publication of some names including those whom the witnesses may want to criticise or attribute blame?

In the end a way through was found. Not easy public inquiries.

Eventually the patients and their relatives told their stories. Many were harrowing with the grief and anger only barely contained and visible both to those present and those reading the transcripts. It was the detail in the stories that was so damning and made them so believable. Many of the witnesses went onto describe their attempts to complain, which were usually smothered or explained away.

Some of the witnesses either had a health background or came from NHS families. At least one had come under pressure to moderate his criticism but had bravely resisted. They expressed a sense of shame that what had happened could have happened in an organisation that was supposed to have care at its heart.

Others describe in some detail the action they took to eventually get a public inquiry established and the respective roles of both local and national politicians. Many witnesses thought that the whole system had let them down but others acknowledged that there were some very good doctors and nurses in Stafford who had to practice under the influence of people that did not have the caring influence in them.

If the NHS ever had a brand it was now indelibly tarnished. Was this the acute version of the scandals and inquiries in the mental health field thirty years earlier?

All Chairs and Chief Executives should sit down in a quiet room and read these transcripts and ask themselves the question; could it happen here?

Day 15-18

Local Government; Quality

The focus shifted somewhat to examine the role that the official patient and public representative organisations had played in Stafford; Patients Forums, LINks, Oversight and Scrutiny Committees, Pals and others. Some had supported the Trust but were now criticised by witnesses for having a cosy relationship and a timid approach to challenge.
Interested patients and members of the public described how they found it difficult to get access to infection rates and the like. Accessing patient records was even more challenging even if the relative paid. As the public pressure mounted on the Trust it seemed to have gone into defensive mode with their legal department calling many of the shots about disclosure.

The evidence given by witnesses relating to the performance of local government was challenging to say the least. We will have to wait for their response.

The patient focus continued as one patient representative described what they considered to be unacceptable behaviour by nursing staff. As one witness put it ...sharp to the point of rudeness and focused on explaining how expensive drugs were rather than relating to a nervous patient.

A number of witnesses came with solutions which the Inquiry team will no doubt consider. The advice that resonated with me was for senior managers to get out of their offices and incessant meetings and go walk the floor and talk to patients. One relative who had been critical of nursing standards had got to see two modern matrons who blamed it all on Project 2000.

One witness summed up her view of the regulatory systems as follows; “I think there are too many organisations. They are too complicated and I don’t think they talk or listen to each other. I also think regulation is a box-ticking exercise. There were all these targets. It’s all about getting operations done. But if somebody comes out of hospital in a coffin, what is the point of tick boxing? When my mother was in hospital too many nurses spent their time gathered around the computers but not enough actually nursing. They need to listen to people and not treat people as whingers. They need to train nurses properly “

There followed an exchange between the lawyers about whether a ward sister criticised in a witness statement could be named. She was named.

Another member of the patient group with a background in quality and safety policies offered his advice that the NHS needed stronger and better standard operating policies and procedures. This discussion led eventually to a description of the Trust’s preparation for foundation status which had so preoccupied the Board.

By the spring of 2009 everybody it seems was involved in the Stafford problem including local MPs; Ministers, RCN, Department of Health, Monitor, Health Commission. The Secretary of State claimed that Stafford was a one off, which may turn out to be a brave statement that he will regret. The publication of comparative mortality data further muddied the water. Was it right or were the statistics dodgy?

By now witnesses are describing their conversations and interaction with the big players in the NHS. Many will later be called to give evidence.

Day 19

More patient stories about alleged inaccurate diagnoses and poor nursing and accounts of what witnesses thought was an ineffective overview and scrutiny committee in Staffordshire.
Day 20

Truth and Reconciliation

Was the Chair of CQC right to call the Dr Foster data flaky? Was this an inappropriate remark or fair comment the Inquiry asked. Andy Burnham gets a good deal of stick from witnesses but Alan Johnson gets a better press...he listened. The Trade Unions come in for critical comment by witnesses although the RCN clearly spent some time in Stafford talking to the patient group.

The possibility of a South African style truth and conciliation committee is raised. Langley and Cameron visited Stafford on at least 7 occasions which no doubt heightened the political temperature.

Little has changed said one witness sadly... the culture was very, very intractable. An interesting point to reflect on is a comment by one witness about the comfort and support they had received from being a member of a campaigning support group [Cure the NHS].
Day 21

**Patient Forums and LINks**

The sixth week of the Inquiry began with more evidence about the effectiveness of the patient forums and the LINks organisations.

The members in Stafford had been banned from discussing MRSA in the run up to the general election! There had clearly been a major spat between members which the Inquiry went through in some detail. Inappropriate behaviour: breaking the rules; probably associated with talking to the press.

Was there a place for mavericks? Familiar stories about how the complaints procedure had failed to satisfy complainants. They clearly had not got the message that if a mistake is made good organisations recover brilliantly and get credit for this.

Age Concern’s role in setting up the Patient Forum was covered in some detail. The Patients Forum at the Stafford hospital had a good relationship with the hospital in their view.

Day 22

**It’s what you expect of the NHS today**

As the examination of Age Concern continued the key questions begin to emerge very clearly. As one witness [a senior nurse by background] put it “how could all of this happen and we not see it “.

And yet this same evidence produced some really excellent examples of how volunteers could add value... despite worries by some about volunteers becoming a safety net rather than an addition to professional care.

There was also one of those killer answers to the question as to whether Stafford was an exception... it’s what you come to expect in the NHS of today !The final witness of the week who had played a major role in the Patient Forum and as a Foundation Governor claimed to have been shocked as the patient stories emerged.

Some individuals must, he thought, have been blocking the information flows and obstructing open visiting by governors. More of this to come I think as the Trust defends itself in due course.

Days 22/23/24

**An Independent complaint handler?**

Two days listening to patient associations. Did CHCs need fixing, not replacing, the inquiry team asked as they heard evidence of their chaotic breakup and transfer to CPPIH [which you will recall lasted only a short time].
Was this cock up or conspiracy. Were CHCs getting too troublesome for the DoH or was it a new minister wanting to put their own brand on patient power? Probably a bit of both the witness explained. Were PALs ever truly independent?

It is already clear that the Inquiry will have much to say about patient and public engagement with NHS organisations.

Safety came up once again with the assertion that there were 200 instances of trusts not complying with safety alerts over 5 years old. If I were a Chair/Chief Executive I would check before I was named and shamed!

The Chair asked one witness about the apparent asymmetry between the accountability of health professionals to their regulator and that of managers who moved from one job to another when things went wrong [sometimes after big pay-outs].

The proposition that an external body should put an independent complaint handler into each Trust was examined and may run as an idea. Trouble is it leaves complaints in the negative box. Some would argue that complaints are golden as they tell you how to improve! The negative box will I think win in the end…..it usually does!

The Patients Association reported that whilst the National Inpatient Survey results for 2008 showed that the number of patients rating their care as excellent had increased from 38% in 2002 to 43% in 2008 the number of patients who rated their care as poor had remained static at 2%. Over the years of the survey this represented 10,000 patients and if the result was extrapolated to the whole of England it would equate to 1 million dissatisfied patients.

*The Inquiry Team break until Mid-January to digest what they have heard so far and prepare for the next round of witnesses.*
Days 25 and 26

**Patient Involvement Forums et al**

The Inquiry continued its hearings after the Xmas break on 10th January with an examination of the public involvement organisations CHC’s, PPIF, LINKs and the future Health Watch.

Two organisations who had acted as hosts for PPIF’s and LINKs, Age UK and Staffordshire University described their experiences and the tensions and conflicts they had to deal with.

In Staffordshire there was much personal tension between individual members, reports of misbehaviour on away day’s and complaints by university staff about the behaviour of some members.

The LINKs was clearly dysfunctional. The University offered to give up its hosting contract on at least two occasions and eventually lost the contract which returned to the County Council. What the Inquiry needed to know was whether this was just a problem of relationships in Staffordshire or a more fundamental fault in the whole system.

The interface between Cure the NHS, the loose gathering of patients and relatives, focused on the Stafford Hospital and the LINKs organisation was explored in great detail. Not a happy story.

**Day 27**

The LINKs organisation changed under new management but complex and poor relationships remained a major challenge. The business of the LINKs organisation was clearly dominated by the Stafford Hospital issue which made it difficult to concentrate on other parts of the health care system.

Should anybody external to Staffordshire have intervened is a question the inquiry team will have to answer eventually?

**Day 28**

A day of evidence from POhWER a charity who undertook some training for the Trust.

**Day 29**

**Complaints**

A painstaking examination of the complaints process at the hospital and its many changes over the years. An attempt to devolve complaint handling to divisions proved to be difficult and left the central complaints function to handle progress chasing.

Panel reviews by non-executives were abandoned on the grounds that their report backs took up too much time at Board meetings. Did this not leave non executives blind to what was going on in the wards asked the Counsel to the Inquiry? Complaint numbers were grossly understated at one
point at least in so far as the Chief Executive was concerned. There was much discussion about the distinction between a complaint and a serious incident. All the Chief Executives and particularly those in post in recent times spent an inordinate amount of time handling complaints and seeing relatives themselves, with mixed success. We can expect the Inquiry to have a lot to say about complaint handling when it finally reports.

Day 30

The Granny Test

An important day with the first robust defence of the hospital by one of the Counties most senior General Practitioners who had also worked at the hospital. The LMC had had no significant quality issues with the hospital but was aware of concerns amongst nursing staff about staff cuts.

As far as he was concerned the hospital passed the “granny test”.

As the conversation stretched into tomorrow’s world of consortia this GP expressed the view that patient care had been lost as a result of the governments choice agenda. He thought it very unfair to pick Stafford out for a public Inquiry. Many other hospitals had standard mortality rates above the norm.

Another GP whose practice had been a sleeping member of the local consortia [they accepted the consortia decisions but did not attend meetings] reported concerns about nursing standards [feeding and toileting] from 2008.

His view was that there were other hospitals like Stafford in the NHS.

Day 31

GPs received few complaints

More evidence from general practice that they had received few complaints.

A GP Consortia manager followed who reported that the organisation was growing in membership and influence. He reported concerns about Accident and Emergency going back to 2007. However a trial that drew General Practitioners into the Department was ended in 2009 when no evidence emerged that could demonstrate admission avoidance.

The Inquiries’ interest in tomorrow’s world will be of concern to Andrew Lansley!

Day 32

A growing unease

More evidence from General Practice who again report few complaints about the hospital from patients but a growing unease.
As one put it ‘a disaster waiting to happen’. When did unease become concern? When was the higher threshold reached? As one GP put it 90% of the patients treated at Stafford were happy with their care and that story needed to be set alongside the 10% that did not.

It is now clear that General Practice knew little about the complaints problem that the hospital was handling. It was clearly not something the hospital would want to broadcast...they wanted to retain their market share.

Day 33

Local Medical Committee

Another day with General Practitioners and a fascinating examination of the status and functioning of the Local Medical Committee which of course knew little about any problems at the local hospital.

I always thought of LMC’s as the GPs Trade Union but apparently they also act as the patients advocate!

The excess deaths reported by the Health Commission amounted to one per GP per year which was unlikely to light up any alarm screens. Lots of negative comment about top down Whitehall management of the NHS and not much enthusiasm for tomorrow’s world.

“Pathfinder suggests there is somebody at the head of the organisation chopping his way forward with a machete in order to find the way ahead. Pathfinders are part of a roll out on a broad front”.

The Any Willing Provider model could destabilise the NHS as the private sector creamed off things like cataracts and hernias which were profitable. One of the GPs saw a schism between the LMC and practice based commissioning. Most of the GP evidence demonstrated that they liked the idea of General Practice being in charge of the NHS but had little enthusiasm for taking the reality into their day to day professional lives.

Given the weight of evidence being presented to the Inquiry about tomorrow’s world they will have to say something about it in their report. I wonder if Andrew Lansley is contemplating giving evidence or will he leave it to his officials?

Now there is a thought Ministers being questioned under oath about their policies...

Day 34

Overview and Scrutiny Committee

A County Councillor took the witness box and the Inquiry team spent the day examining over view and scrutiny committees. Were they founded on a critical friendship or were they a political basketball match.

The value of Prime Ministers question time got an airing [which is probably beyond the Inquiries brief but what the hell].

The Councillor explained that he could never understand where the buck stopped in the NHS. Some competition with regard to dealing with Stafford hospital between the County and District Councils
was reported. It also became clear that in tomorrow’s world the Health and Wellbeing Committees are expected to have a role in commissioning with GPs in order to make it “smarter and better”. Commissioning may in future be at some distance from national politicians but local politicians can clearly see a major opportunity to get involved.

Out of the frying pan into the fire comes to mind.

By way of a summation we find at the end of the day; “I doubt there is any organisation involved with scrutiny or the oversight or regulation of health that does not bear some responsibility, because it happened. I don’t necessarily think that it is directly the fault of any one organisation. There was however a weak legislative framework created by Government”.

So there you go the buck stops somewhere in Whitehall.

Day 35

District Council

The turn of the District Council who when challenged agreed that they did have the responsibility for the oversight and scrutiny of Stafford Hospital but argued that it could only be at a strategic level. They had no rights of inspection.

In any case they had been both reassured and impressed that the hospital had secured three stars and was judged eligible for foundation status. How aggressive should a critical friend be?

It had taken 17 experts to identify the excess mortality problem, how could they be expected to be any better…a fair point!

Interesting proposition that the Local Authority should become a full member of a trust board.

Days 36 and 37

More Overview and Scrutiny

The Inquiry continued its examination of local authority oversight and scrutiny committees in Staffordshire. It is clear that they were never properly resourced and that the respective roles of the County and Borough committees were never satisfactorily clarified. They tended to stand back when other inspectors got interested in the Stafford Hospital. Should the oversight committees find out if things were going wrong or wait to be told, the Chairman enquired?

When the hospital dropped from three to zero stars the County oversight and scrutiny committee complained to a local MP that the system must be flawed. “We don’t like our hospital being criticised; we think unfairly”. Defend our hospital was how the local MP described the culture at the time.

The Borough committee did have some expert advice in the form of a councillor who had previously been the Director of Nursing at the hospital.
There was clearly tension between members and according to one witness the Trust tried to get the chair of one of the committees replaced. Inevitably he found out about their pressure which did little to improve relationships.

If this is the best local authorities can do the Secretary of State needs to think again about their role in the health sector. The Inquiry report will, I think, be very critical and so it should be!

**Day 37**

**Getting the right cases to the Coroner**

An interesting account of the role of a trust medical examiner. They are doctors whose role is to ensure that the right cases get referred to the Coroner and that the cause of death is accurately recorded on death certificates.

Interesting debate about spotting patterns and whether one should have been visible in Staffordshire.

**Day 38**

**Members of Parliament**

The Inquiry starts to take evidence from local MPs who became increasingly involved in the affairs of the hospital once the storm broke. How much did they know? Were there any clues in their constituency mailbox?

Apparently not. The official data “will not pick up cases were care is poor but the patient has not been killed as a result”, one explained.

Did MPs nod through the application for foundation status or give it enthusiastic support as the Trust reported to monitor? Did Monitor check what it was being told...apparently not?

Interesting exchange about whistle blowers and the idea of having an independent support officer in each trust to whom staff could go to with their concerns.

**Days 39 and 40**

Another MP who had been quite close to the hospital and who had worked alongside hospital staff during the parliamentary recess talked the inquiry through his version of events. Interesting story about the Chief Executive of the Trust briefing MPs about financial problems...in the hope of greater allocations presumably.

But did the Trust have a real deficit or was it exaggerated? Could the promises to limit cuts to backroom staff be delivered? How could a Trust said to be performing at the highest level and going forward to Foundation status be on the brink of closure a year later because it could not balance the books? Reflections after the event!
Meetings between local MPs and Ministers produced only tea and sympathy. An MP who had always strongly supported the hospital acknowledged, at the end of his evidence, that if the future was one of continual trade off in the quality of care he might have to reconsider his support.

The next MP referred most constituency complaints to the Secretary of State because he or she was in charge... or so he thought. He expected the Department of Health and the Regulators to monitor quality and tell MPs what they found.

It was difficult for MPs to challenge NHS people...but that would change in the future! Those Chairs and Chief Executives with cosy mutually supporting relationships with local MPs may be in for a shock.

Some concern about foundation status and the distance it created from the secretary of state and the fact that much NHS business was conducted in private. Quite a lot of comment about the early SHA view that there was nothing out of the ordinary in the data relating to mortality in Mid Staffordshire. More to come on this no doubt.

The overall balance of this evidence suggests that MPs were out of their depth in judging local health services and simply reacted to public pressure. Maybe that is all we can reasonably expect of them!

**Day 41**

**Were the Councillors Duped?**

More on overview and scrutiny which demonstrated how difficult it was for councillors to get involved and keep informed about day to day NHS operations and shifting political and clinical policies.

Some sharp comment about some of the Trusts representatives duping the Oversight Committee although things were reported to have improved in recent times.

**Trade Unions**

Next was UNITE one of the unions with a membership base in the laboratories and maintenance staff at the hospital. Unions were, in their view, tolerated rather than encouraged at the Trust who they claimed were hell bent on securing the holy grail of foundation status.

Interesting questions about the role of trade unions in defending quality as well as jobs. Should the Union report any concerns to the Regulators? No but they might in the future...a Pandora’s Box had just opened. In future Unions may well seek to delay management action by a reference to the Regulators!

RCN next with a long standing [30 year] representative and a full time official. No evidence of a fear of whistle blowing. Concern about all the publicity but never read the Health Commission report. Knew nothing about a staff survey that suggested that 47% of staff would not want to be treated at the hospital. Intimidated by the Director of Nursing?

Sadly, a union philosophy of cooperation rather than conflict probably made them a push over! Was this a tough Matron in the old style, which many hanker for, or an unreasonable manager?
Another sensitive judgement for the Inquiry to make.

The RCN are clearly torn between defending local members and representing the wider profession and national standards. The General Secretary may have his hands full when he gives evidence.

Days 42-43

Unions; don’t stick your head above the parapet

Continued evidence by Trade Unions and Unison in particular with 800 members at the Hospital. They clearly made little impact on Trust managers as they sought to balance the books. It was local representatives who tried to engage the support of their MP. No problems or concerns appeared to have filtered up the system to union head office until matters hit the national headlines. More talk about a bullying Chief Executive and a dominating senior nurse. The culture of the hospital was “It did not matter whether you were a nurse, housekeeper or porter you did not stick your head above the parapet”.

A worrying exchange about staff being told to stop sending queries about death certificates to the governance team for review. The Inquiry team will no doubt follow this up as they will the comment that expert staffs at CQC were being made redundant.

Day 44

Independent case note reviews

Important evidence from the external doctor brought in by the Trust to manage the Independent case note review process. The process was set up after discussion with Ministers and eventually involved reviewing 200 cases. The process was there primarily to support the relatives of deceased patients and was a vehicle for informing families as to whether their loved ones had been one of the excess deaths. The reports went to patients whose consent was to be sought before any report was seen by the Trust. Evidence was presented that a Trust manager did seek to review the reports before they went to relatives but were prevented from doing so by the independent external doctor. Once it was clear how big the task was the responsibility for managing the process was passed to the PCT and things speeded up. The themes that arose from the reviews were hygiene on the wards, issues of food and drink, issues of attitude of hospital staff, delays in treatment or diagnostics, communications, healthcare acquired infections, resuscitation, do not resuscitate orders and withholding treatment, skin tissue viability, medication and recording. Complex cancer and neonatal care also arose. All in all most things!

A lot of discussion about how independent case review processes work and whether they should be embedded into day to day practice. Watch for an addition to patients’ rights in the final report...that of having an independent case review!

Should quality be connected directly to the commissioning function...or was that a potential conflict of interest? A funny question or something to think about? Some sharp examples about how poor GPs were in reporting faults in quality and safety issues. A review of anticoagulant therapy [not in Stafford] had led to reports of adverse events in hospitals but not a single one from primary care where many more patients were now receiving anticoagulants.
Day 45

A brilliant personal experience

A witness whose family had had a brilliant personal experience at the hospital when her son was treated and then died of cancer. She went on to join the Patient Forum and then became a Foundation Trust Governor. The Forum did identify faults in hygiene and environment which they reported to managers. They did not get involved in reviewing clinical activity. They did not see this as part of their role. She thought that the Patients Forum had done a reasonable job. As a Governor was constantly reassured by managers that everything was in hand, everything was OK. The excess deaths were a product of poor data they were told and they believed this to be true. This witness eventually resigned after a stormy meeting with Monitor. We could have done better she said. We should have been stronger.

Day 46

Two Difficult Consultants

Two hospital consultants next. Both had a history of difficult relationships with management. The first had been involved in a running battle for some years about low staffing levels and had written a series of letters to clinical directors. He eventually gave independent evidence to the Health Select Committee. Stafford never closed whatever the pressure whilst other hospitals in the region did for respite reasons. Stafford struggled on. Shocked by the Healthcare Commission report but no problems on his ward. If he observed low standards of care he would do something about it. When the Chief Executive asked the Consultants not to talk to the press they did as they were asked. He left with three suggestions for the future. Senior nurses should work on the wards one day a week, that the medical director should be appointed from outside the consultant body and that all hospital directors should have an MBA.

The second consultant had also had a running series of disagreements with managers about nurses not being available for ward rounds and problems with medical secretaries.

If you complained he explained you were seen as being awkward. I am brave but I am not Nelson Mandela he explained. There was a club he said who had a vested interest in protecting each other. You had a battle on your hands. You are living in a hostile environment. You are always watching your back in case a mistake, [and things do occasionally go wrong], becomes the excuse for destroying your career. When asked whether he had raised his concerns with the SHA he replied “No, these people are like God. Nobody has seen God. Far removed from real workers at the coal face”. His other grievances included not being awarded clinical excellence points which he attributed to his pushing for quality standards. He was at one point totally and thoroughly fed up but shocked when he was offered a redundancy package.

He finished his evidence with a plea for calm and an end to neurotic anxiety in Stafford. If things are wrong they would be sorted. Where they were not wrong this should be acknowledged. If you don’t you undermine some very dedicated and hardworking people.
Day 47

A Nurse Governor

A senior nurse who was also a Governor of the Trust described the atmosphere in the hospital after the redundancy programme. People were nervous and uncomfortable. There was a general feeling of unhappiness. She then made a comment that, for your commentator at least, struck at the heart of the problems in Stafford and perhaps the rest of today’s NHS.” Nursing should be about holistic care. Not just giving tablets, putting up drips or changing dressings. It’s about being able to spend time with a patient, being able to listen to them, provide them with reassurance; if they are anxious being able to hold their hand. That has gone from nursing and that is not just Stafford”.

Moving patients out of intensive care at a weekend was always a risky procedure she explained. If you filled in an incident form it was filed in the bin! The teams that were targeted to reduce lengths of stay and hit A and E targets caused tensions when they raised their voices on the wards. Where the new breed of modern matrons bullies or just driving to hit targets as was expected of them?

This very experienced nurse then related her personal experience when her father was admitted via A and E. She feared for his safety as he experienced wildly varying quality of care and treatment in different parts of the hospital. Some wards and services were awful and others brilliant. All however have been tarred with the same brush in the media. “No matter how hard nurses worked, or perhaps what changes management were trying to implement, there is still this element that it is all wrong and all the care is bad”

Some evidence about the role of a Trust governor and the training they received. Were the Governors overly concerned with staff morale at the expense of patient safety? No was the reply but it was soul destroying to be the butt of constant public criticism about poor nursing care.

A short break for the Inquiry team now as they prepare to move up the management structures of the NHS and the leaders of professional bodies et al.

Day 48

Coroner has a hard time

The turn of the South Staffordshire Coroner to give evidence. Did he see any trends in patient mortality? No, he replied, he was always focused on the death in front of him. He had no data base to interrogate and only limited staff resource. He took exception to a freedom of information demand from the Health Care Commission about the number of inquests involving the Trust and the verdicts over the period covered by their investigation. They wanted the answer to questions he could not resolve for them. It would involve a manual search through thousands of files. In any case Coroners are not subject to the Freedom of Information Act. They should have known that. The Commission was in his view” a little unprofessional” and approached him on the basis of seeking to criticise him which he did not think was right.

Many of the problems identified by the Health Commission came up in cases before the Coroner, particularly allegations of low staffing levels. Why these concerns did not emerge more clearly from the Coroners work the Inquiry team asked. The Coroner seemed more concerned about Burton
Hospital which was also on his patch. Was he complacent the Inquiry asked? No, he replied that would be unfair...I had no strong indicator at the time that anything was worse at Stafford than it was at Burton. He did not suspect that there was a systemic failing at Stafford Hospital.

Was he too close to the Trust the Inquiry asked? Why did he invite the solicitor to the Trust to join his team as an assistant deputy coroner along with a doctor from the Trust? Would this have made them less likely to force issues? Were the posts advertised? No, he had a good working relationship with both the major hospitals in his area; he replied but insisted that he had firmly retained his independence.

The Coroner was in the witness box all day and must now anticipate with some concern the outcome of the Inquiry. It might however open up for wider public scrutiny the poor resourcing of the Coroner service nationally and their almost Dickensian methods of working.

**Days 49-51**

*“The service provided by the general surgical department is inadequate, unsafe and at times frankly dangerous” reports the Royal College of Surgeons.*

Evidence from Consultant Medical staff which was deeply unimpressive and at times alarming. Staff shortages had been discussed at Consultant meetings but nobody said much about it other than grumble. In emergency care everybody just worked longer hours. At one point the A and E Department had just one consultant but it never closed or referred cases or sought help from another hospital. Stafford was not exceptional one consultant explained “there were others on a par with Mid Staffordshire”. The consultant in charge of emergency care had never written a report for the Coroner or been to an Inquest which was a mystery to the Inquiry team!

All blamed poor leadership either at Departmental level [A and E] or hospital level. Managers had tried to push problem solving down to a ward/division level. However if a problem could not be solved at this level there was no effective escape route back to the Board. The injection of GPs into A and E had improved relationships between the hospital and general practice but had not impacted on admission levels. One consultant had attended a meeting between the Trust and the PCT and thought he had entered a very hostile environment. One of the consultants had the lead for implementing NICE guidance but it was always a challenge. The medical staffs were reluctant to accept national guidelines and always wanted a Stafford version. They were very old fashioned in their outlook. He thought NICE guidelines should be compulsory. [But who would monitor their implementation the Inquiry team asked?]

An interesting discussion amongst the lawyers as to whether the Inquiry had spent too much time on Stafford hospital and not enough on the higher levels of the NHS and the regulatory framework.
Next to give evidence was a surgeon from a deeply dysfunctional division. Some theatre staff refused to work with one surgeon as the atmosphere in the theatre was so tense. There were allegations of assault, poor relationships and a lack of insight into the many problems. The two colorectal surgeons had no working relationship and as a result there was a lack of agreed protocols. The introduction of a patient dependency based service meant that surgeon’s patients were scattered throughout the clinical area which led to a loss of clinical focus. It was not a disaster one surgeon explained... it was just shambolic. The problem was so difficult that the Trust brought in an occupational psychologist and sought an independent report from the Royal College of Surgeons The first report in 2007 was critical but the second in 2009 was damning. “The service provided by the general surgical division is inadequate, unsafe and at times frankly dangerous.”

In so far as team working was concerned the College inspectors reported “that the behaviour of many of the consultants was unacceptable....poor behaviour ultimately affects team performance and patient care- this must be dealt with in a robust manner by senior managers.”

Perhaps not surprisingly the surgeon giving evidence will be called back to the Inquiry next week for further questioning.

Day 52

“Too posh to wash”

The General Secretary of the RCN took the stand and began by explaining how the College combined its roles as a trade union and nursing policy developer. Neither he nor his staff knew anything about the problems in Staffordshire until the balloon went up. Rather embarrassingly he had visited the Trust at their invitation on the day one of the Health Commission’s negative reports had arrived but it was never mentioned. Nor did anybody tell the RCN steward that he was on the patch, so they never met on that occasion. Nobody briefed him about the impact of the staff cuts. After his visit he wrote them an effusive letter of thanks. It had been a “pleasant and uncontroversial visit”. Not an incident that reflected well on the RCN but at least he acknowledged this. He asked himself the question many others had also asked “how could it happen that a Trust that so many bodies including the Health Commission [three stars] and Monitors [Foundation status] had inspected and given a clean bill of health could be so bad? At around the time he visited it was hailed in the local press as the eighth safest in England. There was clearly a “disconnect “with reality. He wondered whether Prof. Brian Jarman had spotted Mid Staffordshire as an outlier as far back as 2000 but this needed to be checked by the Inquiry team.

His visit to Staffordshire was exactly that, a visit to keep in touch with local members and local employers. The RCN did not do inspections... that was the role of others.

Part of the explanation he explained might be that hospitals have a whole series of “microclimates” some good and some bad. He was shown the good.
Hi’s second visit followed a tip off from the Health Care Commission that something was wrong at South Staffordshire. He was shocked when their report was published.

Some interesting challenges about how close RCN leads at the Trust were to managers...were they too close the Inquiry team asked? When does the role of a steward who is also a senior manager become untenable? Some Trusts paid the salary of RCN stewards as an investment in good staff relationships. Others like Stafford gave stewards reasonable time off.

Nobody at the Trust used the protection of the whistle blower laws to speak up. Nobody rang the RCN hot line. How far did an employee’s duty of confidentiality to their employer stretch? The RCN’s own whistle blowing guidance for members said nothing about CQC or Monitor?

In so far staffing levels were concern the College thought an average balance of 65% qualified and 35% unqualified was about right.

The suggestion that nurses were now “too posh to wash “was resisted. Health Care Assistants who now made up a substantial proportion of the nursing workforce should be trained and registered [bring back the enrolled nurse reverberated silently around the hearing room!] It would be helpful he suggested if the RCN had the same role as the royal medical colleges in regard to the inspection and approval of training! The average age of entry to student nurse training was now 27!

Although the RCN would assist members accused of misconduct they would never seek to excuse the inexcusable when it involved the care of patients. The RCN wanted to work closely with patient groups and CQC. Everybody had to learn the lessons of the “dreadful state of affairs” in Staffordshire and prevent this sort of thing happening again and make the NHS better.

A poor hand well played.

**Day 52**

**How Many Nurses?**

The current Director of Quality and Patient Experience brought the Inquiry up to date with current affairs at the Trust. In 2009 when she took over there were between 80-100 trained nurse vacancies but nobody could agree exactly how many. Finance, personnel and nursing kept their own records. At that time observation and fluid balance charts were poor. They were now much better. Nurses were taught complex electrocardiogram packages when the essentials such as slips, trips and falls training were inadequate. There was a lack of focus on training basic nursing care. The culture was now better and old dysfunctional complaints system had improved. The complaints system has been the subject of much probing by the Inquiry so we can confidently expect some comment in their final report.

**Day 53**

**A former Non-Executive Director**

A former Non-Executive Director followed. He found the NHS baffling at times with none of the commercial disciplines he was used to. The Non-Executive Directors thought they were doing well and had the support and confidence of the SHA. They were shocked at the criticism by the Health
Care Commission. No they were not equipped to judge the quality of clinical care and relied on others to do this.

Both ended with an apology to relatives which seemed appropriate in the circumstances.

**Day 54**

**Bastards**

A full day next with the interim Chair of the Trust who had been flown in by Monitor who was beginning to talk tough to the Trust who had gained FT status in February 2008 only shortly before the HCC launched its investigations. But was this tough bullish talk designed to make up for past failures the Inquiry team asked? Was the Stafford foundation status pushed through too quickly in order to meet the political imperative to prove the foundation concept? Was Monitor right to leave quality assessment to HCC/CQC.

The interim Chair was accountable to Monitor, so who took the final decision to part company with the Chief Executive. He had been invited to consider his position but declined to do so....he thought he could bring the Trust round. Legal and other advice was against a dismissal so an expensive compromise agreement was settled. Nobody seemed very clear whether it included a gagging clause.

The appointment of a successor produced a major tussle between the Department of Health and Monitor both of whom had their own candidates. The people at Monitor were speechless at the behaviour of Department of Health officials.” Bastards” internal e-mails before the Inquiry described them as! They would probably claim that they were just making sure that Monitor did what had to be done.

Monitor is going to have a testing time when it comes their time to give evidence as the probing by the Inquiry team appears to be gathering bite.

The interim Chair ended with the comment that the majority of the staff in Stafford were hard working people who wanted to succeed and treat people properly.

**Day 55**

**Surgeon X**

A return of the surgeon who had started his evidence the previous week. The Inquiry team focused at the start on the competence of surgeon X [Not named I presume because some other legal process is in train]. He had been identified in the 2007 report by the Royal College of Surgeons and sent away for mentoring. Despite this his work in Stafford remained a matter of continued concern but was still not properly audited. A problem with an elderly lady stimulated another independent report on surgeon X which reported “This is either a weak clinician giving in to unrealistic patient expectation or a lack of clinical insight. It shows a complete disregard for nationally accepted best practice of MDT working and a complete disregard of other professional advice”. Surgeon X did not accept the criticisms. With hind sight our witness explained he would have been more aggressive with surgeon X. Handling difficult Consultants has always been one of a management teams most
testing challenges! Doctors it seems are no better at handling wayward colleagues than non-medical managers.

The current Medical Director next explaining how managing medical performance could be seen by some as being a bully. However the duty of care to patients meant that you had to act. It was clear that Consultant appraisals were not very robust in Stafford before he arrived. He had insisted that the Clinical Decision Unit be closed down as nobody owned the patients. Important exchange about the future of specialist surgical services in Stafford and hospitals of a similar size. “General surgery went years ago and now consists of breast surgery, vascular surgery, upper GI and colorectal surgery and lower GI surgery. Should a breast surgeon be on an emergency rota?”

A core question for the future of the NHS but will the Inquiry team of lawyers be able to offer a solution? Do these deep underlying problems come within their terms of reference or are they there just to review the bureaucracy.

Towards the end of the evidence a surprise. The damning Royal College of Surgeons reports had not after all been confidential to the Trust. Bruce Keogh the Medical Director of the NHS had a copy before the Trust and had telephoned the Stafford Medical Director to enquire what he was doing about the report. Who else saw the report and what they did about it will no doubt return to challenge future witnesses. How many other hospitals has been the subject of critical Royal College reports? Has CQC or Monitor ever asked for sight of them?

Some negative comments about the BMA defending the indefensible [a nice contrast with the RCN who declined to do so).

Medical Directors who take on colleagues who are not acting or performing well have to be brave explained our witness. Too true but should that always be the case?

Day 56

The foundation status bid

Evidence about the Trust’s application for foundation status by a witness who worked for the Department of Health and Monitor and eventually ended up as Finance Director and Deputy Chief Executive at the Trust. Securing three stars was certainly part of the Department’s entry gate for an application for foundation status but it reflected the achievement of targets rather than clinical excellence. At the start of 2006 the Trust was judged by the SHA to be two years away from a credible application. However during the following months there was substantial pressure from the top to accelerate the time scales.

Downing Street advisors asked for “clever tactics” to speed up the process and Departmental officials wanted more pressure on SHA’s who were “talking a good game but not delivering “. Towards the end of the Department of Health filtering process [prior to a formal application to Monitor] our witness thought that Mid Staffordshire was not ready and that there was too much of a risk that any application would be rejected by Monitor.
The SHA disagreed and the Trust was allowed to make an application which was eventually approved. It had always been regarded as a borderline case within the filtering and approval process but the pressure for numbers clearly overrode any doubts.

In an interesting aside it is emerging that the Inquiry team now have access to a huge number of internal emails from inside the Department of Health some of which are likely to be very embarrassing for the officials concerned.

Day 57

The Interim Chief Executive; Fortress Stafford

Evidence continued on the application for foundation status followed by evidence from the Interim Chief Executive flown in by Monitor. He immediately got on the wrong side of the patient groups by issuing an upbeat press release that acknowledged the failures of the past but noted that some positive progress had been made. He noted the lack of a focus on quality at Board level and quickly put this right. He wondered how the Trust had got through the scrutiny of the SHA, Department of Health and Monitor into foundation Trust status.

“Fortress Stafford” was not viable in his view and needed the support of a wider clinical community. Putting PAL’s outside the remit of the Trust would in his opinion create more problems than it would solve. The PCT had not been very supportive and he saw little evidence that it had aggressively challenged the quality of care at Mid Staffs. A tough and straight forward view from an experienced Chief Executive.

Day 58

Stop the buggers bleeding

The next individual in the Chief Executive merry go round followed. He was, as he put it, a turnaround specialist who came from the “stop the buggers bleeding model of leadership”. He was what we might call a character, with a strong personality and opinions to match. Some targets were good but not when used as instruments of torture. Did former Chief Executives at Stafford have an exaggerated view of their ability...yes. Would an NHS Staff College help. . probably not, just fancy words!

The NHS needed a different culture. Chief Executives should be rewarded for admitting that their organisation was not good at some things. Currently if you admitted to not being compliant “you get some bloody idiots coming down and crawling all over you “He gave some torrid examples.

As for the foundation Trust application process it was, he said, a bit like judging the X factor contestants on the basis of their cv’s or what their mum thought of them “.

Was the barrier lowered to get more Trusts through. . of course it was !.

Was the £10 million cut really required to balance the books or was it designed to impress Monitor and generate a surplus? He was certain that the rescue cash when it came was from the SHA not the PCT [ despite being a foundation Trust !]
Would today’s regulators spot a Mid Staffordshire? No and “there are some pretty awful failures in care in other parts of the NHS”. Pretty robust stuff which enlivened the proceedings no end but left behind a series of smouldering questions for the Inquiry to resolve in due course!

Having stopped the bleeding this interesting Chief Executive has moved onto deal with NHS trauma somewhere else!

**Bring back the Enrolled Nurse**

Next the current chair of the Trust with a background as a senior nurse. When he first arrived at the Trust as a non-executive director he thought basic nursing care was lacking. Patients ate their meals with full urinals on their bedside tables and nobody thought this was wrong. The initial reaction of the Trust to the HCC report was to defend itself rather than acknowledge the problems and deal with them. In all his 40 years he had never come across a Trust with such an ingrained and systemic culture to turn around. It would take time and pressure for immediate change was unrealistic. The regulators and others had been helpful in the attempt to affect a turnaround but there was some confusion about leadership. Should it be CQC or the SHA? One regulator would be very helpful!

Further evidence about Fortress Stafford and isolationism; a theme that will no doubt return in later evidence because it sits uncomfortably with independent foundation status which reinforces the sturdy independent model.

Nursing needs reform our witness argued. The UK may have “the best technical nursing skills in the world but unless they are delivered in a compassionate and caring way it’s not getting there”. Bring back the enrolled nurse he argued. We have heard this before.

**Day 59**

**The Medical Director**

A day of evidence from a former Medical Director at the Trust, a pathologist by background, who seemed somewhat disengaged from mainstream management during her term of office. The questions naturally focused on the underdeveloped clinical audit system. She had been involved in a review of the Trusts clinical strengths and weaknesses in the run up to foundation status, which had little evidence to underpin it, and as a result was focused on aspirations for the future and the split of work between the main hospital and a nearby [but large] community hospital. Combining the Medical Director role with clinical practice on a 50/50 basis was never practical, in her view. Medical Directors needed training and time. We can I think expect a recommendation from the Inquiry to beef up the medical directors role but a full separation from clinical practice might be a big mistake!

Our witness confirmed what others had said to the effect that the clinical community in Stafford did not comply easily with clinical governance procedures or follow protocols. Consultant staffing in A and E had been a problem but had been covered by recruiting acute physicians….was this the right thing to do asked the Inquiry? Were acute physicians qualified by training and experience to undertake the full range of emergency practice?

The Consultant appraisal system appears to have been weak and designed not to identify “bad doctors” but instead built on “doctors who were doing well”.

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The Inquiry went again through the problems in dealing with a difficult surgeon who had been the focus of two reviews by the Royal College of Surgeons. Although the gut reaction was that his surgical practice might be unsafe there was no objective evidence to support such a conclusion. His interpersonal relationships might be poor but that was not evidence about his clinical competence. It would not be appropriate to be aggressive without the evidence. The Royal College of Surgeons first report took a year to complete during which time the surgeon continued to operate “I was reasonably junior in the role of Medical Director and hoped that the RCS report would say whether we or not we had a problem.” Only the second report proved decisive.

Limp is the word that comes to mind!

We must all hope that the Inquiry will have some proposals to deal with suspected incompetence fairly but quickly in the patients interest.

Self-certification by Regulators was a weak process. Did the questions seek to establish whether a Trust had processes in place or whether they worked? If the former it was easy to tick the box.

Overall a dismal day for the NHS. A clinical community that believed in excellence would deal with professional competency matters decisively as a body and not leave it to a new and inexperienced Medical Director. Better to be accused of aggression than letting patients suffer.

Day 60

Finance Director

Another former Director of the Trust who had served as Finance Director, Deputy Chief Executive and at times Chief Executive of the Trust. Before the Inquiry got down to finance they wanted to explore his role as the “designated officer” under the whistle blowing policy. A series of allegations had been made in 2005 about poor nursing care on one of the wards…..poor management, inequitable management based on personal relationships, failure to keep incontinent patients clean, poor nursing practice and poor levels of staffing…and so on! “The culture of the ward supported the concept of the autonomous nurse practitioner “. An independent report [one of many it now appears] concluded that there “ appeared to be a lack of concern at the highest levels in the Trust to tackle these problems “.

A clear precursor to the problems that would lead to the Inquiry, but what happened to the report. It never went to the Board. A question for later witnesses!

The whistle blowing report coincided with the Trust’s growing financial problems. After a couple of years of break even the Trust slipped into a £2 million deficit in 2004/5 which the Trust attributed primarily to the cost of the new Consultant contract and one of the PCT’s pulling out of an agreed orthopaedic development. By January 2005 the Trust found itself in a health economy with a forecast deficit of £12 million. This led to the establishment of a vacancy review process with a target establishment reduction of just under 180 posts during the year in order to save £7.7m. The transition path was smoothed by £1.8 million loan from the SHA which had to be repaid eventually.
But then we get into a tangle as the Trust is already carrying 250 vacancies. Were these vacancies funded? Yes if they were filled with agency staff or overtime was the answer but no if they were not!

Was the surplus reported in 2005/6 real...no because it ignored the underlying recurrent deficit of £3 million which was a product of the non-achievement of the cost improvement programme in the current and previous years. And it ignored the loan repayment [or perhaps they thought that this would be written off by the SHA!]

The Trust managed with a highly devolved budgetary process but how did staff on the ground factor in vacancies. Did they understand their budgets? Did they know about the loan repayment schedule and their share of the action?

By the start of 2006/7 the Trust was forecasting a deficit of £10 million unless further action was taken. A further tranche of jobs had to go!

I am struggling with the numbers said our witness. So am I said the Chair!

What do you do, asked the Inquiry, when the squeeze gets so hard you cannot deliver reasonable care? You just get on with it was the reply. You cannot close a ward because that will lose more income! There were no challenges from clinical staff or complaints about staff shortages from nurse managers. They understood the hard world of the NHS. The Trust ended up in recurrent balance in 2007/8....or so they claimed!

Was this all a product of poor local management or the jungle of NHS finance the Inquiry team must be asking themselves. As the Trust slid deeper into crisis did anybody care or was balancing the books such a dominant target [Was it set regionally or nationally]. How did the Trust slide into financial crisis in the first place did nobody notice or was it hidden?

Day 61

I never went to work to do a bad job

Evidence from a former performance manager at the SHA and Director of Operations at the Trust for a short period. At the SHA Stafford was regarded as a fairly typical trust. Nothing exceptional about it. The Inquiry went again through the cost cutting trauma but then it popped out that the SHA had banned the filling of all vacancies on its patch such was the state of the finances in the region as a whole. We also had a change of SHA at this time as three were reduced to one. The new West Midlands was a tougher animal than its predecessors. A lot of evidence that the Trust was missing many targets which clearly began to dominate the lives of local managers. But did this concentration on targets mean that there was no time to look at other parts of the Trust the Inquiry asked? Who assessed the risks to patients of specific cuts?

“Was it of any concern to you as Director of Operations that information was not available to enable the Director of Nursing to know how many nurses she had?” Yes it was frustrating came the reply!
By this stage the questioning was getting down to great detail which caused the Chair to remark that if this level of questioning continued the Inquiry would extend into the next decade. Counsel should have spotted that the witness’s most common response was now “I don’t recall the detail”.

More evidence that the PCT had not been thought to be helpful.” The tariff is the tariff” seemed to be their standard response to requests for help.

At the end an apology from the witness for any pain that had been caused but “I never went to work on a daily basis to do a bad job”.

Was it the people or was it the system?

Day 62

Peeling the Onion

A former Director of Nursing and Governance described the Trust when she arrived in 2006 as it was gearing itself up for the application for foundation status. “The basics of nursing were just not being done”. It was like peeling an onion finding some things then finding more. The problems were deeply engrained. Staff cuts had been made before she arrived and she found it difficult to establish what the exact funded nursing establishment was. Finance had one number but HR had another. It quickly became clear that she had a major problem on her hands. The Trust needed to reinvest in its nursing services. A skill mix review reported in 2008 that the Trust was 120 nurses short of establishment and needed at least £1.15m of additional funding. The suspicious minds of the Inquiry team wanted to know whether the report had been delayed in proceeding to the Board until after Monitor had paid a visit! Did the most senior nurse in the Trust ever contemplate a reference to the NMC?

They also wondered how the Trust could have declared compliance with clinical participation in clinical audit when it was clear that the system was weak and clinician compliance was variable. Who knew about the Royal College of Surgeons reports...not many it seemed. Should the PCT have been told?

The initial focus in the Trust on the critical mortality data was on poor coding as the explanation to the exclusion of other possibilities.

Relationships with the PCT were explored as preparation for later witnesses. As the problems unfolded the PCT became more interventional.

The usual apology...no doubt sincerely intended ,but of little value to patients relatives.

Day 63

PCTs have their day in the witness box

The lead commissioner for the Stafford Hospital gives evidence and responds to the first challenge. Does your prime role include securing high quality services for your community? Left hanging in the ether is the question ”So what the hell were you up to".
The history that led up to GP Commissioning was rehearsed and the point fairly made that PCTs went through a steep development curve. PCTs were quite small until the 2006 reorganisation which saw a major amalgamation of the four PCTs in the area. They are, our witness argued, getting quite good and it would be a pity to throw all this hard won learning down the drain. The most successful commissioners would be a blend of GPs and managers.

All PCTs worked with the fundamental assumption that self-declaration was accurate and that the regulatory bodies were doing their job. As the Chair put it in a question “if there was no smoke signal of trouble you did not go hunting for one”. Do GPs have the expertise to take a view about the running of hospital services? How could the Trust declare itself compliant with the requirements for clinical audit? How could the PCT claim compliance with the requirement to protect patients? Well we had a system…. but did it work? The self-reporting system looks ripe for review!

For a year at least the PCT and the Trust had no signed contract as issues such as the timeliness of letters to GPs could not be resolved. The PCT imposed a penalty on the Trust at one stage but it proved to be a two edged sword. “OK we never intended to take out £3m. We wanted a penalty that would get the Trusts interest and incentivise them to solve the problem, but not so severe that it forced a financial problem. In the end we settled at £400K. For a Chief Executive getting into deficit was the biggest black mark of all.

Competition between Trusts did make them reluctant to be completely open with PCTs.

Day 64

What did the PCT know?

The PCT Director of Quality and Performance next for a long spell of evidence testing how much the PCT knew about quality standards at Stafford Hospital and what they did about it. They had no local quality standards in contracts until 2008. Quality was defined as hitting national targets.

What do you do if a Trust failed to meet targets or the service was unsatisfactory? Could you close it down...the nuclear option? “That is a wicked problem” our witness replied,” because of the 80,000 people who turn up at A and E every year. Closing down would give them a worse service. It’s easier to suspend some services and there are other willing providers around for varicose veins and elective surgery, but no other local provider of A and E services. “It is much more preferable to work with the Trust than it is to suspend the service.”

But when making judgements about quality there has to be a threshold beyond which care is unacceptable. An unannounced visit by the PCT prior to the critical Healthcare Commission report had uncovered problems and“ undeniable areas of concern “but many patients were positive about their care and the situation in A and E was not considered unsafe and clinical care was appropriately prioritised.

“When you look back of course and piece together the jigsaw there were indicators of concern. But it wasn’t that simple in the reality of the day to day world. ”

We return again towards the end of this evidence to the levers and sanctions the PCT had available to them. Monitor could sack the Board, CQC could suspend the services all the PCT had was the
contract. They had issued a performance notice which seemed to achieve little. The truth was, the Inquiry counsel suggested, that the PCT had no understanding of the essence of the problems at the Trust until they met the patient group. Yes was the reply.

Finally an interesting comment on the many criticisms of the nursing profession. Modern healthcare is too complex for its registered nurses not to be educated to degree level. The answer might be to base the students in hospitals and local community units and lend them to the university for academic training and not the other way round.

Day 65

PCT Chief Executive: The ninth safest trust in the country!

The Chief Executive then gave evidence followed by his Chair. The Inquiry team established once again the PCT’s accountability for quality and safety in respect of both their provider units and service providers. It was not enough to rely on other agencies. As the Chair of the Inquiry put it “The principal responsibility for crime is the criminal but a duty can be placed on the police force to prevent crime.”

Perhaps the problem lay with the powers and levers available to the PCT. Unreliable data was discussed at some length. The mortality data for 2009[based on 2008] made the Trust the ninth safest the country! Today the PCT has 40-50 indicators which gave it a broad view of the Trust [provided they were accurate].

When it came to the relationship between the PCT and the Trust the Chief Executive thought it was reasonably open and quite professional. Why then the Inquiry team asked did the Trust not share all their internal problems with the PCT? When it came to the foundation trust application the Trust declined to let the PCT see the business case citing commercial confidentiality. The PCT told Monitor that the Trust had a good management team who embraced the quality agenda. Clearly nobody wanted to rock the foundation bid boat!

However by May 2008 the relationship became more strained. The Healthcare Commission had begun to ask questions and the Trust needed to show Monitor a clean balance sheet. The PCT told the Trust that it was morally wrong reduce staffing levels in order to generate a surplus that would impress Monitor. It around this time that Monitor told the PCT to back off and leave it to the Trust and them to provide assurances that things were being done properly. And yes they did it in writing!

Day 66

PCT Chair: A weak contract framework

The chair described the skills required to chair a PCT Board. Finance and business experience, an ability to think strategically and a commitment to public service values. Coming as he did from an industrial background he regarded the whole contract framework as being weak. In reality was it a fiction the Inquiry counsel asked...yes it was as it was almost impossible to enforce a contract. The A and E contract could not specify how many Consultants should be on the staff that was a matter for the Trust. When the problems at the hospital began to engage the politicians they had a visit from Dr
Moyes the Chair of Monitor. “He was a fairly difficult chap” who reinforced the message to the PCT “get your tanks off my lawn”.

The argument that Staffordshire was historically underfunded was rehearsed. If you were underfunded it was difficult to afford national standards.

The Dr Foster data had been a problem but he had not seen the Foster report that confirmed that their data had been checked and was accurate.

Looked at with hindsight this evidence shows how ineffective PCTs were in their early years. They did get better by the time the government wanted to close them down. Why were there no pilots so that the learning could be done in a few places prior to a national rollout is a question waiting to be asked.

Day 67

SHA, Dr Foster, Michelin Stars and Smoke Detectors

The first of a series of witnesses from the West Midlands Region takes the stand in the form of the most recent Chief Executive [from 2009]. Evidence from earlier predecessors, now in major national posts, will follow.

During the period under review the region had three SHAs which merged in 2006 into the West Midlands SHA. The new Authority had a limit of 125 staff which represented a 60% cut in the total numbers of staff employed by all three. It was said to be quite a small organisation.

Was it fair, the Inquiry team asked, to describe the SHA as an independent local branch of the Department of Health? Yes, was the reply as long as you remembered that the SHA was part of the NHS and not part of the Department of Health. So who can sack an SHA Chief Executive? The SHA Board after consultation with the Chief Executive of the NHS was the reply.

Confused? Don’t worry it’s called creative ambiguity which has covered over the structural cracks between the Department of Health and NHS organisations for years.

Foundation Trusts are indeed independent but not, our witness explained, in limbo. There was no thick black line between them and SHAs. In the West Midlands all Chief Executives go to the monthly regional meeting of Chief Executives.

Quality dominates this part of the Inquiry. How did the SHA monitor and measure it. What did they do when it was inadequate? Was it true that the NHS only began to think seriously about quality after the Darzi report in 2007? No our witness explained but Darzi did define quality more explicitly as safety, effectiveness and patient experience.

“Targets had been used as a proxy for quality in the early years but quality measurement today was much more sophisticated and focused on outcomes.”

To what extent were the problems in Stafford a product of budget cuts? Didn’t cost improvement programmes always lead to staff cuts? Not necessarily came the reply. The prime purpose of CIPs was not to balance the books but improve effectiveness. If a time ever came when a service was
judged to be unsafe because of financial pressures then questions had to be asked about its continuance.

Questions have been asked of a number of witnesses about the hand over from three SHA’s into one. There had it appeared been “little or nothing” on quality matters.

An interesting exchange on the comparison between NHS stars and Michelin stars. The Restaurant loses its Michelin star if the Chef leaves. NHS Trusts kept their stars what ever happened during the year. The new CQC system was much closer to the Michelin system our witness thought.

The links between SHA/Monitor/HCC and CQC are explored in some detail and will no doubt be followed up later. Pretty patchy at the start but better now!

So what did the SHA notice about Stafford Hospital. Why was it thought to be unexceptional. Why were there no red flags flying despite many straws in the wind. The answer seemed to be that there were no indicators that would show when a hospital was systematically failing. Plenty of individual targets but no systematic fault indicator Would the SHA know if a Trust was hitting it 4 hour wait target in A and E by shipping patients into so called admission areas. Maybe but probably not!

There is now a long passage of evidence about the Dr Foster report on mortality and whether the data was flawed. “A high HSMR on its own does not necessarily mean that an organisation is failing.” There may be other reasons such as poor coding or the absence of a local hospice.

HMSRs are like smoke detectors which can go off for three reasons [1] the battery may be flat [2] someone may have burnt the toast [3] the house might be on fire. You have to investigate all three and assume the worst at the outcome.

Stafford was not the only hospital in the West Midlands with a high HSMR and this prompted a regional review. The University of Birmingham was commissioned to review the Foster data which they did and reported a year later in June 2008. The Healthcare Commission meanwhile continued their own investigation as they were unconvinced that poor data was the sole answer.

There was clearly a major argument going on amongst the experts about the reliability of mortality data in judging quality. The Inquiry conclusion may well be that they took too long about it and wasted time, and perhaps lives, with the fig leaf of poor data quality.

All Trusts have to be in foundation mode by 2014 but it is getting harder to pass Monitor’s tests. It was easier when growth was 6/7 %. Tough when it is effectively zero and these are now the most challenged Trusts! The deadline may never be met.

The SHA had given the Trust a major financial boost [£14.5m] to enable a new management team to bring it round. Probably against the rules but there was a crisis. No, Ministers did not tell the SHA to do so; it was their decision. Why did the SHA support the foundation Trust application in the first place the inquiry team wanted to know. They knew the Trust had problems?

Towards the end of the evidence we get more philosophical and Don Berwick is quoted “Every system is perfectly designed to produce the results that it does. If you get adverse results something is wrong with the system.”
Mid-Staffordshire had been a disaster for the NHS which” would never be the same again.” It must never happen again. The lessons must be learnt.

A polished performance by an experienced Chief Executive who was not under any significant personal pressure. The clarity of his evidence was a breath of fresh air.

More regional evidence to follow in the coming days when the challenge is likely to get tougher.

**Day 68**

**Regional Director of Public Health**

The second of the senior Regional witnesses is the Medical and Public Health Director. In the first of these roles she had lead executive responsibility for patient safety until it was passed to the Director of Nursing in the middle of 2009. This was a period of major change as SHAs reduced from three to one which might have played some role in the systems failure to spot problems at Mid Staffordshire.

The region acquired a patient safety expert when the National Patient Safety Authority devolved its regional office in December 2006 and they proceeded off their own bat to appoint a head of patient safety in September 2007 who reported to a Regional Patient Safety Group. This group had patient representatives amongst its membership. The Healthcare Commission were invited to its meetings. The Group reviewed some of the 100-120 Serious Incidents that came into the region each month with the most serious being red flagged. There were very few reports about the quality of nursing care.

Despite this elaborate machinery the system seems to have missed a highly critical internal report at Mid Staffordshire about the death of a patient. The reports described “a failure to control diabetes and prescribed drugs or undertake proper nursing handover. The case was never reported as a Serious Incident or referred to the Coroner. The report said that “nursing staff appeared to be demotivated and on occasion ignored instructions given by line managers”. The ward in question was described as “an unpleasant place for a patient to be “. Then comes a crucial comment “There were several systemic failures...which are not isolated instances”.

Neither the PCT nor the SHA saw this report. If the SHA had seen it alarm bells would have rung said the Medical Director. There was another report relating the care of critically ill children in the region that highlighted problems in Stafford but the Medical Director was never given a copy. Nor did she know about the Trust’s request to the Royal College of Surgeons for an independent review of surgical practice and staffing.

The evidence then turned to a lengthy analysis of the Regions response to the Dr. Foster HSMR review which had disclosed relatively high mortality rates within the region including Mid Staffordshire. The West Midlands had six of the bottom ten Trusts in the country. The initial reaction in the region was that if the numbers were accurate they could be looking at as many as 2000 excess deaths in the region in 2006. But were they “real or were they artifactual” had to be clearly established explained our witness. They commissioned a review by experts at the University of Birmingham and talked directly to the Trusts concerned. Mid Staffordshire reported that they had no concerns about individual clinicians or the possibility of a systemic failure in relation to clinical care.
It sounds said the Chair that your first step on seeing these figures was to question them rather than act!

In the following months there were many meetings and discussions about the mortality numbers with strongly divergent views amongst the experts. The concept of “constant risk fallacy” emerges which appeared to discredit HSMRs as a proxy for quality. However this is a bridge too far towards the end of a long day for the Inquiry who put it to one side for another day and another witness!

At one of the other West Midlands hospitals with high mortality rates [George Elliot] the Birmingham team had undertaken a detailed case note analysis which found that 30% of the cases reviewed had identified issues that might have contributed to death. This was alarming as the Dr. Foster team continued to argue that a hospital with an excessive case mix weighted mortality rate might be an indication of a failing hospital. The Birmingham team however stuck to their guns and argued that there was no reliable relationship between SMRs and quality of care. They turned their attention to exploring the extent to which any variation in SMR was reflected in staff and patient attitude surveys. The outcome appeared to show no causal linkages between mortality and the surveys although there was a statistical association which might justify further examination.

When the report on all of this went to the SHA Board it was reassuring “There is no evidence to suggest that hospitals with high SMRs were failing across the board”

What the SHA never saw was the piece of the jigsaw relating to complaints. The Health Care Commission on the other hand was receiving unsolicited complaints from the public which led them to undertake an unannounced visit to the Trust. The SHA was left in the dark. We will no doubt hear more about this visit when the HCC give evidence.

As far as the future was concerned one of the lessons was that the SHA had been operating a system that relied on a high degree of trust and with an expectation that the various parts of the NHS system were working together. Whatever the data picture showed there was no substitute for observing clinical practice on the ground.

Day 69

The Buried Jigsaw

Next in the witness box is the Regional Director of Nursing who starts with a dangerous admission that the SHA was ultimately responsible for making sure local health services were of a high quality… a duty they discharged through Primary Care Trusts.

More discussion about the handover from 3 SHAs to one. Good in financial areas but non-existent in others. The regional nurse had been involved in setting up the skill mix review in Stafford and had been surprised at the outcome. He did not however connect his concerns about nurse staffing with the Dr Foster mortality data.

The Region never saw Patient Safety alerts at this time. Like his colleague the Medical Director he knew nothing about the Trust’s approach to the Royal College of Surgeons. The Region were, he believed, misled on this issue by the Trust. Nor were the Region in the loop in so far as the national group that dealt with difficult doctors [a process that was fraught with confidentiality agreements].
The pieces of the Mid Staffordshire jigsaw were either buried in the Trust or scattered across a number organisations both within the region and nationally. Some pieces of the jigsaw were clothed in secrecy and protected by confidentiality agreements.

The evidence continued with another review of the Regions response to the Dr Foster mortality data and with this witness a concentration on the data relating to Accident and Emergency where the Trust appeared to have had a high mortality rate for some years. Our witness first became aware of this in January 2008. The HCC had wondered why it had taken so long as the rates had figured prominently in the local press well before this date. Was the press comment just local background noise counsel wondered?

The Regional nurse had by coincidence been visiting the Trust at the same time as the unannounced visit by the HCC. He reported that he had seen nothing to concern him. So you were telling your Chief Executive that everything in Stafford was alright said counsel. I was telling the truth as I saw it at the time replied our witness.

Another lengthy review of the handing of Serious Untoward Incidents [SUIs] by the RHA and how individual cases were red flagged for referral to senior managers. Was there a bias towards infection control and matters that might cause public embarrassment the Inquiry team asked? When our witness assumed responsibility for patient safety he discovered that thousands of the SUIs had not been closed [ meaning that action had been taken and the learning completed].

Why did the SHA need a defence position in the run up to the HCC report as had been disclosed in a series of emails unless it saw its role as defending the Trust. When the HCC report was published our witness was shocked, concerned and dismayed about the issues relating to nursing care. But counsel challenged “how many more flags needed to run up the flag pole given the number of alerts you had received “?

Some updating towards the end of the evidence about dash board monitoring. words sounded good but not very convincing given the history!

Was this witness too focused on defending the Trust and its senior nurses? Was he working so closely with the Trust that he lost the element of scrutiny the Chair asked. Probably.

Our witness did express his regret “ how sorry I am for what happened on a personal basis, it affected me greatly and for any part that I may have played in this I am sincerely sorry”

**Day 70**

**A complicated story: Noisy signals**

The evidence continued with the Head of Planning and Information [ and later performance]. A witness with a former background as a research psychologist. A slow start as the Inquiry dived into the detail of information and performance management in the NHS. Was there a central system to monitor the achievement of the A and E target or was it a paper process? How did information flow and to whom? Important but tedious!
Matters get more interesting when we came to the Dr. Foster mortality data and for the first time we hear the other side of a very complicated story. We also have some evidence about the experience of another hospital in the region with a high HMSR score. Walsall. In that case the Trust had invited Dr Foster in to explain their findings. A year later the score came down as a consequence mainly of changes in clinical governance procedures. [Was it that easy!]

The big unanswered question our witness explained was how good HMSRs were as an indication of quality. He gave the example of the difference between Royal Hampstead and George Elliot hospitals which was 100%. It was surely inconceivable that half of all the deaths at George Elliot were preventable. Other issues such as coding and chance must come into play to some extent. And remember he said, no statistical model is perfect.

It was in his view irresponsible to publish statistics of this sort without attempting to explain how much of any variation was due to poor quality and how much other factors. “Dr Foster did not try to find this out nor did the Department of Health at the time”. The SHA tried to fill the vacuum.

Put it another way he explained, the SHA was getting a noisy signal. Whilst there might be quality of care issues there were others mixed in. The SHA needed a purer signal about quality. If the predicted excess death number was correct it would influence the overall population SMR but there was no sign of this.

When asked later about whether having a high HMSR was something that needed immediate investigation his answer was NO. “We no longer need academic research. We have a real world example of why this is a very poor indicator and that is Mid Staffordshire Hospital. During 2008/9, he explained, we know that the quality of care was appalling. Yet in the same year their HMSR was the ninth best in the country”.

No you find a better signal and CQC now had one, he explained.

He then referred back to the smoke alarm analogy used by an earlier witness. “What do you do if you have a fire and the alarm does not go off ? You never trust that alarm again.

For this witness at least the excess death numbers that had gained such prominence in the media were still unproven. This assertion must have made the Inquiry team and the relatives in the audience very uneasy!

Day 71

Regional Finance Director; Encouragement and Persuasion usually worked

The next witness had been the Director of Performance and Finance at the Shropshire and Staffordshire SHA prior to the merger within the region. At this time the organisation was very focused on national targets. They had however brought in the Modernisation Agency to help Mid Staffordshire with problems in the A and E Department in 2003/4.

We move onto to examine the financial problems at the Trust who recorded a £2m deficit in 2004/5. The financial recovery plan for 2005/6 was robust as balance had to be achieved. What leverage did
the SHA have counsel asked “No formal powers but encouragement and persuasion usually worked. Organisations don’t like being in a financially challenged position. It makes life difficult!

How great was the pressure. Could individuals lose their jobs ? “ Well if you are the FD of a financially failing organisation it is difficult to get another job because your cv does not look very good”

The Stafford plan included a workforce reduction of 180 jobs. But these were not people just funded vacancies. But what if these posts were filled with locum or agency staff ?

If you close a ward and lose 35 staff the other wards are OK. But not as the Chair remarked if the number of patients remained the same and where simply spread across a small stock of beds. Well then you need improved patient management ! Yes reader we have been here before.

The risk assessment of the consequences of any manpower reduction was a matter for the Trust not the SHA..

In fact our witness interjected the number of clinical staff in post between 2004/5 and 2006/7 was almost the same [1103 and 1111]. The bulk of the savings came from non-clinical areas where staff reduced in the same period by 209.

Day 72

Another Regional Finance Director

Next came the Director of Finance and Capacity at the West Midlands SHA who the inquiry team led through a mass of emails and letters between all the agencies involved with Mid Staffordshire. We cover the mortality data yet again and a comment by one witness that the SHA was more concerned with the data than the patients. Not true said our witness, as well as trying to understand the data we put in on the ground support. The mortality data did improve year on year but was the SHA response adequate, What would the SHA do if they discovered that a Trust in the previous year had through some avoidable cause killed a patient and done nothing about it since. Would they do nothing ? No came the response, we would go back and make sure the review loop had been closed.

The inquiry team now press hard on the witness to explain the SHA role in the run up to the critical HCC report. What did they know; did it come as a surprise ?

The Chief Executive at the Stafford Trust was telling them about the pressure he was under and how his organisation was being swamped with data requests which was getting in the way of remedial action. Was the SHA just waiting for the HCC to report ?

What about accountability the Inquiry team asked once the HCC report was published. Well the Trust Chief Executive resigned. Yes the Chair interjected but not because of action on your part. Well our witness explained the SHA had been trying to persuade the Trust Chief Executive to move on for some time but Monitor wanted him to stay. He still thought he could pull the Trust around.

There is a break in evidence at this point and the witness returned a week later [Day 76]. We pick up the transcript here.
With hindsight a better knowledge management system would have helped the SHA put together the Mid Staffs jigsaw better. The HCC clearly had doubts about the University of Birmingham study. It had been extensively criticised by Prof Brian Jarman. The work had, our witness responded, been peer reviewed prior to publication in the BMJ and you had to remember that Prof Jarman and his organisation had a commercial interest in Dr Foster so there was always a bit of professional tension. More about this tension in later evidence.

Towards the end of this evidence the Inquiry team turned to the Trust Chief Executive severance package. Do you have a view the Chairman asked as to the appropriateness of somebody being allowed to go into retirement with a compromise package rather than being dismissed or subject to disciplinary process. People who are responsible for failure should be held to account but it was usually quicker and cheaper to use the compromise route and this is what the lawyers usually recommended. He agreed that the NHS culture of moving people sideways might be a barrier to accountability.

Only one witness has so far used the defence that the SHAs had been explicitly told by the Department of Health to keep their distance and stop meddling in Trust affairs. Maybe this will come next week when we hear from more SHA witnesses.

Day 73

Pinning the Blame

Day 73 opened with a direct challenge to the new witness a former Chief Executive of the West Midlands SHA. Your statement does not include an apology!

I am deeply sorry for what happened and the fact that we did not pick up the failures in care but I do not accept that this represented a serious failure by the SHA. Looking back we missed some signals but I was not conscious at the time that Stafford was an organisation that was withholding information from the SHA. The SHA had no concerns about quality at the Trust until just before the HCC Report. There were other organisations in the region causing more anxiety than Mid Staffordshire.

Counsel and the Chair came back to this challenge on a number of occasions during the course of a long day but our witness stood her ground.

Nor she said could you blame the hand over to the new West Midlands SHA. The people at Shropshire and Staffordshire SHA had no major concerns about the quality of care in Mid Staffordshire to pass on.

The whole of the NHS was learning about quality measurement during this period. It was down to the Trust to ensure that they had a safe level of staffing.

Spending money on a Report by the University of Birmingham was justified although our witness did not appreciate at the time the academic minefield she was about to enter. The Dr Foster use of mortality data was controversial. Should this whole question have been left to the Department of Health? I wish it had came the response, but I wanted to know what was happening in the Trusts in my region.
No mention was made of the mortality controversy when the Trust applied for Foundation status but the SHA believed that the Trust had taken the matter seriously and that Monitor and the HCC were talking to one another. If the HCC had had concerns about the Trusts response to their mortality alerts they should have told the SHA.

It would not be reasonable to blame the SHA for any failing on the part of the PCT our witness claimed. The SHA were helping PCTs develop along the lines of national policy. PCTs had to be accountable for their own actions [as had NHS Trusts]

The following morning the evidence continued with a challenge about the Trusts decision to get PriceWaterhouseCooper do a due diligence on quality as a means of demonstrating to Monitor that the Trust was taking the concerns of the HCC seriously. [The HCC thought the study might undermine their investigation] No... the SHA did not offer fund this study.

At the end we return to the question of blame. “Given the fact that Mid Staffordshire went, as it were, undetected for an appreciable time under your authorities watch, whilst you were Chief Executive, do you accept any responsibility for this”. Yes, but I will not accept that this represented a serious failing by the SHA. “We had an organisation that was deliberately ignoring the suffering of patients and deliberately presenting itself in a light that was clearly unacceptable and false.. it was an extremely hard thing for the SHA to have uncovered. That is why I do not accept serious failure.

This Chief Executive was not prepared to be an easy scapegoat and will return to the witness box in due course with her CQC hat on.

Day 74

Organisational turmoil

The Chair of the SHA followed and described the wider context at that point in the history of the NHS. In 2006 three SHAs were merged into one with a 60% reduction in posts and at the same time PCTs were merged. It was a time of organisational turmoil.

Our Chair had considered resigning but concluded that as you learn more from mistakes than successes it would serve the NHS better if she stayed for the short term rather than leave immediately. The overall responsibility in this whole affair was corporate with all Directors being equally accountable.

Her appraisal of the Mid Staffordshire Trust Chair was examined and she admitted that the judgement “a fully satisfactory performance “was, with the benefit of hind sight, wrong, She had never seen the SUIs or most of the other material that might have flagged up concerns about Mid Staffordshire Trust. Now a days the appraisal process is much more robust she said.

Our Chair was disappointed at the evidence of organisational rivalry involving some SHA staff. In so far as service closure in Stafford was concerned it was very difficult as the NHS always “ran hot” with little spare capacity.
What would happen to the SHA function when it was abolished was a matter for politicians. Scattered to the four winds was the import of her answer although these were not the words used by the witness.

This was evidence from an experienced Chair who took her duties seriously and was determined that lessons should be learnt for the future.

**Day 75**

**An Unexpected Return**

An unexpected return by the Regional Director of Nursing to correct some evidence that he had given on his first appearance. He had, after all, received a SUI report in April 2007 about a patients unexpected death [G. Asbury the diabetic patient]. He had not however opened the attached incident report. He rarely did as there was a team reviewing the 1290 SUIs the SHA received every year.

The Inquiry team then track this SUI through the system and discover that the Department of Health had logged onto this case in August 2008 and seven days later the Trust closed the file and sent a letter to the relatives. Had somebody been pulling strings behind the scenes?

As far as the SHA was concerned this SUI seems to have disappeared in the system [despite being very serious]. It is difficult to see what the point of sending it to the SHA had been, the Chair remarked!

The next witness is the former Director of Commissioning at the SHA. He had worked with colleagues on a set of quality metrics which were to be included in the 2007/8 contracts. This did not happen in the case of Staffordshire but nobody told the SHA. No the SHA did not examine the thousands of contracts in the region. A report on services for seriously ill children had not raised major alarm bells despite some criticism of Mid Staffordshire.

**Day 76**

The second part of the evidence from a former Director of Finance at the SHA which was reported alongside the earlier evidence.

_Easter and a break as the Inquiry approaches week 21 of public evidence._

**Day 77**

**An Absence of a Culture of Care**

The evidence from the Healthcare Commission [HCC] which will occupy the next two weeks starts with the former Chairman. A member of many royal colleges who chaired the Bristol Inquiry in the 1990s.

The evidence begins with a question about the politicisation of the NHS and how far his organisation was independent. “You’ve got this enormous tension between a very large and complex organisation that you need to let go and be run properly and the political demands of being responsible for how
its spends its money”. The notion of having the courage to politically let go is something we have never achieved in the UK.

There were many parallels between the Bristol and Mid Staffordshire stories. Clearly some lessons had not been learned.

The relationship between the HCC and the Department of Health was clearly close, if occasionally tense. Our witness got his knuckles rapped for threatening to publically criticise an SHA .... outside his brief he was told. There was a major row when he insisted on publishing a critical report about maternity care [citing patient interests] in the run up to a general election.

Managers with a " make do and mend” philosophy focused on the existing portfolio of services are criticised as are nurses with a Dunkirk spirit “There are not enough bandages so we will make our own”. Some nurses and doctors became professional guerrillas against a system which did not provide them what they thought they needed.

GP Commissioning was just transferring power from one group of professionals to another group.

Then something most people have forgotten. The standards against which the Commission judged health organisations were set by the Department of Health. The Commission tried to get them changed from time to time but the Department declined to change them. Even a plea to include indicators relating to the prevention of venous thromboembolism, which caused thousands of deaths a year, was rejected. The questions in the Annual Health check also had to be approved by the Department.

Independence was fine if exercised within tightly defined boundaries! One way round this was to develop other mechanisms such as peer reviews and investigations which the Commission did.

The respective responsibilities between the HCC and Monitor were never very clear in his view but the two regulators did develop a collaboration agreement. There was clearly a spat about the use of mortality figures which got to a meeting with a minister. Monitor had argued that there was no firm evidence to support the assertion that there were a high number of avoidable deaths in Staffordshire and as a consequence a speculative number range [400-1200] was removed from an HCC report.

Like the rest of the NHS the HCC was threatened with budget cuts in 2007-8 as they were about to be wound up. The difficulty was our witness explained “whether to go out and shoot the cavalry only to find that the cavalry were crucial to the new regulators portfolio of activities.”

The NHS would be better with a single regulator that could monitor integrated care.

We end with a message for the Inquiry team. The responsibility for the care of patients lies with those who are looking after them. There is a tendency in the NHS to look for an organisation to blame. What really need to be done is to work out how to create a culture of care. The problem with Mid Staffordshire was the absence of such a culture.
Days 78-79

A Rapping of Knuckles

The day started with the Department of Health getting its knuckles rapped for the delay in submitting material to the Inquiry which would push back the date for witnesses giving evidence. The explanation was the mammoth amount of material that had to be sifted. The running total so far was 2500 documents. We have to hope that the Inquiry will not call all 42 senior civil servants that had been identified as having duties relevant to the Inquiry.

The next witness was the senior HCC assessment manager for the West Midlands SHA who described in considerable detail how the HCC worked at a regional level. She reported good and close relationships with the SHA. They did have some concerns about corporate governance at the Trust but accepted their assurance that matters were being put right.

HCC inspections of the private sector were very hands on whereas they accepted what the NHS told them which she acknowledged was a massive leap of faith. She did not deal with complaints from patients nor pay regard to press reports as the intelligence they gave was “too soft”.

When asked how Mid Staffordshire appeared on any radar of concern we got the now familiar response “There wasn’t anything exceptional about this Trust at the time”. There were doubts about one of the former Directors of Nursing but our witness was much reassured by her successor.

Next came the HCC regional lead for the West Midlands who confirmed a good working relationship with the SHA despite occasional disappointment they did not always send senior staff to important meetings such as risk summits. They did share information about peer review programmes which was a potential area of overlap. Our witness also saw no signs or indications of problems at the Trust.

But how did the Trust get through an inspection in 2007. With hind sight it is surprising our witness said but not at the time! The HCC regional team were apparently convinced initially by the Trust that the mortality problem was a coding issue and were surprised by a national decision to investigate further. They got their knuckles rapped for getting too close to the Trust Chief Executive when during an investigation all communication with the Trust should have been via the investigation manager. It also emerged that the Trust Chief Executive had wound up the SHA who complained about the style of the investigation which appeared in their view only to be searching for evidence that would support a conclusion that the Trust was failing.

Her conclusion on the final HCC report “How could we have missed it all”.

The final witness of the week was in charge of complaints and investigations nationally for the HCC. We explore the complaint handling system once again and note that the panel review at the top of the HCC process was so resource intensive it was rarely used. Finally a plea “When will the NHS accept that there is a systemic problem with basic care being given to older people”
Day 80

**Mortality data is a sensitive Issue**

We continue with evidence from HCC staff starting with the Head of Investigation. A man with a background in CHC’s and the Multiple Sclerosis Society. He judged when an investigation was necessary according to the Commission’s criteria. Sixteen inquiries were launched during the term of the HCC. He drew an interesting parallel between Mid Staffordshire and Papworth Hospital which had also displayed high mortality rates amongst patients who had had cardiac surgery. Papworth recognised and accepted they had a problem and wanted it solved. The transplant unit was closed and they collaborated with a speedy investigation lasting two weeks. The report came out a matter of days later and the recommendations immediately implemented. The HCC staff felt that they were working with the Papworth Trust in contrast to Mid Staffordshire who never fully accepted or recognised the extent of their problem.

The NHS does not like bad news our witness claimed, and there was concern at a senior level in the Department of Health about the impact the investigation in Mid Staffordshire might have with its emphasis on mortality rates. They asked to be kept in touch with the investigation and asked for regular reports on progress.

High mortality was one trigger for an inquiry but there could be others including high readmission rates. A high HMSR on its own would not trigger an investigation explained our witness who was also chair of the Commissions mortality outliers group.

A number of mortality alerts relating to Mid Staffordshire had been issued prior to the decision to investigate. The response from the Trust chief executive was slow but they were initially reassured that he was investigating the problem. [In practice he was attributing the problem to inaccurate coding].

The use of mortality data was clearly a sensitive issue in the Commission and there were some who were worried about its use as a proxy for quality. They took their time in making sure that the data was accurate as they did not want to be accused of chasing people inappropriately. However as they dug deeper serious concerns began to emerge about the outcomes following emergency admissions.

Monitor and the SHA wanted the inquiry speeded up. The Commission staff rejected the allegation that they were “data dredging” for information that would demonstrate a predetermined conclusion.

Day 81

**“Bayonetting the wounded after the battle “**

The next witness was the doctor who was the investigation manager and regarded by some witnesses as a problem and by others a hero. She had a background in the CHC world and had been a Director of Commissioning and Primary Care so understood the NHS well. Managers under pressure learned how to fudge upward reporting, she explained. You could never say that something could not be done!
She described in some detail the pressure under which she managed the Mid Staffordshire investigation. Neither the Trust nor the SHA believed one was necessary. SHA’s did “sometimes go native” and become too sympathetic to Trusts and too remote from the experience of patients.

They did not have the objectivity that was possible at a national level. She had actually been forewarned by a colleague that the West Midlands SHA was very supportive of the Trust and the manager they had sent in to turn it around when it ran into financial and other difficulties.

Some managers dined out on stories about how to “game” the Health Check” in order to minimise the possibility of any further investigation.

Her views about the need for an investigation had been influenced by the large volume of complaints she had received from the patient group CURE.

The investigation started in March 2008 with a pretty senior team including a surgeon, two medical consultants, a chief nurse and a Trust chief executive. The investigation team were so concerned about A and E that they arranged for a team from a nearby teaching hospital to fly in. They seriously contemplated issuing a notice to close the unit but eventually decided that from a patients point of view this might do more harm than good. The Trust were informed immediately about the concerns. The Chief Executive of the Trust seemed shocked and appeared to have no idea as to the scale of the problem. Action on staffing did follow.

In an attempt to defend itself the Trust had commissioned a review by PWC but this caused confusion and overlap with witnesses being interviewed twice. The Birmingham University review did not help either as the lead academic had a track record of doubting the value of HSMRs as a measure of quality. She knew about complaints about her by the SHA and the Trust during the investigation. They were worried that the investigation would drag the hospital down but as our witness put it “As it turned out its reputation was not great and deservedly so “.

The preparation of the final report coincided with the final weeks of the HCC as the new team at CQC prepared to take over. The publication could have been delayed but nobody knew what CQC would do with it. Would they even have published it our witness asked? The first witness thought that the new team viewed the report negatively as it was “over critical, unbalanced and too blunt”. The Investigation manager was more forth right claiming that the Chair of the CQC had said the report was an embarrassment and too explicit. In another inquiry in the south west inspectors had been told by the Chair “we don’t want any comments along the lines of patients drinking out of vases”.

Exchanges about a possible inquiry in North Staffordshire are left hanging...presumably for later witnesses.

The story line is now becoming clear. The Trust and the SHA [and probably the Department of Health and Monitor] knew there was a problem and thought it was being fixed. They had serious reservations about mortality data as a proxy for quality. The Trust with the support of the SHA tried to mount a defence. The HCC team, who were also cautious about mortality data, did not believe that anybody really understood the depth of the problem and were determined to expose it. In this they were supported by a vigorous patient group.
At the end of her evidence our second witness deliberately left the inquiry with a headline when she reported that the Chair of CQC had quoted the Chief Executive of the NHS as saying that the Commissions investigations were “tantamount to bayonetting the wounded after the battle”.

More to come about this internal tussle at the top of the NHS as some battled to expose the problems and others sought to fix them.

**Day 82**

**Health Care Commission experts**

More evidence from HCC witnesses. The first was an acknowledged numbers man who dedicated his career to making the most of NHS information. The star rating used in the early years of HCC told you little and got nowhere near the essence of quality of care. The balanced score card was better.

The annual Health Check took the science of assessment forward but it only offered a high level view of an organisation and would not show problems with particular services. Our witness thought public statements about compliance with standards were a powerful tool.

The scoring systems that lay behind all the assessment systems were very complex and understood only by experts...your correspondent is not one of them!

Like many he thought you had to use mortality data with care.

The HCC had searched for service failure predictive factors but failed because the information would not map onto the risk factors. What was needed was a new set of tools but this was uncharted territory. Dr Foster had access to more up to date data than the HCC because of a special deal with the NHS Information Centre.

**Day 83**

**HCC Chief Executive**

The final witness of the week was the former Chief Executive of the HCC who had a background deeply rooted in regulation in the telecoms and energy industries. She had moved on to be the Chair of the Office of Rail Regulation. Her brief when she started in February 2004 was to take over the work of CHI [Commission for Health Improvement] in undertaking clinical governance reviews and was later asked to run the star rating system. To begin with the Star system was a measure of how good a provider was in meeting government targets. The Health Check which followed was a crude instrument required by ministers which is why the HCC developed other tools such as “deep dives” into particular services.

Comparative data could be very valuable she explained using the water industry as one example and ITC’s as another. There had been a problem with an argumentative independent sector treatment centre so the HCC had published data on all the centres. The argument stopped and corrective action was almost immediate.

We need more comparative data in the public domain, our witness argued, provided it is understandable by the public.
The HCC brief excluded commissioners and SHA’s although this had been the subject of some debate with the Department of Health who regarded both of these as their business. HCC also lost the argument about SUI’s flowing to them automatically. The independence of the HCC was significantly constrained by Ministers and the Department of Health.

Interesting evidence about the discussion between HCC and the Department about their budget. They wanted to define their brief and work out how much it would cost to deliver it. The Department gave them a take it or leave it figure...no surprises there! They had considered including leadership and organisation in the core standards but dropped the idea because of a potential overlap with Monitor and the cost of measuring such a standard.

Finally a timely reminder, that we have heard before, that it is those who provide services who are ultimately responsible for their quality.

Our witness was disappointed when the HCC was scrapped and replaced by CQC. All she got was 24 hours’ notice of the decision to do this. Don’t be surprised if future regulators get a higher degree of protection from those whose services are being regulated!

Day 84

Mucky vignettes

The week began with a former Head of External Affairs at the Health Care Commission the forerunner to the Care Quality Commission [CQC].

Like one other former employee of CQC he gave evidence under a Direction issued by the Inquiry. Both had signed a compromise deal on leaving CQC which contained a confidentiality agreement. Was this a proper way for a public body to act asked the Chair? Well it is common place came the reply. In today’s anti super injunction world I see a ban in prospect for public sector bodies or at least an instruction that the confidentially had to be restricted to personal data or commercially sensitive material.

Our witness had been sacked so he did offer a rather jaundiced view of the NHS world in presenting a series of what he described as vignettes that related to bringing information about health care into the public arena. He also highlighted a shift in style between HCC and CQC who did not like “big bang” stories.

One of his vignettes was about Alan Johnson and his political advisors trying to manage the publication of the Maidstone report and slating HCC in the process. Unfairly as it turned out for it forced Johnson into a full and personal retraction. Mucky stuff but no surprises. It’s what political advisors do and get away with all the time!

As far as Mid Staffordshire was concerned he had wanted to publish the estimate of 400-1200 avoidable deaths but had been overruled by his Chair. The reference to deaths had it appears been very carefully crafted to avoid mentioning the higher number.
“We estimate that there were at least 400 deaths in the three years covered by this investigation that could not be accounted for by other factors or by chance variation. This is a statistical analysis of data and does not allow the identification of particular individuals”.

The numbers did however leak out probably, he thought, via a stringer in the West Midlands. He thought that the SHA had been hostile to the Inquiry although they argued that far from being hostile they had offered to help with a detailed case note review but had been turned down.

**Basildon and Thurrock**

He had always thought that the Basildon and Thurrock investigation was uncannily close to Mid Staffordshire with high mortality alerts and problems in emergency care.

It’s a complicated story that’s sits across the period of hand over from HCC to CQC. The Trust got a statutory warning about cleanliness and infection but there had been another report which referred to high mortality alerts, problems with emergency care, poor infection control and concern about the deaths of people with a learning disability. The Trust had been given time to sort these problems out but CQC was not satisfied with progress. They referred the matter to Monitor and in effect invited them to sack the Board.

Nothing was said publically until Dr Foster declared its intent to name Basildon and Thurrock as the worst Trust in the country. Our witness was clear that full disclosure was necessary at this point.

A joint press release CQC/Monitor was agreed which included all the evidence that had been collected. Some later claimed the detail was gory and florid but our witness thought it was graphic but accurate. It was leaked to a journalist, in advance of any joint press release, by our witness’s team. It’s what you do in the press world he explained.

The Department of Health had a fit and tried to intervene. They wanted to manage the news. The political advisor said she was disgusted!

A revised press release was eventually issued but was described by our witness as mealy mouthed and toned down. It talked about nipping problems in the bud rather than systemic failure.

The management of news dictated the content and timing of disclosure to the public. HCC had used the power of the Press whilst CQC wanted a softer approach preferring to use their legal powers as a Regulator.

**The CQC is not a Development Agency**

The current Chair of CQC is next. She took over in December 2009 when her predecessor resigned. We explore the setting up of CQC with a set of questions preparing the ground for the examination of the Department of Health, How well was the transition from HCC to CQC managed, was it rushed? Was it adequately resourced?

We explore the changed role of CQC as a regulator. No central investigation unit but planned and compliance reviews, 16 essential standards and “deep dives” when necessary. What the CQC was not was a development agency.
Earlier witnesses had been challenged about whether the Mid Staffordshire Inquiry should have started earlier than it had in the light of all the alerts that had been issued and the complaints by patients. Would the new style CQC have spotted Mid Staffs earlier than HCC? Yes was the confident reply.

Day 85

Is it all too complicated?

Next the Director of Operational Delivery at CQC. Another Occupational Therapist. So that’s where they all are!

She explained that CQC had 900 inspectors, 170 analysts and 360 customer services staff regulating NHS Trusts, foundation trusts, hospices, day care facilities, 6,000 dental providers, and providers of personal social care, nursing homes, residential homes, 24,000 adult placement schemes and others. In April 2012 they take on general practice and primary care [another 8000]. A truly massive regulatory scan.

The headquarters is in Finsbury Tower London with nine regions. Compliance managers and Inspectors work from home with enhanced home working equipment.

Inspectors typically have 50 providers each usually including one NHS Trust. They are backed up by evidence and information staff who use quality and risk profiles for each provider and keep up to date risk assessments. If a problem was spotted the Inspector would be alerted.

GCHQ comes to mind or more unkindly the Starsi once complaints and comments by patients drawn from NHS Choices are added. But maybe regulating health care is a complicated business that justifies the current investment. The Chair wanted to know whether it was all too complicated with 325 pages of guidance for Trusts and 400 for inspectors. Matters lawyers would put in three sentences CQC managed to get into 50 pages! Simplification is a great idea but difficult in practice.

Back to history with a question about the HCC report on Mid Staffordshire. Was it HCC’s swan song? Well, came the reply, their media strategy was surprising given that it was only 2 weeks away from handing over to CQC. The report was OK, our witness thought, but the summary was sound bites rather than substance. Readers will recall the doubts that HCC staff had that CQC would publish the report in anything other than a very benign form. So out it came before HCC closed its doors! Fireworks rather than a swan song!

Should there be minimum qualifications for Board members? Should they be registered? Maybe... it was being talked about at the centre.

Could CQC intervene if they thought a planned emergency service rationalisation was potentially dangerous? No, CQC had no powers to regulate against the plan but the risk plan would be looked at in some detail. Would CQC spot a Trust bumping along at the bottom without triggering alarms? Yes our witness thought. What about staffing levels? Who set the standards...the Royal Colleges? What about cost effectiveness? Should we have national staffing standards...back to the 1950s!
CQC now used “experts by experience” from organisations like Age Concern to join inspectors. A really good idea with a nice label.

A lot of to and fro about how much information CQC could absorb into its risk profiles of providers. SUI’s, Section 43 reports by Coroners, press cuttings and complaints. They could hoover it all up but would it help and was it worth the cost? We are now at the heart of some pretty important and challenging questions for the regulatory process. Sir Fred Goodwin’s extra marital affair has been reported to the Financial Services Regulator…. can we expect the same for NHS professionals when it has the potential to impact on interpersonal relationships at work? The mind boggles at the thought!

Early relationships between CQC and Monitor were very frosty but have now warmed into a positive partnership. Trusts under investigation by CQC may find their progress to Foundation status blocked until matters of concern have been dealt with.

Ministers had already made the decision that Commissioners would not be regulated by CQC.

**Day 86**

**We should all be nervous about black boxes**

Next the Director of Intelligence at CQC.... An enthusiastic techy who explained the complex machinery with some reasonable clarity. The role of HCC was to use Health Check to generate a judgement about whether a hospital was good or bad. CQC on the other hand used information as a guide as to whether there was a risk of a hospital being bad and then following up to see if it was. Self-declaration was not part of the DNA of the Care Quality Commission our witness explained.

The maths underpinning the risk and quality profiles was so complex that even he got lost. So no chance for the rest of us. HMSR’s had now been replaced by SHMI’s [Summary Hospital Level Mortality Indicators].

We should all be nervous about black boxes whose inner workings few understand. Who will spot a malfunction before the reputation of a really important part of our social fabric has been damaged? These machines should operate in full public view like those hospital boiler houses with glass walls.

**Day 87**

**Was your boss up to it?**

The final witness of the week was the Chief Executive of CQC. The inquiry team examined the start-up of CQC with her. The rationalisation of three regulators into one and the consequent budget reduction from £210m to £165m. Offices reduced from 28 to seven. Politicians saw CQC as a regulator of businesses rather than a commentator on the NHS. It no longer had a periodic review function. We again covered the reasons behind the closure of the central investigation team.

How could a single inspector review 50 different providers? Did they have the expertise? How could an inspector without specialist knowledge make judgements about say services for the elderly? Had CQC ever considered specialist divisions?
It then got a bit personal as our Chief Executive was asked whether her previous Chair had the appropriate skills for her role. Well she appointed me...not the other way round!

More discussion about assessing the competence of Board members and judging staffing levels. The real challenge was measuring outcomes rather than inputs which was what the NHS had always done in the past.

Our Chief Executive was satisfied with existing enforcement powers. Compromise agreements when staff leave under a cloud look set for the chop.

Finally an examination of the independence of CQC. The performance of the Chair is judged by the Secretary of State who has the power of dismissal. Was this right? The National Quality Board adds strength and does not diminish independence. The new systems are still being tested and need time to bed in. The regulatory world is now working smoothly together.

CQC has moved on quickly in the last two years. It will be for the Inquiry to judge whether they have travelled in the right direction.

Day 88

Corporate Manslaughter.

A return visit from the CQC regional manager who told the Inquiry how good relationships were with Monitor and the SHA with whom they had a conversation every Friday about SUI’s in the region. CQC staff now go to regional quality and risk meetings. This is good news but given the circumstances in Staffordshire if all the regulators had not yet got their act together they would have deserved all they got. The question is whether these improvements apply nationwide. If they do Stafford has produced a positive benefit.

CQC inspectors don’t just visit hospitals to have a look round. They are guided by their information sources as to where to go.

But how would an inspector from a social care background spot a problem with medicines management? Well the inspector had support all around including pharmacists. Yes but how would she even know there was a potential problem? Tough questions these with responses that were only partially convincing.

How realistic was it to deregister a hospital? Answer..... not very but warning notices were a powerful tool.

When twin boys died in Stafford the Chief Executive of the Trust was warned that there could potentially be a charge of corporate manslaughter. Two inspectors sat in the car park waiting for the police to give them clearance so that they did not tamper with evidence. Was that not rather confrontational asked the Chair.? The Inspectors were just following the legal advice they had been given.

Sounds like somebody over reacted!

The evidence for the rest of the week is from the Staff of Monitor.
Days 88-91

Flashpoint

A week of evidence from senior staff at Monitor the Foundation Trust regulator including their reaction to a meeting called by a Minister because he “was having a hard time with local MPs in Staffordshire who cannot understand why Ministers cannot act to require change”.

“Monitor can act when a Trust wheel wobbles but when a wheel comes off Ministers need to be in a position to do something about it “ ...he was reported to have told his officials..

He clearly has forgotten that one of his predecessors made sure that Minsters had no powers to intervene in Foundation Trusts.

With a general election due a new Chair and Chief Executive had to be appointed in order to demonstrate that somebody was taking hold of the problem. The former Chair had resigned but only before she was pushed thought one witness.

The Department of Health wanted to “suggest” some names for Monitor to approve. This was not well received! Was the Minister giving Monitor an instruction asked the Chair ? No, the Minister was careful not to make it an instruction but he did threaten a review of Ministers powers in the event that a wheel did come off.

In the end Monitor sorted the Chair out and Monitor accepted a suggestion from the Department of Health in relation to the Chief Executive who Monitor appointed directly.

Earlier in the week the Inquiry had waded through the process through which Mid Staffordshire had become a foundation Trust. How robust had the assessment been lay behind many of the questions. Monitor did not assess the quality of clinical care. . that was the role of the HCC. The definition of an organisation that was well run largely focused on its financial plans and business organisation. Monitor’s early systems were based on premise that they were only being asked to consider three star Trusts. They were not a clinical inspectorate.

Mid Staffordshire was the 125th applicant so by that stage the staff of Monitor had a lot of accumulated experience. No alarms bells rang in respect of Mid Staffordshire. The local PCT and SHA seemed satisfied. They knew about the mortality outlier situation but matters seemed to be improving as coding was sorted out.

Prior to the formal application the SHA had undertaken a diagnostic exercise with the Trust but Monitor ignored this[ in fact created a Chinese wall around it]. Their assessment had to be pure and independent. The point behind the questions was if Monitor had fed off the SHA work would they have spotted alarm bells ? Probably not as the SHA didn’t....

We have a blow by blow account of the Board to Board meeting between the Trust and Monitor. [45 questions in two hours ].

The Trust claimed that “Quality is what drives our business and makes people want to come to us”. Monitor appears to have accepted this salesmanship from the Director of Nursing.
The Trust was authorised on 1st February 2008 and proudly announced to the public their promotion to the first division of NHS Trusts. A side letter with some qualifications was never mentioned. The HCC published it’s critical report only 12 months later and a few weeks after that the SHA pumped in £4.5m. So how good had the assessment been!

Witnesses denied that Monitor had protected the Trust in order to protect the reputation of the wider foundation world? They did not attempt to stop the HCC investigation but did express concern about the manner in which it was being conducted and its time frame.

Monitor did however commission KPMG to review the lessons from Mid Staffordshire. They asked about the quality bar. Had it been unreasonably dropped by Ministers in order to accelerate the pace? More of this to come when the Department of Health give evidence in July.

Finally we returned to an old question. If HCC [CQC] and Monitor were not performance managers; the SHA was excluded because of foundation status who performance managed the Trust. Answer the Board.

Days 92-93

The Chair was offered a revolver and a bottle of whisky.

Monitor evidence continues with evidence first from the Chief Operating Officer and then former Chair/Chief Executive of Monitor.

In assessing a Foundation Trust candidate Monitor had to be able to provide assurance to Parliament that the Trust was legally constituted, financially sustainable, effectively governed and locally representative. Monitor relied heavily on HCC’s assessment of the quality of care provided. Monitor did not at that time have a systematic and robust framework for testing clinical governance. There was a gap in this regard between HCC and Monitor.

Perhaps because Monitor was stuffed full of accountants mused the inquiry team!

With hindsight the decision to reduce the entry threshold from three stars to one had not been properly thought through by either the Department of Health or the Regulators.

There was a tight deadline for getting the first tranche of Trusts through which dictated a light touch review. Did nobody tell the Secretary of State that his time scale was impossible? Well he only got half of his target!

If the Secretary of State wanted an all Foundation Trust health economy why have entry qualifications at all? The question was left hanging in the ether.

The suggestion that Mid Staffordshire had prioritised its financial affairs over its clinical quality was rejected. All Trusts have to provide good quality within their income. MRSA performance was used as a general proxy for clinical governance.

Monitor had essentially two statutory powers. To remove a Board and a power to direct a particular action such as implementing an action plan. A power it now shared with CQC. Our witness agreed it
would be better if the power was lodged with one regulator. But which one the accountants or the quality assessors!

The Chair was not all clear what vision the Department of Health had about Monitor, if any! The staff seconded to set Monitor up before his arrival saw the role as acting as the Headquarters of the Foundation movement that would dictate in some detail how Foundation Trusts would operate. He did not share that vision, nor he judged did the Secretary of State. He was disappointed that Monitor never became a non-ministerial government body. It remained an executive Quango of the Department of Health.

Then a sharp and clear statement of his attitude to the NHS. The government is the paymaster. The NHS is a mutual insurance society. It’s a risk pooling arrangement whereby an individual who is ill can get free health care without limit. However throughout the history of the NHS the Department has increasingly been seen and seen itself as the headquarters of a hospital company with the Secretary of State as its Chief Executive or Chair depending upon the individual.

Monitor did not get involved in SHA Foundation Trust diagnostic exercises but “perhaps the Chinese walls need not have been so perfect”! If the SHA and the Department of Health regarded Mid Staffordshire as marginal they should not have referred them to Monitor in the first place.

The highly critical Royal College of Surgeons report should have been disclosed to Monitor. How could a Royal College issue a report like that and not follow it up our witness challenged? Good question said the Chair...they have been invited to talk to the Inquiry. I look forward to being in the audience responded our witness!

As far as mortality was concerned CHKS and the SHA seemed satisfied that it was primarily a coding issue and Monitor accepted their view.

Towards the end of this passage of evidence the news about a new raft of documents and emails being submitted to the Inquiry some of which looked in the words of the inquiry counsel “interesting”! The tension mounts!

As the transfer of NHS Trusts to Monitor for review slowed frustration levels grew provoking the comment “Being a foundation Trust is not being part of a club. It’s a key element of Payment by Results, choice and competition. Being managed by SHA’s was actually a very comfortable life. They take the decisions and the blame!

The culture in the NHS was not to embarrass a minister, Monitor on the other hand said “Be honest, acknowledge where things are going wrong and give us some comfort that you are doing something about it. At least 30 Foundation Trusts had been told quite bluntly “If you cannot run your hospital well we will go and find some people who can.”

What about Mid Staffordshire. We authorised them in February 2008. At that point the HCC and the SHA knew an investigation was imminent but nobody troubled to tell Monitor. If we had known we would most likely have paused. Once we had the HCC report we intervened. [A year later and not a few months as reported in the last report] It would have been difficult to intervene prior to this whilst another Regulator’s investigation was in process.
The Trust Chief Executive got the letter about the intended investigation only a few days prior to authorisation as a Foundation Trust, it was a great pity our Chair explained that the Chief Executive did not take his courage in both hands and say to Monitor “I ought to tell you that there is a real problem on the horizon.”

The Chair of Monitor gradually lost confidence in the Trust Board as the HCC investigation proceeded and major issues of concern began to arise well beyond the issue of the mortality numbers. By the later summer of 2008 Monitor was considering the use of its powers to force the implementation of an agreed action plan without getting involved in a judicial review as had been the case in Bradford. Even when they saw a draft report in January 2009 they worried whether the HCC report would be robust enough to justify action [In the event it was].

The departure of the Trust Chair and Chief Executive was complicated because a behind the scenes offer to protect the career of the Chief Executive if he went quietly. Monitor disapproved. The Chair did resign but in the words of Counsel “after being offered a revolver and a bottle of whisky”.

Was there at any stage antagonism or competition between the staff of the Regulators? “Well antagonism is too strong and whilst there was always a difficulty about respective roles and responsibilities the organisations were never at each other’s throats. Perhaps the Chairs of the HCC and Monitor could have got to know each other better he said.

Just before the HCC report came out there was a grand meeting with the Secretary of State. There was a row about publishing the estimate of potential avoidable deaths [400-1400] in an addition to the report that was handed out just before the meeting. Eventually the Secretary of State intervened and said it should be excluded. This evidence appears to be at odds with that of the former Chair of HCC who claimed it was his decision without political pressure. We shall no doubt hear more about this as witnesses yet to appear were present at this meeting.

At the end of his evidence our witness records again Minister’s frustration at not being able to intervene. Even Monitor could not withdraw Foundation status or force a merger. Ministers were also said to be fed up with HCC and CQC’s attempt to mission creep into quality improvement.

There was little political appetite, he thought, for a public service failure regime. They must all succeed!

In a final thrust our Chair wondered why at no point had any clinical staff at the Trust raised concerns with their professional bodies about the quality of care.

Tickets only I suspect when the Royal College of Surgeons gives evidence.

Day 94

Who gives a monkey?

The former Chief Executive of one of the Staffordshire PCTs, and before that a PCG, takes us back ten years to the time that he and his GP colleagues were expressing the view that the managers of the Trust were incompetent. The initial tension seemed to have been caused by the General Physicians at the hospital unilaterally deciding to discharge diabetic patients back into primary care.
in what he called unplanned workload dumping. There were also allegations that standards had dropped as a result of waiting list initiatives. Getting the hospital to change was like hitting ones head against a brick wall he complained. He and his GP colleagues wanted the Trust Chief Executive sacked and said as much.

Their pressure came to nought but it does illustrate the long standing history of poor relationships between the hospital and parts of primary care in Staffordshire.

He alleged that the SHA threatened and bullied people who were not achieving targets. The SHA “did not give a monkey “ about how organisations in the region secured their financial bottom lines.

Institutional dishonesty was he claimed common place in the mid 2000’s” Everything is great isn’t it “ was the authorised mantra. In the longer term he wanted the NHS out of politics. I suspect he had national politics in mind but in the case of Staffordshire poisoned local politics were , according to his evidence ,a bigger problem.

Day 95

Health Check

A former Head of Standards Based Assessment at the HCC gave evidence about the Health Check and how it worked. Whilst core standards were imperfect they were not without value. However in making their annual statutory declaration Trusts did only have to answer yes, no or don’t know. No evidence was required. Did this very light touch regulations lead to Trusts pulling the wool over the eyes of the regulator ? Well maybe. You could not design a system that could catch every poor performer.

Light touch was in vogue at the time in a number of sectors but will I suspect be unthinkable to tomorrow’s world.

Day 96

The staff behaved in the shadow of their leader.

A former Finance and Performance Director at a local PCT takes the Inquiry once again over the troubled financial history of the NHS in Staffordshire. When she joined the PCT in 2004 they thought that they had an accumulated deficit of £2m. Within 3 months it was clear that the deficit was much larger and approaching £6m. The SHA had, initially, been very helpful and supportive and a deal was struck to secure break even over three years. At this time only fairly generic national quality standards were used in agreements with Trusts. “The provider shall carry out services in accordance with best practice” or the PCT will need to be assured “that the Trust has an overall strategy to comply with all the requirements of clinical and corporate governance”. Local standards did eventually arrive including in particular ones relating to hospital discharge. She had accepted the assurance of the Trust that the removal of 170 nursing posts was a vacancy removal policy.

Despite having the right to visit the Trust the PCT never did, except for meetings, although their community nurses were in the medical admission unit every day.
Things started to go wrong, in her view, when a new Finance Director arrived at the SHA. He demanded that the outstanding deficit [now £3.7m] be repaid immediately which in her view would have decimated health care. Take it out of the prescribing budget she was told...get it fixed. The pressure, which she found very intimidating, often came in Friday evening telephone calls. The finance staff at the region behaved in the shadow of their leader.

[The following day this evidence was strongly refuted by the Chair of the SHA. It was “unbelievable” he said. His Finance Director was not a financial attack dog.]

Was this a strong managerial response to an overspending PCT or did it amount to bullying is a matter for the Inquiry to judge.

The next witness managed the cancer peer review processes in the region as well as a number of other peer reviews including one on services for critically ill children. Her work led to the development of the West Midlands Quality Review service with a substantial programme of work within the region.

Reviews had a high clinical content. Reports were produced quickly and usually started with positive findings before going on to identify shortcomings.

The Cancer reviews of Mid Staffordshire were broadly positive although personal and professional problems associated with one clinician were identified. The Children’s review had found that there was no triage of children who arrived by their own transport which was thought to be a risk for moderately ill children.

Immediate risk letters were not at that time copied to PCT’s. It was down to the Trusts to respond. PCTs did however receive a copy of the final reports and had the codes to identify their local Trusts. The cancer reviews did enter the public domain but the children’s review did not.

In the summer and autumn of 2006 when the three SHA’s were being reorganised into one she had briefed regional colleagues about problem areas in the region. No evidence of follow up can be found. Was this due in part to the reorganisation ..yes came the reply.

What happens to the Quality Review service when the SHA disappear. Don’t know came the reply.

My bet is that it will probably disappear as GP Consortia may regard it as an overlap with the role of CQC. Why invest twice ? No other region does ! Pity ,it’s what happens during reorganisations. The good disappears with the not so good.

Day 97

The rhythms of life

Finally we come to the former Chair of the Shropshire and Staffordshire SHA between 2002 and 2006. The underlying philosophy of the region was about developing autonomous NHS organisations and getting away from “learned helplessness”. That was the policy rhythm in the NHS at the time. He conducted his business through Chairs but worked closely with his Chief Executive to ensure that their messages were wholly consistent. He did not know that his SHA actually had legal powers of direction over Trusts but he doubted they could have been used without cover from the Department
of Health. The SHA did on occasion engineer change at the top of Trusts. Trust Boards who did not deliver what they promised needed “refreshing”. The SHA rated Mid Staffordshire as a Trust in need of support and development and not one that was about to crack. When you have to choose between repair or replace he usually chose repair.

He was involved in selecting the chair of the Mid Staffordshire Trust and her early appraisals were positive.

In a final plea he argued for transparency even when it might be embarrassing. What happened at Mid Staffordshire was in his view incredibly unusual and out with his experience.

Whether a developmental philosophy can survive in this age of stern regulation and blame and shame remains to be seen.

Day 98

Managing, Interpreting and Manipulating Data.

One of the UK’s leading experts in medical statistics and the head of the academic Dr Foster unit at Imperial took the stand. The academic unit is 50% funded by Dr Foster Ltd.

First some politics. “The NHS is extremely centralised and the political importance of a government in the centre to have a good news story, spin rather than a good service is paramount”. Chief Executives should have a code of ethics and they should regard patient complaints as golden.

Then we get technical about the value and use of HSMRs. Having a hospice nearby apparently makes little difference to HSMRs [1% in the case of Walsall which was checked after a challenge]. Dr Foster does not adjust for complications arising within the hospital. “If a hospital is making errors you don’t want to make an allowance for that.” CABGs have roughly half the mortality if they are done with an arterial graft rather than a venous graft. You should not adjust for who does what. Both should deploy the latest proven technology.

“Having a high morbidity/mortality caseload does not mean that you get a high HSMR if you do relatively better with that case load than the average hospital in the country and that’s the whole idea of risk adjustment”. The two points people still argue about; the clinical procedures in use and the socio economic factors affecting the patient, in practice make very little difference.

What, the Inquiry asked, would happen if a patient came into hospital with a broken leg and died from a hospital acquired infection? The answer is that the primary diagnosis would be broken leg and infection marked as a complication.

In July 2007 the Mid Staffordshire Trust appointed a new coding manager and many coding changes resulted. One report suggested as many as 80% of primary codes were changed which was described by a later witness as a remarkable level of inaccuracy. Was there a concerted attempt in the West Midlands to recode their way out of the worst results in the country? Well you could only get the sort of real change required if the three Trusts in the region with high HSMRs had all become terminal care hospitals overnight explained our witness.
In Mid Staffordshire the fractured neck of femur deaths were moved to a secondary diagnosis which produced a sudden and dramatic change which was unlikely to be a genuine representation of the situation on the ground. Our witness did not object to the SHA bringing in somebody to review their figures and methodology but thought they might have chosen people other than the team from Birmingham University who were known to be critical of the value of HSMR’s. The constant risk fallacy quoted in earlier evidence did not apply in Mid Staffordshire as direct standardisation was used.

He assumed [wrongly] that the Trust would advise the SHA about the Dr Foster mortality alerts. The Medical Director of the SHA had said that if Mid Staffordshire was so bad it would have fed through into the general population mortality data. It did, said our witness, emphatically.

When he had tried to launch a “save ten thousand lives” campaign he had been blocked by the CMO. He was encouraged by the NHS Bill [2011] and its attitude to publishing health care data.

Next a co-founder of Dr Foster took the stand and argued that the public were entitled to information about health care even if it was imperfect. Like all benchmarking Dr Foster had to deal with the response from those at the bottom that the data or the methodology was wrong. He did not see any conflict of interest in offering Trusts a means of “improving your mortality rating “.

In compiling their good hospital guide they used 16 indicators. They did not disclose them in advance for fear that hospitals would manage the 16 indicators at the expense of others. Gaming as it is called. As far as coding was concerned the changes that might make a difference were age, whether the patient was an emergency admission and primary diagnosis. If high risk patients were coded as low risk then a Trust would have a higher HMSR than they ought to.

How difficult was it to manipulate the data behind the HSMR? Well if everybody published their methodology the results could be independently checked. As far as Mid Staffordshire was concerned it was extremely unlikely that inaccurate coding could explain their high HMSR. As far as the Dr Foster alerts were concerned Bournemouth Hospital had found that one third could be discounted, another third was down to data problems but the final third indicated a need for change.

The reports in the press that there had been between 400 and 1200 unnecessary deaths in Staffordshire was a misuse of the data. The data showed a higher than expected level of mortality not actual deaths.

There is then some suggestion that the SHA threatened Dr Foster with a loss of all its customers in the West Midlands. They did lose some business to the Birmingham University team but the SHA had denied that they had taken any concerted action.

Day 99

NHS Information Centre

Next the head of the NHS Information Centre an organisation with a budget of £50million and five hundred staff. He wanted his national organisation to be the single source of data “ truth” which could be confidently used by others. The Department of Health set the agenda for the data that
could be collected but could not influence “the message”. The NHS Bill 2011 planned to turn them into a non-departmental public body thus emphasising their independence.

The Centre could trace Mr Smith treated in Wigan for an ingrowing toenail and whether he died within 30 days of leaving hospital. In the next few months the Centre would publish data on patient complaints which was very valuable. They also had a way of comparing workforce data between Trusts but it was not yet available to the public. In his view the NHS either loved or hated Dr Foster with the principal negative founded on fears about commercial secrecy [denied by Dr Foster in their evidence].

The Summary Hospital Mortality Data [SHMI], which had been developed on a consensus basis [including the Birmingham team], would be available later in the year.

In his view Regulators should get on and regulate leaving the NHS Information Centre to collect the data from which they could draw conclusions. In the future the whole of the NHS would operate within an outcome framework with 51 measures.

It is clear that data management is no longer a difficult but peripheral policy issue for the NHS. It is approaching centre stage. We can expect some critical but important comments from the Inquiry. In the meantime take care, data manipulation will be spotted!

Days 100 - 101

C. difficile: No wonder the patient groups are angry!

A public health specialist who was head of clinical governance and health strategy at the Shropshire and Staffordshire SHA takes the stand. [Witness 135 on day 100] Evidence begins with a distinction between making sure systems are in place and monitoring their use.

The SHA did react when “never events” occurred [accidents or mistakes that should never be allowed to happen]. The example given was a mistake involving spinal chemotherapy.

The SHA always responded to SUIs which were regarded as prioritised work. In the early 2000s the annual review processes were in place during which the SHA reviewed the performance of Trust Boards [every six months if the Trust had less than three stars]. Mid Staffordshire had been reviewed and the briefing notes show that our witness thought there was a fair chance that the structures and processes for clinical governance were robust. Fair apparently meant patchy evidence.

A report on the treatment of critically ill children did not appear to have been followed up. Had it got lost in the reorganisation of SHAs? The hand over briefing to the West Midlands SHA had been sparse. Monthly updates on live clinical issues during the transition period reported that it was increasingly difficult to keep up with chasing action on SUIs as staff were leaving or moving to new posts.

Health Protection Agency; At odds with the Trust

Next the Chief Executive of the Health Protection Agency [4000 staff] followed by one of his clinical regional directors. The HPA operated the mandatory national surveillance system for health care associated infection including MRSA and C. difficile. They provided a leadership role when there was
an outbreak in a community setting but outbreaks inside hospitals were a matter for hospital management to lead with advice and support from HPA. They had no powers to instruct hospitals what to do although they could go public. Trusts including Mid Staffordshire were sometimes reluctant to declare an outbreak because of the potential of bad publicity. An outbreak declaration brought in the top management of the hospital together with external agencies such as the Primary Care Trust. An “outbreak” would indicate transmission between patients in hospital, rather than a series of unconnected cases. This could be confirmed by Ribo-typing. The HPA would not publish the declaration of an outbreak, that was a matter for Trusts. They would only report outbreaks and inadequate responses to regulatory authorities as a last resort. But asked the chair “how close does a last resort have to be before concerns about matters which might affect mortality are made known “?

There were at least two occasions when Mid Staffordshire found itself at odds with HPA experts. The first in 2008 occurred when a cluster of seven cases presented on the gastroenterology ward. Our clinical HPA witness was in no doubt that this was an “outbreak” and should have been managed as such from the beginning. There were further outbreaks of infection later in the year. The HPA expressed concerns about the lack of dedicated isolation facilities at the Trust and reported the fact that the policy of isolating and nursing infected patients within the main wards was not proving to be successful in controlling the spread of infection. An internal audit report in January 2009 found that the Trust had a poor adherence to audit standards for prescription charts and 0% adherence to commode cleanliness.

In January 2009 new cases are reported including four on one ward. Early in February more new cases are reported which this time involve the satellite hospital at Cannock Chase. The HPA again advised the Trust to declare a Trust wide outbreak. The Trust agrees but takes no action to follow up an HPA offer to set up an outbreak data base. At this point all cases are being managed in side rooms throughout the hospital which is a matter of concern to HPA who on the 25th February ask for a meeting with the Chief Executive. It never happened as the Chief Executive resigned on the 3rd March. Three days later an Outbreak Control meeting is convened and the HPA again express their concerns about the mortality associated with the outbreak of C.difficile. It is still not clear what arrangements are to be put in place to manage the outbreak. Four days later a further meeting of the outbreak control team demonstrates that no further action has been taken on the data base, no overarching plan has been developed and no reactive press release has been prepared. The SHA demand to know what is happening. On the 12th March a large HPA team turn up and with a range of recommendations for controlling the outbreak. The Trust accept most of them.

A meeting involving the HPA and the PCT in March 2009 [by which time there had been 10 deaths since January] reported “There have been a consistent number of C.difficile infections at Mid Staffordshire with a seemingly high death rate but the accuracy of the numbers cannot be guaranteed. An offer by the HPA to help create a data base was not taken up by the Trust.”

Part of the problem was investing in isolation capacity, an issue which was tossed into the long grass[a strategic planning committee]. The PCT apparently knew the Trust was arguing it did not have the resource to upgrade or increase isolation capacity but apparently did nothing. The Trust was also resistant to C.difficile or other hospital acquired infections being written into death certificates.
But the chair remarked “there were a group of patients who were potentially suffering in a way they should not have been suffering if the Trust had put its house in order! Both the PCT and the HPA felt that they were beating their heads against a brick wall.

In June 2009 the HPA organised a debrief on what had happened and what might be learned for the future. They identified a lack of preparation within the Trust and delays in coming to understand the nature and scale of the incident. Ineffective communication was at the root of many of the problems. Some Consultants failed to provide appropriate leadership by failing to recognise the valid concerns of others upon whom the services for which they were responsible were dependent.

When the HPS was abolished in 2012 their function would transfer to Public Health England which would be an executive agency of the Department of Health. In tomorrow’s world they would report a Trust who failed to adopt good practice to CQC. No report would be made to Monitor as CQC was in their view the more appropriate body!

This evidence does highlight the importance of the role played by HPA and the worry about what will happen to it in the future and what powers, if any, it should be given to demand action by foundation Trusts.

This evidence once again highlights a clinical and managerial community at Mid Staffordshire with priorities other than good care who spent time arguing with external agencies rather than taking action. At this stage the Trust needed decisive clinical leadership but none appeared to be available. Nobody wanted to give up beds to create a dedicated isolation facility. No wonder the patient groups are angry!

**Day 102**

**Difficult Doctors and Patient Safety**

The Director of Patient Safety at the National Patient Safety Agency [NPSA] who operated a voluntary reporting system for the NHS. Why was it voluntary asked the Inquiry Team? Was this an attempt to reduce bureaucracy or avoid the blame culture in the NHS? Whatever the balance in this argument the NPSA received nearly a million reports a year.

Mid Staffordshire had been a low reporter and appeared to have a culture were reporting was not encouraged [It has improved!]. The Inquiry tracked a particular death where insulin appeared to have been mal-administered. Sure enough it had not been reported to NPSA. A coding team from NPSA had reported a number of incidents recorded as potential harm rather than harm which had actually happened.

A number of individual incident reports were put up for review. One staff member had reported “For an 18 bed acute ward only 1 trained and 1 untrained staff. Most of the night shifts start with lots of outstanding jobs from the previous shift. Three confused patients who climb out of bed. Some patients needed 1 to 1 care. 2200 medications given at midnight or later. Leaving the ward to get help in checking IV antibiotics. This staffing level is seriously dangerous”
If I was the risk manager, our witness reported, I would want to do something about every single incident. Unless a SUI was reported it was unlikely that the PCT or the SHA would pick these cases up. It was down to local management.

There were now 25 “never” events for the NHS which had helped in focussing people’s attention in key risk areas.

The functions of NPSA would transfer to the new NHS Commissioning Board.

Professionals seem to contribute better to voluntary patient safety systems but patients unsurprisingly demand more certainty. Tricky balance for the Department of Health to explain in due course.

Next the Director of the National Clinical Assessment Service who dealt with allegedly poor performing doctors. Trusts must consult them before they suspend, move or sack a doctor. Designed to stop the problem of clinicians being suspended for years [sometimes unfairly] whilst the regulatory bodies or the courts consider cases. Became part of the NPSA in 2005 with a Chinese wall to preserve confidentiality. Have now completed over three hundred assessments at the request of Trusts. A review of 103 cases found that 69% of referred doctors eventually returned to work and only 14% were referred on to regulatory authorities.

Between 2009-2011 eleven doctors were referred by Mid Staffordshire [7 surgeons, an associate specialist and two trainees]. One surgeon was referred twice. Surprisingly they were not the highest referrer in the country lying only 141 out of 164. The Trust responses were usually tardy and incomplete. Clinical difficulties and behavioural reasons were the major cause for referral.

Difficult confidentiality issues in so far as reporting doctors to the GMC but attitudes had shifted a little in recent years in favour of more openness. A duty of candour and cooperation would help.

An intriguing question is left hanging at the end of the day. Do we need a similar assessment service for managers?

**Day 103**

**Trouble in North Staffordshire**

A leading academic in the field of health policy who had been chair of the North Staffordshire Trust between 2000 and 2006 gave evidence. In his witness statement he had some harsh words for the Shropshire and Staffordshire SHA which was in his view one of the weakest in the country with a Chief Executive who was too nice for the job. There was no strong leadership and the SHA was in his view inept at decision making. One problem was that the government of the day “didn’t seem to understand how their orders were being implemented by its national and SHA henchmen who were over enthusiastic to please”.

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They were no help to his Trust in a very difficult health economy. When his Trust ran into financial difficulty he had been invited to “consider his position “. He did and resigned.

Counsel for the SHA decided not to challenge these opinions but just lodged a disagreement. Probably wise as these strongly expressed views were not going to change and a cross examination would expose them to a wider audience [although for the record witness statements are available to the press and public].

In his evidence our witness was critical of the 2000/1 reorganisation of the NHS which abolished health authorities “ acting in the belief that moving the deck chairs can make substantial differences when there might not be much evidence to suggest that the particular forms of moving the deck chairs did any such thing “.

Money, money, money were the prime targets set for the NHS and not quality. When his Trust faced the choice between quality and cost they chose quality.

When his Trust ran into financial trouble they argued that the PCT had not paid for patients treated. The PCT said “tough, we ain’t got the money, you should have turned the patients away”. What from A and E! Do you think the Secretary of State would have approved? That was the culture of the NHS at the time.

The 2005/6 reforms had pointed the system back in the right direction in his view by creating a single SHA for the West Midlands. If the reality of the NHS was central political control it was highly inefficient to have local structures which pretended the opposite. A lot of the reforms in the past had been a sledgehammer to crack a nut. But at the end of the day the nut was not cracked it just rolled off the table!

The future lay in integrated care.

Day 104

NICE

Next the Chief Executive of NICE since its inception in 1999. NICE had been asked by the Department of Health to undertake two pieces of work in the field of patient safety [ventilator acquired pneumonia and inappropriate prescribing on admission or discharge from hospital]. They were not asked to undertake any follow up work or produce standardised procedure manuals [which the Inquiry team seem quite keen on]. Technology appraisals were unique in that when issued they were accompanied by a directive from the Secretary of State that required NHS organisations to implement them. The topics for NICE review were chosen by the Department of Health.

The process for developing clinical guidelines was very transparent with evidence upon which the guidelines were based being published. The chair had downloaded one guideline and the evidence that underpinned it that morning and it ran to 698 pages!
NICE also produced internet based clinical pathways for professionals to access and check that their practice was consistent with the latest evidence. They also produced a library of quality standards [50 so far].

“It should be sufficient for a commissioner to limit their monitoring, at least as a first line step in understanding what their providers are delivering, to the delivery of service in accordance with the statements in the quality standards. These quality standards could be aligned with the data collected by the national information centre.”

[Big brother is on the horizon and if this data is available to the public powerful comparisons will be possible. Politicians will be nervous and the professions seriously worried so it must be right!]

In so far as Mid Staffordshire was concerned the NICE local improvement consultant did not identify Mid Staffordshire as materially different from any other he visited. What the inspector did not know was that the Trust had set to one side the NICE recommendations with regard to head injury assessments despite having declared themselves NICE compliant!

NICE and CQC now work closely together.

At last the Inquiry team must have thought we have heard from a part of the NHS that appears to work.

**Day 105**

**GMC; Hunting down poor performing doctors.**

Finally for the week the Chief Executive of the General Medical Council. A GMC team had inspected Mid Staffordshire in 2008 as part of a review of Keele Medical School and the feedback had been relatively positive. Mid Staffordshire was an Approved Practice Setting [APS] for medical training. The GMC registers individual doctors and is not a system regulator—that was the role of CQC. The GMC now have staff who work alongside and support responsible officers [usually medical directors]. The GMC is now interested in proper clinical governance. Revalidation is not as some people refer to it... a five year process. As our witness put it “It cannot be that the whole system goes to sleep for five years and wakes up to find something terrible has happened. Medical directors were increasingly confronting doctors whose performance was judged to be poor by their colleagues. “Those nobody working at the hospital would have gone near!”

Removing APS status was fraught with difficulty if the hospital was expected to continue to treat patients.

Interesting exchange as to whether the GMC just dealt with doctors referred to it or whether they went out hunting for poor practice. As the chair put it “If you are told about a murder do you go out and find who committed the murder or do you wait for somebody
else to do that part of the inquiry and present the name of an individual who is alleged to have committed it “. We are moving towards the latter came the reply.

The idea that the GMC will actively, maybe even aggressively, hunt down and deal with poor performing doctors is radical indeed.

The GMC does not have a whistle blowing line but many doctors ring the contact centre.

The GMC is attempting to speed up its processes but there is nothing to stop employers taking action under employment law.

The GMC should have been told about the Royal College of Surgeons report relating to Mid Staffordshire much earlier by the Trust.

When there are very significant failings by a doctor/manager, which puts patients at risk, the GMC would take action. At least one case was under review at present. The chair was clearly very interested in this as he had represented Dr Roylance the Chief Executive at the Bristol Inquiry. The outstanding cases against a number of Mid Staffordshire doctors had been put on hold until the Inquiry reported putting everybody including the doctors in a very difficult position.

Consultant appraisals were judged to be patchy in the NHS with some no more than a conversation about holidays. It is a developmental issue explained our witness [what 20 years!].

Our witness was not keen to sign up to the idea of a single regulator for the health professions. Doctors are different! However the GMC itself was now half medical and half lay. It did see itself as a patient safety organisation.

Finally an obscure question that might have a deeper meaning. “Were you aware of the procedure for consensual resolution of proceedings brought by the DTI under the Company Director Disqualification Act.” No said our witness.

Day 106

Was Mid Staffordshire a good place to train nurses?

The Chief Executive and Registrar of the Nursing and Midwifery Council, the organisation that is responsible for setting and maintaining standards of education, training, conduct and performance of nurses and midwives, gave evidence.

Is it true the Inquiry team asked that in recent years there has been a lack of emphasis on practical nursing? Well it’s a complex area came the response! We have now put in skill clusters for areas like hygiene care.
Mid Staffordshire was an Approved Educational Institution for nurse training linked to the University of Staffordshire.

Did the NMC know about the HCC investigation? There was nothing in the records our witness responded but the organisation was in a state of flux at the time! Would they have cared you can sense the patients in the audience asking themselves.

The NMC does currently have a number of open “fitness to practice” cases relating to nurse leaders at the Trust. Early in 2010 his predecessor had been advised by the Regional Nurse at the West Midlands SHA to await the conclusions of an SHA investigation in order to see if that would crystallise into referrals to the NMC. Our witness would not have accepted this advice.

The NMC have ,in the past, had to deal with a number of cases relating to nurse directors in the performance of their managerial duties.

The NMC are now following up the CQC report on dignity and nutrition with those Trusts failing to meet essential nursing standards. The NMC was now he claimed a proactive organisation.

He would like a Royal College of Nursing modelled on medical colleges and not the trade union movement. The university based education produced in his view better nurses.

“The vast majority of nurses I meet do a fantastic job, have clear values and are well educated. I would happily have them look after my mother “. 

This important witness was clearly trying to make progress within the current model of nurse training and conduct review. It was not convincing and showed no recognition of the need for radical change in the profession. Sad and very worrying!

**Royal College of Surgeons**

Next the President of the Royal College of Surgeons who had to defend the College against the allegation that they had produced two highly critical reports about the surgical department at Mid Staffordshire [dysfunctional ] and done nothing about it.

Independent reports were ,he explained, intended as a diagnostic tool for Trusts. The College would not start an investigation of an individual surgeon without the knowledge and consent of the NCAS [Day 102] and/or the GMC. They offered a diagnostic service to see if a problem existed. Any report would be the property of the Trust concerned although this could be overridden on ethical grounds either by a colleague surgeon or the surgeon who conducted the review.[So not very confidential at all !] What would the College do if it identified a service that might not be clearly dangerous but operated with inappropriate practices? Make a report to the Trust came the reply. What if a Trust did not follow up on a
critical report, would that not be embarrassing to the College, asked the Inquiry team? 
Clearly it would.

The College had never referred a Trust to HCC or CQC and had no memorandum of understanding with CQC, GMC or Monitor.

The first report by the College about Mid Staffordshire produced no evidence that patients were being endangered claimed the President! What do you do asked the chair “await a high mortality before deciding whether or not it was a safe place to send a relative?

The College did not follow up their first report. Do you accept asked the chair that for a member of the public listening that is unacceptable to put it mildly? I would accept that agreed the President.

The second College Report which was after the HCC investigation was more severe in its criticism. Yes said the President because they had more evidence! Of the 300 cases examined 5 patients had died. A number way out of line without what might have been expected. The College reviewer was so concerned he went over the head of the Trust and reported the matter to the Medical Director of the NHS in London. He rang the Trust medical director and the surgery [cholecystectomy] was stopped. Simple really!

The College did believe in standard operating procedures. The WHO operation check list had been mandatory in the NHS since January 2010.

In the future all reports that identified a threat to patient safety would be shared with regulators.

Day 107

Training Doctors in Stafford

Next to give evidence was the Postgraduate Medical Education and Training Board [PMETB] followed by the Dean of the Keele Medical School. Had they spotted anything wrong at Mid Staffordshire? No appeared to be the answer. The hospital had been inspected by the Royal College of Physicians in 2006 and regularly by the local Deanery and no real problems had been identified. PMETB had never seen the report by the Royal College of Surgeons. When the inquiry team probed some of the trainee feedback they discovered that Mid Staffordshire was high on staff bullying in emergency medicine and an outlier for work intensity in the same specialty.

Are students good whistle blowers? Well one student [it was only one] reported that the educational climate in A and E was dreadful. Patient safety was compromised in their view by the drive to avoid breaches in targets.
No Trust had ever had their approval to take students removed. There is obviously a mutual interdependence once the placement process starts which can be a strength but can also be a significant weakness if the partnership is not robust.

At this point we hear again the argument that by and large Mid Staffordshire was a good training hospital that was let down by a few bad apples.

PMETB did attend “Risk Summits “ with other regulators and reported an amber rating for the Trust i.e. concerns reported that were being addressed. The first they knew about the HCC report was when they were sent a copy.

Sounds like another organisation with a complex system that did not work at least in so far as Mid Staffordshire was concerned!

The Dean explained that medical students were first placed at the Trust in 2006 and the numbers increased in 2008. Was there any benefit to a Trust in having students asked the inquiry team ? I have a thousand answers responded our witness including status and money. In deciding to send students to the Trust were any questions asked about the quality of care ? Well we spoke to the Consultants and Managers ! No is the only way we can reasonably interpret the reply. Are the problems identified in the HCC report matters about which you would have wanted to be aware about in the interests of your students and their education ? Of course came the reply. Then your systems must be at fault as you saw nothing wrong! If poor quality was endemic in an organisation was it not possible that students would regard this as the norm?

When the HCC report came out no students were withdrawn but the planned expansion programme was halted. [In practice it would have been very difficult to secure alternative placements at short notice]. By March 2009 one of our Deans colleagues was telling the GMC that “the issues in the current public debate were in the past and had been resolved. The University had an excellent relationship with the Trust senior management and an agreement had been reached to increase investment from 2009-10.

Was this not a bit premature only a week after the HCC had reported the inquiry team asked? Was not the University being slightly defensive about the hospital? The question was left hanging. The University had clearly accepted the Trust response to the HCC report that it was biased and the high mortality was a product of coding errors.

Day 108

Ombudsman: A Dreadful Complaints System

The Parliamentary and NHS Ombudsman investigates complaints where a person has sustained injustice or hardship as a consequence of service failure or maladministration. The two legal concepts of service failure and injustice have both to be present and linked. These are the tools Parliament gave me to work with. The Ombudsman might take a case if
somebody had been so “mucked about” by the complaints system and had completely lost faith in the body complained about to ever resolve the matter. Our witness could not shed much light on events in Mid Staffordshire. The complaints brought to the Ombudsman were few and far between. The pattern of complaints did not provide any information to distinguish Mid Staffordshire from any other NHS Trust.

The Ombudsman had however formed the view that the old NHS Complaints procedure with its three stages was not fit for purpose. It was dreadful. We operated with it as best we could but we hated it!

The new two stage procedure which came in in 2009 was quicker, simpler and more effective. The Ombudsman had received a complaint from a relative of a Mid Staffordshire patient but had decided not to hold an investigation. The relative received a letter in the following terms. “Whilst we can see there were a number of areas where the service provided was deficient the Trust was clear in explaining what had happened, what should have happened and what steps had been taken to prevent a repetition. “ In the light of this there was no evidence that the complainant has suffered an on-going injustice and consequently there were no grounds to warrant an investigation.

It was our, witness agreed, a rather clumsy letter but it did not reflect, as counsel, suggested a cosy and overly close relationship with the provider.

The ombudsman could not undertake a full scale service review. The Ombudsman did however have regular meetings with CQC and Monitor. If the Ombudsman came across a doctor about who there were doubts about fitness to practice the GMC would be informed.

One interesting thought was whether the Ombudsman should have the power to hold to account individuals who were responsible for service failure.

Day 110

“In the Thick of It”

Slightly out of sequence came the former Chair of CQC from its inception to December 2009 when she resigned. Compared to its predecessor [HCC] the new CQC had substantially greater powers to conduct periodic reviews, investigations, inspect premises, take copies of documents and interview people in private. It also had the power to suspend or revoke registrations. It was a very different regulator from HCC and did not have to rely principally on the power of press disclosure.

She had been unimpressed with the inspectors CQC had inherited from HCC. They made her extremely anxious as they inspected by rote. They were not of the right calibre to stand and challenge senior people. CQC had decided to close the central investigation unit developed by HCC[ and the team that led the Mid Staffordshire investigation] as it no longer fitted the new style of working. The HCC report had taken too long and used emotive language that
was in her view inappropriate. Providing a critical report eighteen months late kneecapped
the place by exposing it to huge press attention and public concern that undermined those
trying to take the hospital forward. Health Check a system inherited from the HCC was
hopeless. Basildon demonstrated in bucket loads just how unsatisfactory and unrealistic it
was. It was flaky.

She had reviewed the continued appointment of her Chief Executive [who had for a time
been Chief Executive of the West Midlands SHA] but decided that she should continue in her
post.

We go over once again the meeting that led the Secretary of State to ask for the number of
predicted excess deaths to be removed from the HCC report. Our witness had absolutely no
influence over this issue. HCC would have died in a ditch rather than let her have influence
over it!

Whilst Mid Staffordshire was not unique, all hospitals have pockets of excellence and poor,
it was affected by a poor decision making process that got things wrong in the pursuit of
foundation status. It was also unique and distinctive because of the complete silence by
health professionals.

Next a rhetorical question. Who is the Department of Health? Is it the Secretary of State,
the Chief Executive of the NHS or the Permanent Secretary and her team? Did you ever find
out ask counsel? Well it was bit like living through an episode “In the thick of it” [A dark
political comedy set in the corridors of Whitehall].

The government hated the idea that a regulator would criticise the government because
they managed the NHS. There was however surprising little attempt to intervene by
ministers but it varied between politicians.

Was it true you had a healthy disrespect for Dr Foster? Well their league tables were not
always accurate and sometime they wanted to provoke discussion rather than produce hard
evidence about failure. The public was confused when experts disagreed in public.

In earlier evidence there had been reports of a serious dispute about the language used in a
press release about Basildon and Thurrock. Putting phrases like “11 out of 12 trollies were
stained and two had a foul odour” was designed to catch the headlines rather than address
the problem.

There had been tensions between CQC and Monitor which led to at least one “unpleasant
meeting”. This was structural rather than personal tension because the two regulators had
complementary powers. Only Monitor could sack a board and a chief executive.

Our witness resigned for two reasons. The job was always going to be fraught because
whilst the Department of Health wanted a strong independent regulator, in doing its job it
would on occasion put the Department in the dock and find it wanting. The second reason
was a pessimistic view of the future that would lead good care to be put at risk as a result of health care cuts. She promised herself never to work for government again, any government!

As for the future she wanted the management of the NHS out of the Department of Health.

Day 111

Criminal Prosecutions?

Next two witness from the HSE. First the local Inspector for Staffordshire followed by the Chief Executive of the HSE [incidentally a former civil servant at the Department of Health].

HSE had to prioritise its enforcement duties and health and social care were nowhere near the top of the list on the grounds that other regulators were in place. If two regulators overlapped the specialist regulator took precedence. Although there were clear overlaps there were also a number of gaps in the regulatory framework. CQC did not look at individual cases and if they did find fault they had no criminal sanction. HSE did look at incidents involving major trips or falls by patients, scalding’s, electrocution or other such injuries. In effect two complementary systems were in place.

However if a patient was killed as a result of a hospital using a faulty trolley then it might result in a criminal prosecution but if the patient died as a result of a faulty system of care then prosecution was very unlikely. The HSE could never use a statistical analysis of mortality as grounds for action.

HSE had considered prosecutions in a number of NHS cases including Maidstone, Tunbridge Wells and Stoke Mandeville but the HSE was usually brought in too late with little prospect of building up an evidential base. An HCC/ CQC report was not regarded as a sufficient evidential base. The HSE had only been informed about the HCC report on Mid Staffordshire in January 2009. The local inspector was sympathetic to the HCC inspectors decision not to involve them but the Chief Executive of the HSE disagreed with his colleague. In his view both the HSE and the police should have been consulted at an early stage to allow them to decide whether to get involved.

The decision not to investigate Mid Staffordshire was had nothing to do with the availability of resources but to the judgement that there was no prospect of getting the evidence that would be needed for a successful prosecution.

CQC and HSE had met on a number of occasions which were friendly and constructive but CQC was clearly worried about a major intrusion into their territory. One issue was in stalemate and that related to prosecution, a matter that could only be resolved by government.

CQC could be given powers to launch criminal investigations and made the single regulator for the health and social care sector. Our witness argued this point on a number of occasions. It was a solution he preferred.

Minsters had not intervened at all although one email exchange between civil servants did suggest that ministers might think that an HSE prosecution might be preferable to a costly and lengthy public inquiry.
Days 111-112

**Anybody who took comfort from CNST levels would be deluding themselves**

Next the Chief Executive and local risk manager of the NHS Litigation Authority which provided a risk management for NHS Trusts. One a Trust received a claim they passed it to NHSLA to handle and settle. Trusts were assessed and graded on their risk management processes. CNST Level 1 secured a discount on the annual fee of 10%, Level 2 got 20% and level three 30%. In 2004 and 2007 Mid Staffordshire was a level three. Surely that assessment was a little inflated suggested counsel! Well we never claimed the levels were “Good Housekeeping “ seals of approval. They were intended as incentives to good risk management practice. Trusts were assessed on their submitted paper work and a two day assessor visit once every two years. They were what they said on the tin and anybody who took comfort from CNST standards to judge overall quality of care would be deluding themselves.

However major changes were in the wind in the way in which standards were set and assessed which might include for the first time standards relating to clinical practice. NHSLA might also be given powers to act like a commercial insurer and refuse to give an indemnity unless required changes were made. This was our witness explained highly sensitive!

Then another little titbit in response to the question as to whether there was a proposal for CQC to take over the setting and monitoring of risk management standards came the cryptic reply “choosing my words very carefully on the contrary “?

The NHSLA encouraged Trust and clinicians to apologise to patients when things went wrong without admitting liability.

They had found out about the HCC report on Mid Staffordshire when it was published. Had they know earlier it might have influenced the CNST rating. The Trusts claim history was unexceptional until after the HCC report when it peaked.

Interestingly NHSLA does provide claims data to CQC but not to Monitor.

**Day 113**

**The safety level in many emergency departments is lower than it should be.**

The President of the College of Emergency Medicine was the last witness before the summer break. The College had 3500 doctor members but had no regulatory powers over its members. It did issue guidelines and worked closely with NICE. The College did not do hospital visits but Trusts could audit themselves against college guidelines.

The 4 hour target had generated problems because it became an emergency department target rather than a hospital or health system target. Clinical Decision Units were a good
idea if run properly and provided they did not become a dumping ground to stop the clock running.

The safety level in many emergency departments was lower than it should be. Mid Staffordshire was not unique. Their idea that acute medicine and emergency medicine were the same and that the skills and competencies were interchangeable was wrong. Doctors in emergency departments will see patients of all ages, presenting with all illnesses and injuries, at all hours.

The Trust had submitted a draft job description for a new consultant post to the college but it had not been approved as it did not provide the split in sessions required by the College[7.5 sessions clinical time and 2.5 sessions non clinical]. The row about the job description brought up questions about continued approval for training junior doctors.

In the event three consultants in emergency medicine were appointed. He visited them in early 2009 and had been impressed with their enthusiasm. Sadly two had now left and the support for the emergency medicine department had in his view not been sustained.

The inquiry adjourned at this point until September. For the record the Chair made a restricting order in relation to all medical evidence which the inquiry has received or may receive relating to the health or fitness of witnesses to give evidence. The Chief Executive of the Trust for most the period under review has not given oral evidence.

Day 114

A Suitable place to Train; Dean’s view.

The Postgraduate Medical Dean for the West Midlands, one of the few deaneries that is fully integrated and accountable to a Strategic Health Authority, gives evidence. Despite the organisational integration the Dean was not in the loop in so far as the problems in Stafford were concerned. She was not told about the impending HCC investigation or copied in to SUI’s. There was little if any quality assurance prior to 2008 and the oversight of training was “somewhat superficial”. The clinical tutor at the Trust had been in post for 14 years. A report in 2007 had identified problems with excess work intensity in emergency medicine. There had been only one critical comment about the Trust but that did apply to that same specialty. Confidentiality seems to have been a problem between the deanery and the HCC.

Moving the specialist registrar from emergency medicine had been contemplated but judged to be impractical.

This was another piece of the jigsaw that never got into the main picture.

Next was the Dean of the Faculty of Health at Staffordshire University who placed around four hundred student nurses at the Trust and provided some continuing professional
development. Students on placement were supernumary and not part of the established work force. Few student nurses it appeared looked for work at the trust once qualified.

The working relationship with the Trust was now good but there had been problems in the past. One Director of Nursing had been difficult to deal with and another had strained the relationship by seeking to give contracts for continued professional development to Birmingham were she had previously worked.

The University did evaluate the quality of the educational experience but not the quality of care provided to patients. That was a matter for others. The Dean agreed that student nurses might be reluctant to report poor care for fear of the consequences.

The NMC had undertaken an extraordinary review of the nurse training programme in 2010. It had made a number of criticisms and recommended that all placements at the Trust be withdrawn immediately. The NMC had however been persuaded not to take this step when they received an action plan from the University and the Trust.

Breaking down confidentially barriers in the interests of patient safety seems likely to be an issue for the future.

Day 115

*Yes Minister*

A day in the witness box for Andy Burnham who had been Minister of State and then Secretary of State at the Department of Health for much, but not all, of the time period covered by the Inquiry.

He was, by his own admission, a hands on minister who tried to be the voice of the people rather than an expert. Prior to his election as an MP he had worked for the NHS Confederation so understood the health brief. His evidence was given quietly and thoughtfully. At times he was frank but he gave little away. It was as one of the patient group watching said, sotto voce, a fine performance from Jim Hacker in *Yes Minister*.

He was first asked to comment on a report by Joint Commission International who had spent 15 days between December 2007 and January 2008 interviewing key public and private sector managers about central quality and oversight. It was pretty heavy in its criticism. They reported that a shame and blame culture of fear appeared to pervade the NHS and certain elements within the Department of Health. This culture had been embedded in the system by legislation. Andy Burnham had never read the report and would have disagreed with its conclusions if he had. On the contrary he had tried to break the NHS culture with its reliance on the tier above and wean the Department of Health off top down directives.

He had been involved in setting core standards for the NHS on the advice of officials including the CMO and CNO. He remembered the challenge about the standards from HCC but had been persuaded not to accept their advice, The system was at that stage going through enough change as it was without more being foisted upon it. The core standards might have been a blunt instrument but they were better than anything the Department had published ever before.
He confirmed the evidence given by others that the NHS was on a quality journey that would take time to unfold. There had been a problem at the transition from the star system to the Annual Health Check as many Trusts scored less well under the new system which appeared to suggest they had deteriorated when they had not. As a minister he had been right to ask questions despite the fact that the system was being managed by an independent regulator. He was not trying to bury bad news but ensure that the system was fairly reflecting the truth.

The model of an independent regulator regulating services provided by a government minister was never going to be an entirely satisfactory model. It was always going to be, he said, incredibly fraught because whilst the Department of Health wanted good strong regulation they knew that from time to time this would put them in the dock and that they would be found wanting. What was needed, he implied, was a more constructive relationship and that had at times been missing particularly so far as Monitor was concerned.

The decision to let Mid Staffordshire proceed to foundation status was a decision made by Monitor not him. He had, on the advice of his officials [the Application Committee] let them through the gate to apply. He knew the Trust would then be turned upside down by Monitor in what was a demanding approval process. He was surprised that Monitor claimed to place great weight on his support for the application. They normally fiercely asserted their independence.

He was still puzzled why, if there was such a major problem at the Trust, the clinical community had said nothing. The advice he got from his own officials was gone through in some detail [and more to come in the following days] but nobody mentioned the Dr Foster mortality data or the impending HCC investigation. Was he let down by his officials. Difficult for him to judge but a fuller briefing might have been helpful.

When the HCC report came out he did ask the Chief Executive of the NHS to identify a new team to take over which as we now know provoked a major spat with Monitor who regarded this as their business.

He had wanted to deregulate the Trust but had no powers to do so. Nor could he intervene in the termination payment to the Chief Executive in the wider public interest. Some Foundation Trusts had taken their freedoms but paid lip service to their obligations for local accountability.

He acknowledge the difficulty of changing the NHS and the resistance by MPs to change on their patch but the NHS had to change. The DGH model was not sustainable into the future.

As the evidence from the Department of Health unfolds we are given a fascinating insight into the policy advice ministers receive. One paper marked restricted can be found at the back of the evidence statement of Ben Bradshaw [Day 116]. It was about foundation status “a sensitive terrain with difficult and important issues “. Foundation Trusts were not a standalone policy but an interconnected system of reform policies. The policy aim was to move the debate away from national policy levers to local transformation. The Foundation Trust model had flaws as well as strengths. When first proposed in 2002 they had been seen as a way of giving a small number of high performing NHS Trusts more freedom but this had been extended to all Trusts. The last in the pipeline would be the most difficult and would include some very large Trusts in Leeds, Nottingham and London. Foundation Trusts had built up a huge pot of financial reserves (£3 billion] but raiding
the pot to take the pressure off the rest of the NHS would not be easy. The FT financial regime needed urgent reform as their reserves were all set against the D of H budget. Part of the problem was how Monitor operated. It was not an easy relationship. The Department had already decided not to extend the contract of Dr Moyes and change his job to that of a part time chair rather than a full time executive chair.

Our witness wanted to regulate NHS managers in the same way that doctors and nurses were regulated. I doubt he knew that most managers these days had a clinical or professional background.

He was asked why he had resisted a public inquiry when he was Secretary of State. He had agreed to an independent inquiry and would have given the chair whatever powers he needed to get the job done. In his view the final accountability for the Stafford tragedy lay with the Trust Board. No doubt other parts of the NHS could have performed better but that was where the final accountability lay.

Andy Burnham’s final words to the inquiry tell us a great deal about his evidence. “I want to say that those who criticise me and other ministers of being in the business of managing news, managing things and closing things down and not letting the facts come out that I did not accept the departmental advice. I did set up the initial inquiry as a result of which the patient stories came out. I wanted the full enormity of what wrong to come out for the whole of the NHS to see.”

Day 116

Downing Street: Have you got any clever tricks?

The witness was Ben Bradshaw Minister of State for Health during Alan Johnson’s period as Secretary of State. Before becoming an MP he had been a journalist. He was the minister with the oversight role in respect of HCC.

He starts his evidence by reflecting on the consolidation of PCT’s in 2006, a measure he approved of as a means of shifting the balance of power between PCTs and hospital providers. In his view there should have been a greater consolidation in London. He was clear that the HCC should regulate PCTs who would in his view benefit from independent regulation. David Nicholson the Chief Executive of the NHS had disagreed. He thought regulation would get in the way of developing world class commissioning.

He did recall complaints from David Kidney MP about the Staffordshire LINks and had sent in the Director of Patient experience to sort it out.

If he had known that the West Midlands SHA had commissioned independent advice on the interpretation of mortality data he would have been displeased. Everybody should have assisted the HCC in their investigation and not tried to second guess them. He thought the HCC had done a fine pioneering job. As far as he was concerned they could investigate what they liked and did not need his prior approval. In steering the NHS Bill through the Commons he had made sure that CQC had a full range of investigative powers available to it.

Relationships with Monitor were always at arm’s length and Bill Moyes always guarded his independence jealously. Moyes had, on occasion gone directly to Downing Street. He had objected when he thought ministers had given the impression that they would sort out the Trust after the
publication of the HCC report. When it came to the time to replace the chair and chief executive of the Trust he had made it plain to Alan Johnson that the decision was for him not the Secretary of State.

Bradshaw’s view was that “there was a failure on the part of Bill Moyes to realise that ministers were ultimately accountable for the delivery of services “. By May 2007 his officials were asking questions about the future of Monitor and its relationship with the Department of Health. The advice from officials at the time was to raise the stakes by threatening serious consequences if Moyes failed to cooperate better.

An exchange about “gaming” on targets…..cheating you mean said the minister. This was the worst Trust he had come across but any trust that had been caught gaming would have been dealt with firmly. Prior to the HCC report nobody had expressed concerns about the Trust to him. Nor did he have any concerns when Cynthia Bower was appointed Chief Executive of CQC from her former post as Chief Executive of West Midlands SHA.

The inquiry spent a long time on the foundation Trust pipe line trying to establish whether marginal applicants were passed through to Monitor as a means of accelerating progress for political purposes. Ministers certainly encouraged all NHS Trusts to prepare themselves for foundation status. Was it possible, the chairman asked , that your encouragement might be interpreted by the front line as something a career depended upon? Well , whilst Alan Johnson had not gone cool on the foundation trust idea he was not an enthusiast. Ministers had realised that all trusts would struggle to get through and had discussed what to do if this happened and what steps to take if existing foundation trusts failed. He favoured deregulation.

Downing Street had applied some pressure and asked if any “clever tricks” could be deployed but the number of referrals to Monitor had slowed. After the Mid Staffs Trust failure he had instigated a review of the approval process during which he had asked whether Monitor had undertaken any detailed clinical scrutiny. They clearly had not. He had asked to see all the application committee papers after the event when he saw for the first time that the application had been judged as marginal and difficult to support.

As far as the future was concerned he thought that the Coalition was unlearning the lessons of the past. In Staffordshire GPs had not spotted or dealt with appalling standards in their local hospital. PCTs and SHAs were being demolished with little clear idea about what would follow them. More problems would slip through reorganisation cracks.

He apologised unreservedly for what had happened but he was not culpable. The first he had heard about the problems were a few days before the HCC report. As to a Cobra type committee to handle future crisis he declined to comment.

Finally, a reflective comment wondering whether there was something special about the health economy and political landscape in Staffordshire that had made it less likely for alarms to be raised. Some people did know what was happening at their local hospital but no alarms were raised. Was there a cruel confluence of events that meant that this did not happen ? Why he wondered had the local press had so little to say before the HCC investigation commenced.
The representatives of the local press present were far from pleased!

Day 117

No Nursing Crisis

Dame Christine Beasley, Chief Nursing Officer and a Director General in the Department of Health gave evidence. She defined her role as professional leadership, patient and public involvement policies, improving cleanliness and reducing healthcare associated infections. Her brief changed from time to time following internal reorganisations within the Department.

The Department of Health did not operationally manage the NHS so there was no line of accountability been her and nurses in the field. Her role was professional leadership to the nursing and midwifery professions.

The NHS needed nurses who were intellectually able and emotionally aware who could combine their technical skills with a deep understanding and ability to care. It was not an either/or choice. Nurses had to care intelligently and with compassion. Nurses had become empowered in recent years[e.g. nurse prescribing] which had increased the complexity of their work, given them greater autonomy and enabled them to design and lead services.

There was, in her view, no evidence that Project 2000, which had moved the education of nurses into the higher education sector, produce a lack of compassion. It was not true that nurses were “too posh to wash” or “too clever to care”. Whilst nurses were educated in universities they spent 50% of their time in clinical settings.

Perhaps, she acknowledged, nurse recruitment had not paid enough attention to values and behaviour in the 1990s and early 2000s when the profession had expanded rapidly [A rise of 80,000 between 1997 and 2009]. But you did have to remember that society had also changed. Do you mean that we were no longer willing to accept military styles of leadership asked the chair? Yes when I trained the patient was a passive recipient of care whereas patients these days are more assertive and vocal.

Nurses now had a full seat on Trust Boards but there was no national specification of the DNS role, nor would one be helpful in her view.

The Department of Health had no control over local staffing levels and had not mandated minimum staffing levels. In truth there would always be a range depending on local circumstances. There was a danger that any national number such as 65/35 registered to unregistered would end up as a ceiling. Instead the Department had concentrated on tools such as Safe Nursing Care which calculated staffing requirements based on the acuity and dependence of patients. In the case of Mid Staffordshire you did not need a tool to work out that a ratio of 40/60 on acute wards was wrong. The RCN had produce guidance entitled Evidence based nurse staffing and she agreed with almost all of it. The Department of Health had told the CQC that they would be operating outside their brief if they tried to set staffing levels.

Another tool was Essence of Care which included 12 benchmarks of clinical quality which could be measured locally. The 12 included bladder, bowl and continence care, personal hygiene and the
management of pain. It was a self-improvement tool with no national sanctions and formed part of *Energising for Excellence* the quality framework for nursing and midwifery.

**There was no crisis in nursing just issues around nursing in some areas.**

The problem observed the chair was that you only needed a few places like Stafford to have a serious deleterious effect on the whole profession as public confidence was shaken. Yes, the CNO replied, and the same was true of hospital infection which was experienced by only a few patients but which produced widespread concern and fear amongst patients.

She had regular contact with the RCN and the NMC but Stafford had never come up until after the HCC report. The RCN and Unison had called for the professional regulation of health care assistants but no national consensus had emerged. She did not support such a move and favoured a system of assured voluntary registration for all unregistered staff. Enrolled nurses had gone because there was no easy route for them to move up to a registered nurse.

After the HCC report she had kept a close eye on what happened in Stafford. She had asked for situation reports on shift vacancies and sickness levels; a very unusual level of detailed oversight for a CNO.

Why did standards slip so low in Stafford? Maybe the staff became desensitised to poor care and just carried on with their job.

There would be a CNO at the proposed NHS Commissioning Board and another Director of Nursing at the Department of Health who would be the principal advisor on public health nursing.

What we heard was evidence from an experienced and articulate nurse who had assimilated well into her civil service role. There was disappointment and a perhaps a degree of shame for what had happened in Stafford but there was no strong anger or sense of disgrace, nor was there any passion for radical change. The profession was doing well and enjoyed a lot of public trust. The noise was about a few bad examples which needed to be dealt with.

**Days 118-119**

**Becoming a Foundation Trust**

The head of the foundation Trust branch at the Department of Health at the time of the Mid Staffordshire application described the process of securing ministerial support to proceed to Monitor.

The decision to extend foundation trust status to all NHS Trusts, rather than just a small number of high flyers, was made by ministers in 2003. The HCC had reviewed progress in 2005 and noted some progress but no significant quality gains. There was a feedback loop with Monitor about failed applications which led the Department to be much more stringent about reviewing long term business plans. Mid Staffordshire was in wave 5. There were doubts about the financial plan and one member of the applications committee thought the case was difficult to approve because of this. They had a clean external audit record and nobody had raised any quality alarms.
The recommendation was that ministers agree to let Mid Staffordshire through the gate to Monitor. Any outstanding issues could be sorted out by the “can do” attitude of the management team. It was inconceivable that a poorly performing Trust in terms of clinical quality would have been put forward by an SHA.

With the benefit of hindsight it had become clear that there were substantial concerns around mortality rates, but that was not the view at the time of the SHA, the Trust or CHKS their external advisors. The problem was one of coding they had explained. There was no negative evidence available to the Applications Committee from HCC about service quality. On reflection the information available to the applications committee had not been as full as it might have been and for that he accepted responsibility.

Sir Andrew Cash who had been seconded to the Department of Health as Director of Provider Development followed. He had been chair of the Applications Committee when the Mid Staffordshire application had been presented. He confirmed much of story already presented in evidence by others. He denied there was undue pressure from ministers to speed up the pipe line. If they had known about all the problems in Staffordshire the application would probably not have gone through to Ministers in the form it did.

This now a dead story. There seems to be a broad consensus that Mid Staffordshire should not have been approved as a foundation trust. The screening process was inadequate at least in so far as clinical quality assessments were concerned.

The only outstanding question is whether today’s assessment process would pick up another hospital like Mid Staffordshire.

**Day 120**

**Tip Toe Thro’**

Next the senior civil servant in charge of system regulation at the Department of Health. His answers were measured, thoughtful and calculated, with many pauses, as he considered his answers and as he put “unpicked questions in his mind”. He tip toed neatly through his early evidence perhaps because he knew what was coming.

He was head of the foundation team for a time and dealt with the fallout from the HCC report. He declined to comment on the culture of the NHS having never worked in it. He was a career civil servant.

We go through payment by results and tariffs. Adjusting the tariff to lower lengths of hospital stay was fine the Chair said provided it did not incentive trusts to throw people out of hospital early.

The power to authorise a foundation trust rested with Monitor and not the Secretary of State. The screening exercise undertaken by the Department was not part of the approval process.
Foundation trust status was not a kite mark of quality but it did recognise the hard work that had gone into securing the status. He would not have used the Premier League description. The research did not show any strong association between foundation Trust status and increased clinical quality although it did show other benefits.

He knew about the start of the HCC investigation but received no updates as it proceeded. In any case by that time Mid Staffordshire was subject to Monitors compliance regime not the Department’s system of performance management.

He was not ,he said, attributing blame when he said in an e-mail to a colleague “There is no doubt that the regulators failure to consult HCC meant that Mid Staffordshire was authorised in ignorance of the imminent investigation”.

His email continued “It generally suits us to argue that Foundation Trusts are subject to a robust regulatory regime and it could backfire if we throw mud at the regulator.”

He told a colleague who was preparing a Q and A on Mid Staffordshire “I would not believe a word they [Monitor]say...and don’t buy that bullshit about relying on the Secretary of State’s support for the application”.

All a bit embarrassing really but the Chair was very forgiving. The email had been sent late in the evening and even civil servants were allowed some latitude in their language at that time of day.

He had read the first Francis report with incredulity. The events in Stafford had cast a long shadow within the Department of Health.

**Day 121**

*Just tell them to do it!*

The Deputy Chief Executive of the NHS.A finance man by professional background and a former regional director for the north east. We start with some complicated stuff about NHS finance and how foundation trust expenditure was treated as if it remained within the Department of Health budget. In 2005/6 the annual NHS revenue allocation was £66.6 billion and there was a net overspend of £512m.

One PCT Chief executive had told the Inquiry that the SHA had told him to get its financial problems sorted. They did not give a monkey how they hit the bottom line he explained. That was not acceptable behaviour said our witness. However he explained that every time one part of the NHS overspent another part bore the consequences. There was only one budget. It did require very sensitive judgement to know whether a Trust was just trying it on or whether they had genuine problems. How did the Department check that cost improvements did not involve substantial risks to patients? Did Monitor check?
After the HCC report the PCT[ or was it the SHA despite it being a foundation trust] pumped in £4m and later a further £10m. Why was this required when the Trust’s reference cost position was neutral at 100. To deliver the Alberti recommendations was the answer. Entirely understandable in the circumstances but a dangerous precedent for others in trouble. Generate a crisis. You might lose a chief executive and gain a financial bung!

Our witness rejected comments about doctors and nurses being bullied into fiddling targets. Wild, outrageous statements he said. He had never seen evidence that the Department or the Regulators used public humiliation as a quality improvement driver. Targets were not dreamed up to complicate manager’s lives they were there to drive up standards. There was a danger of hitting a target but missing the point but this did not negate the power of well-constructed targets to push the boundaries of good performance. World Class Commissioning had exposed variation in PCT performance but it was a steep learning curve and they had to both deliver national priorities and respond to local priorities.

He did not think it sensible to use HSMRs as a tool to range trusts in a league table. They were a useful screening tool. Indicators that merited further investigation. They should not be used to jump straight to a conclusion about clinical quality.

The Dr Foster contract is clearly being reviewed inside the Department of Health, [ Shush’ it’s a secret]. They are also looking at the speed with which HES information is made available.

He thought that the West Midlands SHA decision to contest the mortality numbers without at the same time investigating with the Trust what had caused the numbers to be as they were “ was not a wholly appropriate response”. They had been too easily reassured in his view.

Why Counsel asked cannot the Department of Health simply issue instructions to the NHS when for example issues of patient safety were involved. Well our witness responded “I smile wryly at your; why don’t I just write out and tell them...they don’t always do those things straight away “. The Department issues guidelines not orders [ in the case of foundation trusts they don’t even have to open the letters!].

Mid Staffordshire had shifted attitudes to foundation trust independence. When the HCC report came out ministers could not tell Parliament or the public that it was nothing to do with them. They felt that they had to act and they did and almost certainly would again.

Who performance managed foundation trusts...their Boards.

As the evidence accumulates it is becoming increasingly clear that the independence wall around foundation trusts is developing large cracks.

Paying poorly performing Chief Executives to go was not on. Such payments now had to be approved by him and as a result the numbers had fallen sharply.
No the Department did not have a standby team available to parachute into trusts in difficulty. Will Counsel not listen!! Foundation trusts are nothing to do with the Department of Health in managerial terms.

A good robust witness who told it as he thought it was. The patient group was I think less impressed.

Day 122

**Honest failures need to be protected**

The Chief Medical Officer, an expert in patient safety, described how throughout the 1980’s and early 1990’s the patient safety scene was dominated by experts and enthusiasts. The safety of care not recognised beyond statutory requirements covering areas such as fire hazards, environmental and building standards and quality assured medicines and devices.

The understanding of system failure developed slowly and owed a lot to learning from other industries such as aviation. It took a long time to mature. Clinical audit was still not deeply embedded into clinical practice within the NHS.

The NHS was not an army but did respond to leadership and national priorities. Honest failure needed to be protected. Too often blame had to be attributed to an individual or individuals. A scapegoat.

He quoted a number of inspirational examples of families who had been harmed by honest failure being drawn in to identify the problem and find a way of preventing a reoccurrence. A blame culture impeded patient safety policies.

He approved of core standards provided they did not become like a telephone directory. Light touch regulation had become a mantra. The HCC had been a good organisation that had broken new ground. Despite being a civil servant he had challenged the system. Mid Staffordshire did not figure as an outlier in the National Patient Safety Agencies data base. You needed a flow of softer data to supplement to hard statistics.....complaints and visits. He had spoken to a colleagues who had told him that it was well known within the profession locally that the standard of care in some parts of mid Staffordshire were poor. He talked about the Diffusion of Innovation theory with innovators, early adopters and laggards [the bell shape].Responding to SUIs was frustratingly the same.

He was disappointed that the NPSA would be closed but reassured that its function would be relocated within the National Commissioning Board. He approved of appraisal systems for doctors and agreed that there should be a duty of candour.

He would involve patients far more in running the NHS. He did not think that the HSE role should be extended but agreed that their role needed to be clarified.

Competition and quality could work well as evidenced by competitive cancer centres in the USA.

At the end of this evidence the Chair announced a series of seminars. 

[Details on the inquiry web site](#)
Day 123

**Publishing clinical data improves medical practice**

A long day of evidence from the Medical Director of the NHS, Sir Bruce Keogh, a cardiac surgeon by background. He had also been an HCC commissioner. He is responsible for most things clinical within the Department of Health with the exception of public health. He had created the national Adult Cardiac Surgery data base with results presented on both an institutional and a surgeon basis. You can find the current listings on the CQC web site if you plan to have cardiac surgery in the near future!

The production and presentation of this data had demanded a change in the culture of professionalism amongst cardiac surgeons. Publishing clinical data improves medical practice. When the outliers were reviewed the usual explanation was system problems rather than surgeon failure.

The NHS Constitution and the GMC expected medical professionals to acknowledge, apologise and explain mistakes. The same rule should extend to organisations.

If you improved process[e.g. blood pressure] you got improved outcomes[heart disease and strokes].

The Department had seen drafts of the HCC report but chose not to intervene. The HCC and others were already on the case and reporting improvements. The Secretary of State [Alan Johnson] had not been briefed as a result of a foul up inside the Department. Sir Ian Kennedy had told him and warned that it was going to “be bad”. The report had ticked away like a time bomb whilst it was checked for accuracy.

He supported the decision by the Chair of HCC to delete the reference to 400-1200 avoidable deaths. The calculation used unproven risk methodology. The international evidence was that only 10% of excess deaths had an avoidable element. Nor did he argue with the graphic language used in the report.

Perhaps SUIs and breaches in *never events* should be published. Was death from a laparoscopic cholecystectomy a never event?

When he had been told about the second RCS report he had recognised the confidentiality issue but decided that the public interest overrode it. He rang the Medical Director of the Trust and advised him to stop laparoscopic cholecystectomies. He had no authority over foundation trusts and had been challenged by the surgeons in Mid Staffordshire who asked him what authority he had to intervene. He had made his position clear and would have gone to the chair of the Trust if they had declined to act.

Should the Royal College have told CQC... they will in future!

We then move onto a complex review of the developing quality framework within the NHS. It was currently like an alphabet stew of standards set by many organisations[Royal Colleges, NICE, Regulators, Department of Health et al ]. The system needed credible and consistent standards.
But how was quality to be defined? After extensive consultation some standards had been produced. The inquiry looked at two in particular PE37 which related to respect and dignity and NRLS patient safety events. Complicated stuff which led onto Quality Accounts which like financial accounts had to be signed off by Trust boards. When our witness had reviewed the early drafts he thought.. could Mid Staffordshire have put together a good QA….. if so we have got it wrong ! Even now in their current state of development a member of the public would not be able to make much sense of them.

Any outcome framework would be underpinned by NICE. Medicine is a very complicated science and perhaps the quality assurance framework has also to be complicated. However the more complex it becomes the less effective it will be.

Next, some management speak. The hospitals with the best clinical results were usually very effective and cheap. The “get it right first time argument”.
He is right of course which may explain why Mid Staffordshire is still struggling to balance its books.

The NHS was going to have a leadership academy which would involve doctors.

We move onto the question as to why doctors cannot have normal contracts of employment like other staff. Why did they need such a high level of protection when they were judged to have misbehaved in one way or another. The question was ducked and put on the list for David Nicholson the Chief Executive of the NHS. He thought the appraisal system would pick up doctors who were underperforming or who need help.

How do you hard wire quality into the NHS?

The National Quality Board brought all the quality players together in one room which helped as might a planned Director of Patient Safety[BUT, hold on, this was currently planned as an add on to the CNO role so don’t expect much!]

We stray into CQIN [Commissioning for Quality and Innovation] which is an agreement between a commissioner and a provider to generate some improvement for a particular condition. If it is not achieved the cash is withheld. Like retention payments in the building industry. An early example might be preventing blood clots in hospital.

He felt deeply for the families as his own family had suffered the consequences of a medical error.
He would do his best to ensure that the lessons were learned.

A powerful witness who impressed the inquiry.

Day 124

More witnesses called after anonymous tip off

Following an anonymous tip off from within CQC about an internal document comparing some of the evidence given by CQC witnesses and what actually worked on the ground, four CQC witnesses will now be asked to give evidence in the closing week of the inquiry.
In addition the inquiry will hear from a former chair of the Trust [by video link] and a statement will be read from the former Chief Executive of the Trust.

A nurse who led on clinical governance is also to be called at the request of CURE the patient group.

Earlier that day evidence was taken from a former director of commissioning at the Department of Health. We went through practice based commissioning again which led naturally to “world class commissioning” which had been developed to accelerate progress in the commissioning function.

PCTs did need more levers to influence and shape provider performance and attitudes.
Commissioning performance had improved.

Bringing private sector providers into the NHS would not of itself raise standards but competition did tend to make providers raise their game.

GPs were expected to be aware of the quality of secondary care and even more so in the future.

The PCT[s] in Staffordshire should have seen the warning signs.

Day 125

The Permanent Secretary

Una O’Brien the new Permanent Secretary at the Department of Health gave evidence and assured the Inquiry that the Department had made a full disclosure of documents that might be relevant to the inquiry.

Her evidence was based primarily on her period of office as director of policy and strategy between November 2007 and November 2010 when policy relating to regulation had been evolved and implemented. The wide ranging policy changes had their roots in the budget statement in 2005 which announced that the burden of regulation was to lessen. Inspection bodies were to reduce from 35 to 9 and in the public sector to 4.

CQC was a merger of the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission. There had been talk about incorporating Monitor but the financial and quality sectors in health were judged to be too big to shove together. The changes had resulted in substantial savings. Whilst the whole programme was Treasury driven the Department had expressed its own views which had resulted in a years grace being secured to enable a proper transition. They had also provided CQC with non-recurrent support for things like computer systems.

Did anybody in the Department question whether these changes were inconsistent with an emphasis on quality and safety. No, came the reply but the new regulator [CQC] did have more powers than its predecessors.

Yes, CQC should test whether clinical governance systems were working. Standards should focus on clearly articulated outcomes for patients. We do need national standards.

The Department had a close relationship with CQC and would leave them in no doubt if it was thought that they had got their priorities wrong. The Department also retained some responsibility for ensuring that CQC had methodologies that were fit for purpose.
Independence clearly has its limits!

Regulation of itself cannot always root out deeply embedded problems and a good standard could slip away with the wrong leader on a ward. There had been progress with tools like the *Essence of Care*.

CQC and Monitor did have to work together so that a balance could be struck between quality improvement and financial restraints.

The debilitating relationship between CQC and Monitor described by other witnesses had not helped. Monitor had become a lobbyist for the foundation movement as well as a regulator.

When it came to the culture of the NHS there was only so much that the Department could do. There was no monoculture in the NHS it was vast. PCTs *needed* to get out and see for themselves what service was being provided for their communities. Embedding a patient view into the NHS was crucial for the future.

Had the Department of Health put its hands up about Mid Staffordshire? Well the whole of the NHS Quality Board had done that in effect by the speed and strength of its reaction. Everybody was appalled and shocked by what had happened.

The Department of Health did accept the final responsibility for the lack of stewardship in Mid Staffordshire. But who is the Department when it comes to holding to account, ministers or their civil servants.

A polished performance from the former secretary to the Bristol Inquiry!

**Day 126**

**Department of Health accountable for whole system failure**

Sir Hugh Taylor Chair of Guys and Thomas’s Foundation Trust and former permanent secretary at the Department of Health gave evidence. He had also been the HR director for the NHS between 1998-2001 and in this role played a major role in the expansion of the NHS workforce following the NHS Plan.

The Department did not issue guidelines on staffing levels...too many local variants. Most good trusts benchmarked themselves against others. The Department needed to be careful about prescribing inputs to services.....better to measure outcomes. Despite a number of challenges he stood his ground on this point.

Monitor was not set up to regulate quality but at the time the NHS was abuzz with the rigour of monitor’s process which in his view was done well and effectively. After the HCC report more attention was paid to quality. He did not agree that FT independence was illusory.

There was sometimes a tension between what a local population wanted and what professionals thought was the best way of delivering care. In the real world some services needed to be subsidised.
In his view ministers did not regularly interfere with the running of Trusts. Alan Milburn had removed minister's powers to appoint foundation trust chairs.

The relationship between the Department and health regulators was always going to be a sensitive one. You just had to accept this. Monitor had not been set up to regulate quality.

He refused to be drawn on the appointment of Cynthia Bowers as Chief Executive of CQC. She had outstanding credentials at the time.

The NHS had been through many reorganisations and coped well despite a loss, on occasion, of corporate memory.

The allegations about a bullying culture were in his view overstated. There had been strong delivery messages in priority areas.

He agreed with the Ombudsman that the NHS was not always good at listening.

The shocking events in Mid Staffordshire were a local failure as well as a failure in the regulatory and supervisory systems.

The final accountability for system failure lay with the Department of Health who now had to learn the lessons from this failure.

Days 127-128

**NHS Chief Executive evidence**

Sir David Nicholson, Chief Executive of the NHS in England spent two days in the witness box a total of nearly 11 hours. First we go over his extensive NHS credentials. Much of his early career was spent remodelling mental health services. He moved on to become, for 10 years, the Chief Executive of Doncaster Royal Infirmary a large DGH in South Yorkshire. He then moved into a number of regional jobs including that of Chief Executive of the West Midlands SHA. From there he moved on to run the London region. He became Chief Executive of the NHS in 2006 following the resignation of Nigel Crisp.

Throughout his career he had always been a keen advocate of close clinical engagement with Doncaster being one of the first hospitals to create clinical directorates. He had always encouraged managers to focus on their purpose; which was to treat patients effectively.

The borderline between regulation and performance management was a thin one. Foundation Trusts were removed from the performance management processes. All that the system retained was the nuclear option of sacking the board [although CQC had a wider range of sanctions against all NHS providers]. Candidates for foundation status had to demonstrate that they were clinically and financially viable. In 2006 the SHAs were in an “ever decreasing hands on role”. Their principle role became supporting the development of commissioners and setting a strategic framework for the local NHS.

The reorganisation of the SHAs in the West Midlands was not chaotic as alleged by CURE, although they did not focus a closely on quality as perhaps they should have done. The prime responsibility
for spotting problems in Mid Staffordshire lay with the Trust Board and their local commissioners. At the time Mid Staffordshire did not come up on any regional radar screens as a major problem. If the SHA had known what they know now they would have intervened.

The NHS financial problems in 2005/6 did present major challenges as it followed a period of major expansion in the NHS. Headcount reductions had to be managed. It was not acceptable to achieve them without regard to the quality consequences. The vast majority of NHS managers understood this. The decision to top slice all NHS bodies in the region to cover the specific problems in some areas was widely discussed and understood. Those who had no financial problems, but still had to contribute to the regional bank, might not have been enthusiastic but they understood why it had to be done. He had done the same in London. The cost improvement target in Mid Staffordshire was on the high side but the local health economy was at that stage still getting substantial growth. The nursing staff reduction was tied to the closure of two wards [46 beds] and a further reduction in 2007/7 to more bed closures. As far as he knew the nursing leadership at the Trust had gone along with these decisions and not raised any concerns at any meetings he had attended.

The local confusion about nurse staffing was due in part to the Trust operating a vacancy factor assumption in its budget processes [as did most Trusts]. The trouble in Mid Staffordshire was that this had risen to very high levels [8%]. They had an establishment but not the money to pay for it. To complicate matters activity at the hospital had not reduced despite extensive plans by the PCT to reduce the load. Patients per nurse was the crucial benchmark not nurses per bed. We go over the Board to Board meeting recounted by other witnesses, at the end of which the SHA had told the Trust that it was two years way from meeting the criteria for foundation status or to put it another way would be capable of achieving foundation status in two years’ time, if it continued to make progress. A subtle but important variation in emphasis with the latter being the interpretation intended.

Why had the SHA not picked up the quality problems? Well neither had the HCC at this stage. At the time he had thought that the processes set up to detect problems were robust enough but clearly they were not. At the time quality was not the driving force underlying NHS systems.

Staffordshire was unusual in the scale of public bodies per head of population. It was always difficult to get everybody in Staffordshire to line up together to deal with problems. There was no local support for a single PCT except for the County Council. One PCT would in his view have produced a better resourced commissioning organisation.

Martin Yeates had been brought in, on an interim basis, to manage the Trust by his predecessor but he had acted as assessor at the interview which had confirmed him in the substantive post. By then Yeates had earned the respect of the chair of the Trust who wanted him appointed. As statutory Accounting Officer were you accountable for his failure?

A noisy reaction from the public gallery at this point was quickly quelled by the chair.

Yes he was, until such time as the Trust gained foundation status when Yeates became an accounting officer responsible direct to Parliament. He did recall a conversation about the strategic direction of the Trust and Cannock hospital in particular. It should either be filled with clinical activity or closed. There were lots of hospitals around the country the size of Mid Staffordshire. They were
designed at a time when you could provide most services for a local population of 300,000 but that was no longer sufficient for sub specialties. Trusts had to seek to expand their catchment populations or build networks with other Trusts. No coherent strategy had yet emerged in Staffordshire.

With the benefit of hindsight Yeates was not a good appointment. He had strong operational experience but lacked the ability to think strategically.

Of the 1000 managerial leaders in the NHS 35% now came from a clinical background. Appointing people from the private sector as Chief Executives had not usually been a success. They found the politics difficult. The principle obstacle to more doctors applying to become Chief Executives was the problem of returning to clinical practice.

He had not felt any pressure from Downing Street to speed up the pipeline of foundation Trust applicants. On reflection letting Mid Staffordshire through was a risk that need not have been taken.

He, like others had been surprised when Bill Moyes had told the Select Committee that he had drawn comfort from the support of the Secretary of State for the mid Staffordshire application. Lessons had to be learned about the poor relationships between the HCC and Monitor.

The Annual Health check had become a scoring machine and had had to be changed.

He had been briefed about the controversy about HSMRs but not paid much attention as the report was bad enough as it stood. The full horror of Mid Staffordshire had only come to him when he had read the first Francis report and its patient stories.

He denied describing CURE as just a lobbying group.

It had been for Monitor to intervene if the Trust did not respond to the concerns in the HCC report. That was the system at the time. Monitor had challenged him on a number of occasions for writing directly to all NHS Chief Executives[ including foundation trusts] but he was unrepentant. It was in his view perfectly reasonable for him to write, as he had, after the problems at Maidstone and Tunbridge Wells, to all trusts setting out the expectations of the customer, their patients, and the organisations that funded them. Monitor still did not have the power to deregulate a foundation trust. In the view of our witness that power should in any case lie with the secretary of state. Under the new NHS Bill Monitor would lose the power to sack a foundation Trust board. That was a matter for the governors for whom training was being organised.

To the lawyers at the inquiry this no doubt sounded pretty woolly!

Physical inspection was part of the new regulatory world. Setting national staffing standards was very complex due to local variation. Regulating health care assistants would be an enormous job and was it worth it he wondered. They performed a wide range of very variable tasks. It needed careful thought. He had been to a risk summit and they appeared to work.

He denied using the phrase attributed to him by Baroness Young “bayonetting the wounded” but he was concerned to support those trying to bring the Trust around. That was why he visited the interim team at the Trust shortly after the HCC report was published.
Throughout this evidence we keep straying into the future. NHS Trusts and foundation Trusts would, in the new world, be accountable to an NHS Trust Development Authority not the NHS Commissioning Board. Foundation Trust independence was not illusory but he struggled with full autonomy. They were after all part of the NHS family. The new NHS Commissioning Board [NHSCB] would design a national model contract and authorise and make allocations to Clinical Commissioning Groups [CCGs]. There would be no automatic authorisation of CCGs in 2013. There would be a CCG assessment process. The NHS Board would have the power to deregulate commissioning groups who did not perform.

It would be for each CCG to nominate their own accounting officer.

What distinguished high performing clinical teams from the rest was that they measured themselves, set themselves targets and then re-measured. IQI although limited to 1.5% of budget was a powerful tool. Quality Observatories through which clinical teams could review their performance against others would also be valuable.

He thought Chief Executives should be regulated in some way and had put some work in hand to identify a set of standards and behaviours and a code of conduct.

It had proved difficult to change the processes governing the discipline and the ultimate dismissal of medical consultants. But why cannot doctors be dealt with like other staff the inquiry counsel asked? Partly because the NHS was a near monopoly employer. If they lose their job they lose their livelihood. Some attempt to retrain should always be an option to be considered.

An understandable but weak response. A recommendation from the Inquiry might well help break the impasse.

Interesting exchanges about patient empowerment. Patients will be included on the NHSCB and it was planned to have an executive director responsible for the patient’s voice. CCGs would also have patient members. More patients would be given personal budgets.

The Department planned to consult on a “duty of candour” in order to understand better the practicalities.

The Department was currently working out the effects of the closure of SHAs and organisations such as the Patient Safety Agency [and patient safety alerts etc.] and would publish a paper soon.

He had not initially been in support of a second public inquiry preferring instead to concentrate on supporting those trying to sort the hospital out and move it forward but had accepted the decision of the Secretary of State and cooperated fully. The final report would be important for the future direction of the NHS.

The big challenge for the NHS was not the forthcoming reorganisation but finding a way of living with little or no growth for the next few years and generating a £20 billion CIP.

40% of this was expected to come from reduced central spending, 40% from operational efficiency within the NHS; reduced length of state, more day case activity etc. [all of which would reduce expensive beds.] The final 2% would have to come from service change which would include specialty centralisation and avoidance of admission to hospital.
In these difficult circumstances CIPs would have to be quality assured by medical and nursing directors and in the short term SHAs would have to sign them off.

He ended with an apology for what had happened and an assurance that the lessons would be learned.

**Day 129**

**Witnesses for the defence !**

A break with routine as a full public gallery in Stafford heard evidence via a remote television link from Toni Brisby the former chair of the Trust. Medical grounds were cited as the reason and the Chair imposed a restriction order on the publication of medical details.

Mrs Brisby had been chair from October 2004 until March 2009 when she resigned at the prompting of Monitor. Mid Staffordshire was her first chair role. She had been told on appointment by the SHA that the Trust was in a mess. She had supported the appointment of Martin Yeates as Chief Executive.

When it came to achieving the £10m savings target the detailed decisions and associated risk assessment had been left to each clinical division as they were closest to the ground. The chair of the medical division had made a presentation of the plans of her division to the Board. She did not accept the criticism that the Board was disengaged from the clinical community. There had been substantial pressure from the SHA for all Trusts to balance their books.

Our witness was guided relentlessly through all the negative external reports about the Trust. Her principle reaction had been to recruit an executive team to find solutions. It was not for non-executive directors to get involved in operational matters.

The majority of clinicians had not objected to the reconfiguration of the clinical floors. The Medical Director and the Director of Nursing had emphatically said that it was a good way of managing patient care. On reflection though it had not been a good idea.

The Julie Bailey group. CURE, did not want to talk to the Board.

Poor care was indefensible but Stafford hospital was not unique. There but for the grace of god said many others. Staff surveys were valuable but 18 months out of date. The reporting of SUIs at Board level had been poor. The governance structure had been confusing when she arrived but had improved.

The external advisors had reassured the board that the high mortality numbers were a product of poor coding so the Board had strengthened the coding team. The mortality group at the hospital had access to all the data.

The application for foundation trust status was not a diversion but part of a development process. She had interpreted the letter from the SHA after the diagnostic board to board [two years to go] as encouragement not criticism.

She knew there were problems in the surgical division but the doctors had a powerful trade union.
She had accepted the external criticism of the A and E but Stafford was not alone with medical staffing problems in that speciality. Nobody had suggested closure on quality grounds.

Relationships with the HCC Investigation team had been difficult. Their final report was based on hearsay and impression rather than evidence. The picture that emerged of the Trust was unbalanced, misleading, often inaccurate and extremely damaging. It was a myth that 1200 patients had died needlessly.

She had little contact with the PCT. Like all chairs she got a pay rise when foundation status came through which had been awarded by the governors of the Trust.

Her own counsel then asked a series of questions.

Had any Consultant ever told her about poor care of their patients? No

What about junior doctors? Again No.

What about nurses? No.

She apologised unreservedly to any patients who had received “bad practice” but it was not acceptable for the hospital to have been so vilified in the way it had been.

This evidence was not believed and scorned by the public gallery in Stafford.

But was the HCC report unbalanced? Did Francis jump to an unbalanced and too sweeping conclusion in his first report. Some patients did undeniably have a bad and unacceptable experience but was it as widespread as some allege. Did politicians jump too quickly in their public condemnation which made any other side of the story unpresentable? Was this chair badly treated?

These are not popular questions with patient groups but they do deserve study before the final report is published. Objective observers of this inquiry will be troubled by this evidence.

Days 130 and 132

A Leaked document

Two days of evidence from CQC staff about a draft internal report that had been leaked to the inquiry.

It was a paper comparing the evidence presented to the inquiry by senior CQC staff and what actually happened on the ground. It had been commissioned by the Head of Operational Intelligence without the prior knowledge of his senior colleagues.

Its content reflected a degree of tension between headquarters staff and regional officers and explored the reality of engagement notes and alerts.

It was planned as a contribution to a review of the service level agreement between headquarters and regions within CQC.

The author of the draft was at one point threatened with suspension but it never happened.
All a bit of a storm in a teacup that helpfully clarified some of the CQC evidence. A whistle blowers story.

Day 131

The lawyers go head to head

The former Trust Solicitor and his boss the Trust Secretary and Legal Advisor gave evidence, much of which centred around a decision not to pass to the Coroner a report prepared by a Consultant in A and E about the death of a patient [not his patient]. An exceedingly complicated and sensitive issue that is still in dispute. Because of this I shall stick to the essential facts as reported to the inquiry.

The facts are that a patient died after a visit to the A and E department at Stafford hospital. A senior Consultant Mr Phair prepared a report after the event which suggested that the death might have been avoided if the patient had been more properly assessed. The Trust legal advisor asked the Consultant to amend his report which he subsequently did. The report appears to have been filed and not sent to the Coroner.

When this matter emerged at the first Francis Inquiry he reported;

“What is troubling about this unhappy story is that it was clearly thought instinctively by a senior employee at the Trust that an adverse report about care leading to a death should be suppressed in part because of adverse publicity and in part on grounds relating to family distress that can only be regarded as specious.”

The next step was for the Trust [Antony Sumara] to launch an independent investigation which became known as the Taylor Report. He found the evidence against the Trust Secretary proven and she was dismissed. There will be an industrial tribunal next year. The conclusions of the Taylor report are hotly disputed. Mr Knowles gave evidence to the effect that “Mr Taylor was given a brief by Mr Sumara to support the decision to dismiss Kate Levy and the criticism about his conduct flowed out of this approach”.

The first Francis report is also disputed [and said to be based on a wrong interpretation of the law] “and had been the source of substantial adverse comment and played a part in a referral to the Solicitors Regulator.”

A decision by the Solicitors Regulatory Authority to refer both individuals to the Solicitors Disciplinary Tribunal has now been dismissed after an appeal.

The law seems now to be clear. The Trust was under no legal obligation to pass the Phair report to the Coroner. If he had asked for a copy one would have been made available.

The inquiry team spent some time on this matter but made little progress with a witness who came armed with counsels opinion that supported his view. His primary duty was to his employer and that included reputation management. As solicitor to the Trust he had no obligations to opposing parties in litigation and no general duties to anybody else other than his professional regulator.

He had conducted a number of inquiries for the Trust including one relating to a drug error which had led to a senior Trust employee taking early retirement. He had gone straight to the Medical
Director when concerns began to be raised about colorectal surgery. He played no active part in complaints management.

He agreed with an open policy with patients and had followed all the guidance on the subject that was extant at the time. There had been some resistance by clinical staff but the younger Consultants understood that they had to be more accountable. The tension between openness and accountability on the one hand and defensiveness on the other were not unusual.

The rules relating to section 43 letters [action to prevent similar deaths] had been changed and were now copied to statutory authorities and this could include families.

Kate Levy told much the same story and will no doubt go over it again at her industrial relations tribunal.

Comment at this stage has to be guarded but Francis clearly thought that the Trust as a whole had a defensive attitude to complainants which had contributed to the problems it faced. It sounds as if he was right but he may have gone too far in calling the attitude specious.

We will leave the lawyers to fight this out amongst themselves. The claim for damages by the family of the patient who died was settled some time ago and included a formal but regarded by some as an inadequate apology from the Chief Executive of the Trust.

Day 132

Another leak from CQC

Two CQC witnesses are called to explain a document [leaked to the Inquiry] that had been commissioned to catalogue the evidence that had been given to the Inquiry and the reported comments by senior field staff that it was all inspirational. The Inquiry also wanted to probe whether all intelligence gathered by field staff was put on the intelligence data base including in particular “engagement notes”. They were not.

All in all not a smoking gun but a helpful clarification of the evidence was how the Chair charitably summed the matter up. The fact that staff elect to leak material does not speak well for the organisation.

Day 133

Back to the Hospital - A whistle blower’s story.

On the last programmed day of public evidence we go back to problems at the hospital. [It wasn’t the last day for we had some late surprise witnesses] The first witness is a former head of clinical governance at the Trust [and before that the Director of Standards].

When she started the hospital was not using the reporting processes properly. We go over once again the handling of SUIs some of which had been on the system for years and not closed off. Nobody seemed to have noticed.
We look in some detail at an incident relating to an elderly lady who had presented at A and E with a painful hip. The SHO on duty had recorded on the casualty card that the patient had an allergy to penicillin. The same doctor later prescribed a penicillin based antibiotic. The patient had subsequently died and there had been an inquest.

Five months after the incident a note had been added to the file to the affect that “the local investigation was complete and a report had been forwarded to the Coroner and the family were pursuing litigation.” Two Years later the SUI was sent to the SHA who were supposed to take a close interest in SUIs.

Another case [the lady with diabetes referred to a number of times in earlier evidence] had been investigated by the authorities solicitor who had made sweeping criticisms about staffing problems and skill mix and low morale. Our witness had excluded herself from the investigation because a family member worked on the ward concerned. The SHA never saw a SUI.

Our witness denied allegations that she took unilateral decisions about how to classify incidents.

We then get into the linkage with NPSA and CNST. Everybody had been amazed when the Trust had been awarded level 3 [high].It had been a tick box exercise but this did not prevent the Trust boasting about being one of the safest hospitals in England.

She had been shocked by the HCC report that there was almost a complete lack of effective governance in the A and E Department. It had always been a problem but action had been taken. She knew nothing about the falsification of records.

Our witness was so demoralised by what had happened to her in Stafford that she did want to work in the NHS again or for that matter practice as a nurse [This is a former modern matron speaking!]

**A whistle blowers story.**

The final witness was a former staff nurse in the A and E and had blown the whistle on what was happening to patients and records. Breach times where, she said, routinely massaged, the pressure to do this coming from the two sisters who ran the department with a rod of iron. They were bullies and engendered a culture of blame and scapegoating. Training was offered only to the chosen few who were the sisters favourites. She had made 50-100 entries in the incident log but never got any feedback. In order to avoid a breach the length of the waiting time would be falsified on notes and computer records. Out witness went along with this if the delay was only a few minutes waiting for a porter but not when it became 30 minutes. One of the sisters had told the receptionist to change our witness’s entry. Sometimes she went home in tears but she was afraid to speak out. Staff were afraid that the A and E might close if it had too many breaches.
In October 2007 she finally spoke out after a day when there had been so many breaches that they could no longer be hidden. Both sisters were suspended. The floodgates opened and a lot of other people also began to complain about poor practice and a bullying culture within the A and E. A group of junior doctors wrote a joint statement but were told it would not look good on their record and so retracted it.

She was interviewed twice in the subsequent investigation and became so uncomfortable in the department that she sought help from the RCN. By this stage she was frightened to walk to the car park after an evening shift. She was threatened she said. The RCN representative was not helpful as he was representing one of the sisters who would shortly return to work after a slap on the wrists. In the meantime the number of breaches had gone through the roof. Perhaps because they were now being reported accurately!

Just as the sisters came back to work the HCC investigation began. The hospital’s chief operating officer now referred to the two sisters as her A team. She had not been one of the staff identified to speak to the HCC investigators. Her life became hell and she left. She knew nothing about the Trust whistleblowing policy.

A lot of poor staff still work at the hospital, in her view, and one of the two sisters had been promoted.

This is of course just one witness’s view of events but sadly much of it rings true.

The inquiry seminars now commence and final submissions for core participants will be heard from 21st November.

Day 134

**Closing Submission: Action against Medical Accidents [AvMA]**

The Inquiry reconvenes for closing statements from the core participants.

First AvMA who opened with the assertion that neither health care commissioning or localism, two of the current NHS dogmas, protect patients or foster improvements in the quality of care.

Human error is an inevitable part of any health care system they argue and should be handled in a climate of openness and transparency. Such a climate allows patients and relatives to understand what has gone wrong and why and therefore improves the relationship between patients and staff and prevents misunderstandings from fermenting into mistrust.

Mid Staffordshire was not an open organisation and practiced concealment and evasion. A duty of candour should be placed on all NHS organisations.

Any effective complaints system should provide a complainant with answers provide managers with information about the quality of care and provide data to external bodies and regulators. The complaints system in Mid Staffordshire failed.
It was not the SHA or the PCT or CQC who treated patients badly it was individual clinicians. There was a catastrophic absence of professionalism in Mid Staffordshire.

The professional regulators [NMC and GMC] were viewed as an unwelcome police force rather than a guardian of professional standards and practice.

Amongst AvMA’s advice was to review nurse training to make it less academic and more focused on basic nursing and caring skills. Health Care Assistants should be registered and regulated. Regulators should be required to restate the duty of professionals to report poor care whenever they saw it.

CQC should prosecute those individuals and organisations who were guilty of poor professional practice. There should be a national whistle blowing service.

The NHS Commissioning Board should issue safety alerts in future and ensure they were acted upon. Health Watch should be independent, properly funded and act like the best CHCs of the past. It should not be part of CQC and have a national headquarters.

A revised code of conduct for managers and Boards should become compulsory. All Trusts should hold their meetings in public.

Finally AvMA would like to see the inquiry reconvened in one year’s time to establish what action had been taken to implement its findings. Any future Inquiries should be established by the Health Select Committee or Privy Council and not by Ministers.

Next to make their closing statement will be Cure the NHS who will have little that is good to say about anybody involved in the Mid Staffordshire story.

According to press reports its members have been threatened by some people in Staffordshire who blame them for the recent partial closure of the Accident and Emergency Department.

The NHS in Staffordshire is going to take a long time healing!

**Closing Submission: CURE**

In the period 2005-2009 there were 1772 separate reported incidents in relation to staffing levels and their impact on patient safety at the Mid Staffordshire NHS Foundation Trust. They speak for themselves but why were they not picked up by those responsible for monitoring, supervising, performance managing and regulating the Trust?

What was it about the culture of the NHS where the voice of individual patients and nurses was drowned by political pressure?

LiNKs had been a failure. The Oversight and Scrutiny Committee demonstrated the gulf between theory and practice in the oversight of the NHS.
GPs were never an effective mechanism for identifying problems at the Trust. The Trade Unions supported the Trust despite the poor result in the staff survey. The RCN was too close to hospital managers. The Coroner did not identify system failure with his Dickensian system of working and the Ombudsman was irrelevant in so far as system failure was concerned. Quality was never really on the PCT agenda and they did little to monitor or ensure patient safety. The PCT did not properly discharge its duties or responsibilities. The SHA was the subject of much criticism including their support for the foundation trust application, not looking more closely at skill mix, monitoring SUIs properly and their defensive response to the Dr Foster mortality reports. It was all part, CURE alleged, of a culture of defensiveness and denial. It was very difficult, CURE claimed, to point to anything that the SHA had done prior to the HCC report by way of performance management to protect patient safety or improve the quality of care at Mid Staffordshire.

The HCC get some credit for their report but its inadequacies are also pointed out. CQC gets criticised for its methods, the quality of its leadership and its culture. The CQC model was flawed from the outset. Monitors main focus was on financial and corporate governance and had had an uneasy relationship with the HCC its sister regulator.

The HSE was still looking for and intellectually robust justification for not taking action with regard to the Trust. The professional regulatory bodies cannot spot system failure and were totally ineffective in identifying problems in Stafford.

All in all the whole system appears to have badly served the people of Stafford.

**Day 135**

**Closing Submission: Patients Association.**

The Department of Health and the NHS failed to ensure that patients were provided with safe standards of care and treatment in Mid Staffordshire. Stafford was not an isolated case and should be a wake-up call for the whole of the NHS.

PA wanted embedded independent Monitors. Self-assessment was dangerous. The Oversight and Scrutiny Committee failed. Inspections must be unannounced. The complaints system was not fit for purpose. Patients needed to be better informed about their rights.

The NHS needed a more open culture. The link between financial health and patient safety needed to be clarified and the Payment by Results system re-examined. Unsophisticated targets caused more problems than they solved. Quality Risk Profiles should be published. The Department of Health had undue influence over the way CQC operated. Health Care Assistants should be regulated.

Managers should be regulated and operate within clearer standards. Foundation Trusts should hold their meeting in public. Doctors should be regularly revalidated by the GMC.
The Deanery should have spotted the problems earlier than they did. The NPSA reporting systems were deficient. The HPA was helpless when the Trust declined to declare an infection outbreak.

A strong thread that ran through the Department of Health evidence was that Mid Staffordshire was a one off. The Chief Executive of the NHS did not accept that there was a culture problem of fear and top down control. Unless the Department could accept that there was a problem it is unlikely that they will ever be able to reform the system. They had showed a lack of openness and transparency. They did not welcome uncomfortable data. Their system for evaluating FT bids was flawed.

Mid Staffordshire was a product of a failed internal market model. The search for quality was being conducted in the dark. The Secretary of State should lead the drive for change in the NHS.

**Closing Submission: West Midlands SHA.**

An unreserved apology from the SHA which counsel said was sincerely meant. The transfer between the authorities on various reorganisations should have been more focused on quality issues. The concept of going and looking was not in the mind-set of the SHAs at the time. Not following up SUIs was a serious error which held bitter lessons for all concerned. The SHA had found itself in a perfect storm. A combination of events all coming together in a rare situation that aggravated an existing situation dramatically. The SHA were meant to be strategic not operational and were entitles to expect that the Mid Staffordshire Trust Board would act professionally in safeguarding quality and patient safety. The SHA was never in a position to micromanage a trusts staffing levels or finance.

The Dr Foster data was very new and their reluctance initially at least to reveal their methodology caused difficulty and concern. The SHA was never dismissive of the mortality data and acted quickly following publication to understand them better. The SHA knew nothing about the Dr Foster or the HCC alerts until January 2008. There was no inappropriate pressure from Ministers to accelerate the foundation trust approval process.

There was a very collective sense of shame in the NHS about what had happened in Mid Staffordshire.

**Day 136**

**Closing Submission: Mid Staffordshire Foundation Trust**

The closing statement for the Trust was made by Sir Stephen Moss the current chair who is about to retire. The Trust had let patients down and failed to keep them safe. A zero tolerance to quality failings was the only way forward. When clinicians failed to treat and protect patients to the best of their ability the Trust must be able to remove them.
Poor doctors cannot be protected at the expense of patient safety he said.

Care and compassion had to be at the root of nurse training. Denial was however deeply embedded in the NHS and would be difficult to shift. Mid Staffordshire was now a more open organisation that needed help not pillorying. NHS regulators were like critical spectators at a football match rather than helpers and developers.

The Inquiry was an opportunity for the NHS to transform itself.

Closing Submission: NHS Litigation Authority

The NHS Litigation Authority was not a regulator their counsel explained, nor were they a risk manager. They incentivised Trusts to achieve good standards. Counsel attempted to justify giving Mid Staffordshire the highest award [much to local surprise as we have heard]. The explanation was not very convincing. The system could not in their view be “gamed” by rogue Trusts. They did encourage openness by Trusts when dealing with problems.

They did not want to be taken over by CQC!

Closing Submission: HCC

A statement from the old HCC. The HCC had been an evolving and learning organisation. The interests of health professionals and Boards needed to be better aligned. Clinicians need to agree clinical indicators. Every trust should have a Chief Information Officer. Self-assessment was an important first step in any quality process. Quality Audits are good. Regulators should be development and improvement bodies. They need stability. Not convinced that health and social care should be regulated by the same body. Whoever does it should be independent of the Department of Health. The NHS needs to take a tougher line on reconfigurations. The patients’ voice is crucial to measuring quality.

The Inquiry should be reconvened in six to twelve months to measure progress.

Now history but a thoughtful submission!

Day 137

Surprise Witnesses; A truly awful day for CQC.

Two surprise witnesses from within CQC, both highly critical of the current management. First came a legal argument about whether the evidence could be heard at all with CQC arguing that it would be outside the Inquiry’s terms of reference.

A few days prior to the hearing the Chair of CQC had told all staff that the appearance of the two witnesses would be highly damaging to CQC and would weaken the work carried out by inspectors. Both witnesses claimed to be acting in the best interests of the organisation in acting as whistle blowers.
The Chair decided to hear the evidence but redact allegations contained in one of the statements about individuals.

The first witness, a compliance inspector, was nervous and had clearly had a lot of support from the Inquiry team in presenting her evidence. She had not taken her concerns to the media but to Public Concern at Work who advised her to approach the Inquiry directly.

She had been part of the central infection team which was eventually broken up in the summer of 2010. She had expressed her concern about this to the Chief Executive but the changes had proceeded anyway. She had been transferred to deal with providers of social care an area which she had no prior experience. She had been told that no clinical or specialist skills were necessary. It was a tick box exercise. The pressure to get all providers registered was enormous. People would be in tears at regional meetings and were told that anybody who did not meet their quotas would be “named and shamed”. “If you cannot stand the heat get out of the kitchen” staff were told.

There was no easy way to verify statements made by applicants for social care provider status, whatever the Chair might have told the Select Committee about checking every possible source. That might have applied to NHS Trusts but not to nursing homes. Despite her lack of experience in the field our witness had been made a regional inspector for nursing homes. The training she had was, in her view, appalling. She had been expected to register four new providers a month which left little space to re-inspect any about which there had been concerns. If the pressure to regulate quickly became too much quality would go out of the window. Desk top reviews were not very effective.

Our witness had also complained to the Audit Commission so was clearly not shy about her challenges.

This witness was clearly not committed to the regulatory changes or to the speed or manner in which they were made. If the changes had been managed more slowly staff like our witness might have had a better chance to challenge, but then accept them.

It was not CQC who set the time scale it was probably Ministers!

Our second witness was more challenging as she was a non-executive member of CQC Board. She had numerous complaints about a lack of strategy and the competence of the Board. She said that she could not continue to be an effective member of the Board without making known her grave concerns and worries about the current leadership and the absence of strategic direction. In her view the current strategies were focused on reputation management and personal survival. The Board was in her view poorly focussed and too much business was conducted in private. The Board was often sidelined when major decisions were made. The Board found out about the policy to conduct annual inspections from the press. Board away days were sometimes hostile and emotional.
She made really quite serious comments about the competence of both the Chair and Chief Executive.

She had clearly been put out when the Chair of CQC expressed concern about her mental health and asked her to see an occupational health nurse prior to attending any more Board meetings. She had agreed to this but her health was, she said, fine. She had considered resigning but decided to continue to press for improvement.

In its defence the CQC presented evidence from the other three non-executive directors all of whom said they were proud to serve under the Chair and that she had their unreserved support.

The evidence from this witness might have been stronger if she had taken the most common public service option and resigned if things were so bad!

A truly awful day for CQC at a time when they are going through a Department of Health capability review.

Day 138

**Closing Submission: Monitor**

An unreserved apology for failing to discover “the shocking failure of care and mistreatment”.

We get another history lesson with an acknowledgement that the relationship with the HCC did not function well enough. Monitor was always a small organisation and never a quality regulator. It was the Department of Health who lowered the bar for Foundation status review by Monitor.

It was extraordinarily difficult to know how a regulator could identify flaws, even serious flaws in the care provided by a hospital when faced with silence from professionals and other stakeholders. Monitor was not resourced and did not provide a routine inspection service. Bill Moyes had been frustrated at the time the HCC investigation had taken and concerned that it left managers to continue fire fighting rather than getting on resolving deep rooted problems at the Trust.

Monitor acknowledged its shortcomings in the Stafford story and had learned from them.

**Closing Submission: CQC**

Next CQC, clearly on the defensive in describing the pressure it had been under at the point of handover from HCC in April 2009. It was a young and developing organisation. It had to build up its staff and expertise.
They did not think a merger with Monitor would help. The two surprise witnesses had added little that was new. Because a Board member disagreed with colleagues did not mean the Board was wrong or dysfunctional.

**Closing Submission: Department of Health**

The Department made it clear that the Mid Staffordshire tragedy was firmly lodged in the collective consciousness. However it was not evidence that the whole system was in crisis.

The DoH did not exercise direct managerial control over the NHS. It relied on others including commissioners, SHAs and others.

Mid Staffordshire did not fail because it was a failing Trust. It was already failing when it secured Foundation status...an acknowledged mistake.

It was not accurate to blame the Department for lowering the bar to foundation status. The tests to be applied by Monitor were unchanged. It was just that more trusts could sit the test!

Clever argument but disingenuous and did the credibility of the statement no favours at all.

They were still of the view that the buck stopped at the Trust Board. Targets were not the cause of the problems; mismanaging them might have been. Quality was not new to the DoH they had been developing it for years.

Regulating Health Care Assistants was not the panacea it was presented as but Managers did need regulating. A duty of candour would be placed on NHS providers by contract.

The Department would consider the Inquiry recommendations with care.

This was a statement by Departmental lawyers, nobody who really cared had written it. By the time the Inquiry reports they may have judged that the caravan will have moved on! Meanwhile intensive training on how not to write emails that might be the cause future embarrassment if made public!

I do hope my cynicism is misplaced. People in the Department were shocked by what had happened at Mid Staffordshire but the machine has no feelings, it expresses no anger or excitement, it just gets on with the business and with the management of tomorrow's headlines.

All we have left now is the closing statement by the Counsel to the Inquiry.
Day 139

The final day.

Tom Kark, Counsel to the Inquiry summed up the evidence in a long final day of the Inquiry. He began by reminding everybody of the evidence of Sir David Nicholson. The NHS was the largest fully integrated health care system in the world. It employed over 1.3 million people and had an annual budget of over £100 billion. One million people were in contact with the system every 36 hours. It was not just an organisation or even a set of organisations. It was also a set of cultures and principles and was broadly loved by the general public.

In a long statement where the strands of the story were often intertwined Kark drew out the following points;

1 The Department of Health had been slow to put quality at the centre of policy.

2 The Department of Health denied a bullying culture although this had been the evidence of many witnesses in the field.

3 There was a limit to what people at the top could do about culture.

4 Organisation failure was more often down to the system than to individuals.

5 The skill mix in Stafford was unusual with a high reliance on health care assistants who worked outside any regulatory framework.

6 The NHS needed to get better at learning from mistakes. It needed a more open culture.

7 Patients did not feature very highly in NHS decision making.

8 There were many targets and some were manipulated.

9 Ministers did on occasion override experienced clinical advice.

10 The bar to apply for foundation status had been lowered and the entry pool expanded. This did affect the quality assessment.

11 Liaison between the Regulators had been weak.

12 Monitor had been slow to intervene and had told the PCT to back off.

13 CQC did not have adequate systems for spotting quality failure although they had improved.

14 There were many outstanding questions about the role of the CQC and the manner in which it operated.
15 The SHA was too focused on finance and the support it gave to the Trust, in the face of mounting evidence, was an error of judgement.

16 Quality needed to be embedded more deeply into the NHS.

17 LINks was a failure partly because of the poor sense of direction given by the Department of Health.

18 Oversight and Scrutiny Committees in Staffordshire were ineffective and relied too much on what the Trust told them.

19 The problem of dealing with incompetent doctors needed to be resolved. Clinicians had to speak out when they saw poor practice.

20 Whistle blowers needed better protection.

21 The Trust had an immature Board who failed in their duty to patients.

When we go to hospital all we want, he said, was a good standard of care, a degree of compassion and we needed to be safe.

The Chair followed up with thanks and a list of subjects about which he would have something to say in his final report.

- Recruitment, standards, training and regulation of healthcare support workers.
- The recruitment standards and training of registered nurses
- The training and qualification of those charged with caring for the elderly
- The recruitment training support and regulation of the senior managers of NHS organisations.
- The standards applicable to health care generally.
- The exercise of the fitness to practice functions of the professional regulatory bodies.
- The engagement of health care professionals generally in the leadership and management of their organisations.
- The nature of standards set for the safety and quality of care and which organisation[s] should have responsibility for setting and enforcing them.
- The relevance of staffing levels and skill mix to these standards.
- The interface between the regulation of governance, finance quality and safety.
- The use of commissioning to require and monitor safety and quality standards.
- The potential adverse effect of structural reorganisations
- The role of Foundation Trust governors and members
- The nature scope and definition of a duty of candour
- The role of external agencies in the complaints process
- The obligations of disclosure to Coroners
• The means of embedding a patient voice throughout the system
• The development of effective data systems to monitor quality.
• The protection of whistle blowers.

The report will come out sometime in 2013 but anybody who is the subject of criticism will get two weeks to react. There will be many people anxiously watching their post box as the publication date approaches and all leave for spin doctors will be cancelled. [The publication date was pushed forward to January 2013]

Inquiry expenditure to date over £10m most of which will have gone on lawyer’s fees. [£13m by August 2012]

**Post Script**

The Royal College of Physicians, a core participant, did not make a closing statement but did make a written submission which highlighted;

- There needed to be a realistic assessment of what CQC could do
- Regulators did need coordinating
- It might be impractical to regulate managers but a code of conduct would be possible
- There were still disincentives to doctors becoming Chief Executives including the perceived high risk.
- There was a need for better clinical leadership
- Consultants needed to support nurses better
- Quality needed to be embedded into commissioning.
The Seminars

The Inquiry held seven seminars towards the end of 2011 and published a summary of the proceedings.

They covered regulation methods, development and training for trust leaders, information, organisational culture, nursing, patient experience and commissioning.
Chapter Four

The wider NHS and Mid Staffordshire Hospitals

The purpose of the second and public Inquiry was to examine the commissioning, supervisory and regulatory organisations in relation to their monitoring role at the Mid Staffordshire NHS Trust and answer the question; why was it that serious problems at the Trust were not identified and acted upon sooner? The Inquiry was seeking to establish lessons to be learned rather than apportion blame. That was a matter for others.

The second Inquiry did however start with the patient stories that had emerged in the first report and the conclusion of that Inquiry that something had gone terribly wrong with the NHS in Staffordshire. The question was not whether it had happened but why it had.

Culture

The organisational culture at the Trust kept popping up as the questioning of witnesses proceeded during the second Inquiry. Behind the questions lay the concern that the culture in the Trust was not locally specific but reflected an NHS system wide problem.

Antony Sumara, one of the many Chief Executives at the Trust, described some of the early indications of problems in Stafford. Staff who did not smile and were distracted in their work by their mobile phones, staff who would walk past litter in a corridor and not pick it up, a shabby and dirty environment and buzzers repeatedly rung by patients without a response. We can add to this wards and departments under enormous strain who got little help or recognition of their problems.

Managers and senior clinicians who clung to over ambitious visions of their place in the NHS and who avoided dealing with deep rooted problems. Poor interpersonal relationships between some senior clinical leaders were allowed to fester by weak managers and clinical leaders. The Chief Executive did go to Consultant Staff Committee meetings but nobody moaned until he had left the room. Stafford was a closed community where poor performance was often tolerated or ignored.

This was an organisation many of whose clinical staff had low professional esteem and felt challenged and sometimes threatened by the outside world. The Trust was described by one of its Chairs as living in a time warp of its own with little internal challenge or stimulation. The turnover of staff was low and they had few external benchmarks against which to compare themselves. Mediocrity was the most common standard....it was as many witnesses explained just an ordinary NHS Trust.

The Trust had no overall performance culture which allowed the culture to vary from ward to ward and department to department. Within these cultural micro climates was some good practice with clinical leaders who ignored the wider problems and just got on with leading their bit of the hospital.
The Board certainly suffered from organisational blindness but that was largely of their own creation. Bad messages, like the Dr Foster mortality numbers or problems identified by CURE were filtered out. Even helpful criticism was unwelcome and critics were labelled as disloyal or the enemy.

Some might argue that the hospital was so compartmentalised that variation was hidden but this does not stand up. It was not just one ward that provided poor care but many and the disorganised and at times chaotic accident and emergency services would have impacted on many other parts of the hospital. The poor practice must have been visible within the hospital but there was no easy way for individual clinicians to intervene or blow the whistle without accepting significant personal risk. As one Consultant put it “I am brave but not Nelson Mandela”. In the modern world this is no longer acceptable. All those witnesses who claimed to be appalled by what had happened under their noses had a professional obligation to stand up and shout. To wonder, after the event “how could it happen and I not notice it” is not good enough.

If Stafford was characteristic of a poor organisational culture what were the indicators of good culture? Did it start at the top of organisations and could it vary and fluctuate in response to local leadership? Was there a negative NHS culture emanating from the top?

This was so central to the Inquiries work that they questioned witnesses and organised a special seminar on the subject once all the oral evidence had been taken. Blaming the culture was an easy copout for some witnesses, finding ways of changing it was much tougher.

Many judged that leadership was key to the answer at both a managerial and at a clinical level. Good organisations always wanted to know how they were doing, and how their results compared with others. They set standards and expected the whole organisation to accept and deliver them. Patient safety and high clinical standards dominated policy making. Leadership was open and constantly listening to what staff and external organisations said about them. Poor performance was simply not tolerated…it was spotted, individuals were counselled and help was always available to those under pressure. Those who could not comply or improve left these organisation. Mistakes and complaints were important learning points. Near misses were routinely reported without fear of repercussion. The best organisations created a culture of constant improvement.

The Department of Health and the National Quality Board agree with all of this…their problem is making it happen consistently in a disparate range of independent enterprises. Francis was clear that the Department of Health had an important leadership role to play in promoting changes in culture throughout the health service system. What he did not allow for was that the leadership of the NHS is located within a civil service culture which is distinctively different from NHS management. This is not to compare the two critically but to observe that they are different.

**Patient and Public Involvement**

The machinery that allowed patients and the public to relate to the NHS has been in a state of constant flux since community health councils had been scrapped in 2003. They had left a mixed legacy. Some had developed partnerships with their local NHS, contributing in a positive manner to planning debates and helping patients to get their problems and complaints resolved. Others concentrated more on campaigning or fighting plans for change particularly when it involved the closure of small hospitals or the concentration of specialist services at major units. They had the
power to refer change of service plans, with which they disagreed, to the Secretary of State for a
final decision thus slowing the decision making process down considerably.

CHCs were replaced by the Patient and Public Involvement in Health Commission and it’s local
Forums in 2003 in what was widely regarded as a chaotic transfer process. In Staffordshire there
were 14 forums which were organised and given administrative support by the South Staffordshire
branch of Age Concern. The Mid Staffordshire forum was regarded by Age Concern as one of the
best in the county with excellent relationships with the Trust. The forums were encouraged to go for
small wins initially and the Mid Staffordshire Forum secured improved public transport between the
hospital in Stafford and Cannock, a small town some ten miles away, and persuaded the hospital to
rethink its policy with regard to the use of mobile phones inside the hospital. They also visited the
hospital to inspect cleanliness but this resulted, as has been related earlier, in one of the “maverick”
members of the Forum going to the local press.

Age Concern ran a highly successful hospital discharge system from an office in the accident and
emergency department at Stafford Hospital. This supported the patient by taking them home,
putting on the heating, ensuring the patient had the right medication at home, picking up groceries
and medication and generally helping the patient settle back into their home. It prevented an
unnecessary hospital admission. Referrals came from many sources within the hospital and in
addition the hospital supplied a list of all elderly people who had been treated in A and E so that they
could be followed up with particular priority being given to patients living alone. However in 2007 the
focus changed from discharge management to community support and the service was limited to a
maximum of six hours rather than six weeks by the Local Authority who assumed full responsibility
for funding the service. The team moved out of the hospital and took referrals via an occupational
therapist who would ring them if she thought that the patient might need their help. They were
stopped from giving care to patients who had been discharged and could only carry out practical
chores for them. This was to ensure that the hospital arranged for social services to carry out a
thorough assessment and complied with their statutory duty of care rather than assigning the care
directly to Age Concern.

In 2008 the PPI forums were abolished nationally. They were regarded as unrepresentative,
bureaucratic and poor value for money.

The PPI forums were replaced by Local Involvement Networks [LINks] and established by local
government, with earmarked national funding (£300,000 for Staffordshire). Their role was to obtain
the views of local people about their needs and their experience of local services. They were to
support people in getting involved in the commissioning, provision and scrutiny of local care
services. They had powers to enter provider premises and insist that providers responded to their
concerns. They could also refer matters to the local authority overview and scrutiny committee.

The LINks organisations were provided with administrative support and in the case of Mid
Staffordshire facilitated by a team at Staffordshire University who had put in a lower tender than
Age Concern to the County Council. It was the only University in England to win such a contract and
was to prove a very unhappy experience for the University.
Each district had a LINks organisation. Members were elected from the local community or seconded onto committees if insufficient candidates presented to allow an election. Two of its members served on a county board which in Staffordshire met for the first time in December 2008. There was a lot of disagreement between the County and District boards particularly when the County wanted to impose some degree of standard practice.

Many of the Borough committees wanted their freedom and their own budget. A huge amount of time was taken up securing insurance cover for legal costs incurred by LINks members in the event that a provider took exception to any of their comments.

Department of Health officials did not think such cover was necessary. There were arguments about whether eligibility for election should be based on local residency or service use. There was disagreement about how much time should be spent on the problems at Stafford Hospital after the publication of the HCC report. An away day for LINks members turned into a fractious and negative event with one group “behaving badly” throughout the day. Some LINks members thought they should collaborate with providers whilst others regarded any dialogue as “talking to the enemy”. Matters became so fraught that in July 2009 the County Council with the support of the Department of Health commissioned an independent review of what was going on in Staffordshire.

The report confirmed that the system was struggling with unresolved tensions and a lack of clarity about who should do what.

The University gave up the contract for supporting the Stafford LINks after eighteen months and the County Council took it back in house. The University continued to support the Telford and The Wrekin LINks which proved to be a much more positive experience.

In 2010 the LINks structures were abandoned and rebuilt. The County Council remained the Host but LINks members were now selected from the community with a coordinating group at the centre. They saw themselves as pulling together the many networks operating within Staffordshire. It seemed to work better with new blood which could leave behind them the history of mutual acrimony between members and between members and the host.

As a foundation trust the Mid Staffordshire NHS Trust had to create its own patient and public involvement process through the election of public governors, which they did. The Governors were shocked and appalled when the HCC report was published.

The machinery for patient involvement was a costly disaster at both a policy level and in its implementation. The new organisations needed a clearer brief as to their powers and responsibilities and experienced managerial support in their set up. The training on offer to members and staff was wholly inadequate. In Stafford they became part of the problem.

CURE, the group made up of patient relatives, was widely regarded as operating outside the system and this was to prove to be, for them, a strength rather than a weakness.

The whole system was in the judgement of Francis a conspicuous failure.
Complaints

During the period covered by the Inquiry the NHS had a three stage complaints process. The first stage was local resolution followed by review by the HCC. Only after this stage had been completed was a reference possible to the Parliamentary and Health Service Ombudsman in order to establish whether the NHS had acted improperly or unfairly. If the complaint had been handled properly, but without a resolution, the Ombudsman rarely investigated further. The Independent Complaints and Advocacy service helped individuals frame their complaint and assisted them through the process. It was, according to Ann Abrahams the Ombudsman, a “dreadful” system.

From 2003 complaints made to the Trust were handled initially by Patient Advice and Liaison Services [PALS]. The Trust also had a complaints officer and a legal department which provided support in major cases and whose attitude and style were heavily criticised by Francis.” To maintain a denial of liability in the face of strong evidence to the contrary, and where there is no intention of looking for any, is entirely inconsistent with the professed policies and guidance calling for openness and transparency about adverse incidents.”

In 2007 the Trust combined PALS and the internal complaints service and reduced the number of staff involved. This was, according to the complaints manager, when trouble began. A backlog of complaints developed. At one point the service was moved off the hospital site which made contact with patients and staff more difficult. The executive responsibility for complaints moved around but for most of the time was located in the nursing division. Only after the appointment of Antony Sumara did the complaints officer report directly to the chief executive. Non-executive directors saw only statistical reports and played no part in reviewing actual cases. A former chair had regarded non-executive complaint review committees as a waste of time.

The complaints officer at the Trust during most of the period under review appeared, to her distress, on the CURE “wall of shame”. She worked excessive hours but got mixed support from within the hospital. Most staff regarded complaint handling as a chore rather than an opportunity to improve services to patients and their families. The whole system was very bureaucratic and slow.

CURE did their own analysis of the quarterly complaints at the Trust in 2005-2007 and presented it to the first Inquiry. The list of top themes always included poor basic standards of care.

The delays and problems with complaint handling was undoubtedly a major contributor to the anxiety and distress expressed by patients and their families. At fault was the system itself, negative and defensive attitudes by both managers and professional staff at the Trust and a lack of recognition by the Board about their importance as a measure of patient satisfaction. There was little learning from complaints in Stafford.

The system was reformed nationally in 2009 into a two stage process starting with local resolution and ending with the Ombudsman [whose staffs were substantially increased]. There is also a national service which helps patients make a complaint against the NHS. In 2012 the Patients Association began to work with the Trust in improving its complaints system. From April 2013 the responsibility for commissioning a complaints and advocacy service will transfer to local authorities.
Overview and Scrutiny Committees

Overview and Scrutiny Committees were set up in 2003 to enable local authorities to engage more directly with NHS organisations. In Staffordshire there were committees at the county and borough council levels comprised of elected members. The county council committee had eight county councillors and one member from each of the eight borough committees. Each borough committee had a county council member. Their principal role as set out by government was to monitor the health and wellbeing of their communities and not to supervise hospitals. They were to be the eyes and ears of their communities in relation to health matters. They had almost no skilled and experienced support staff.

There was a distinct lack of clarity about the respective roles of the county and borough committees particularly when it came to Stafford hospital. One witness thought that the committees asked many of the right questions but too willingly accepted the answers they were given by experts from the hospital. The relationship between LINks and the overview and scrutiny committees was not effective in Stafford.

The borough oversight and scrutiny committee gave more focus to Stafford hospital after Julie Bailey [CURE] wrote to every member of the committee in February 2008 but they backed off once the HCC appeared on the scene. One member of the committee and a former mayor of the borough told the inquiry that in her personal experience the doctors at the hospital were excellent and the nurses fantastic. On a recent visit to the hospital she said, she had inspected the kitchens and found them spotless and the food looked delicious. She had not read the HCC report. This was, one suspects, a local politician desperate to save her local hospital, whatever its quality, and prevent it being turned, as she put it, into a cottage hospital. The county committee wrote all local MPs in 2004 when the Trust lost all its stars, complaining about the system which was in their view fundamentally flawed. Stafford had they explained excellent hospitals served by dedicated staff.

The Chair of the Stafford overview and scrutiny committee became a member of the Trust Board of Governors but quickly got at odds with Toni Brisby, the chair, for talking directly to the press. He actually got a formal letter from the Trust Secretary summoning him to a meeting with the chair to discuss a potential breach in the code of conduct for governors and a flagrant breach of the advice given to Governors by the Trust’s PR people. Hardly a constructive relationship with a man who had vast experience as a former Chair of Staffordshire Health Authority. It was he who pointed out the fact that allowing the same person to be both chair of the board of directors and of the governing council inhibited challenge and criticism.

The borough overview committee was torn between supporting its local hospital against what it saw as external threats and dealing aggressively with the complaints made by CURE. They got the balance wrong.

The oversight system in Staffordshire was a signal failure.

General Practice

The second inquiry took evidence from many of the practices that regularly referred patients to Stafford hospital. The evidence is best summed up in the comments of the first GP witness, a man with long experience of practicing in Staffordshire. “I never had any idea that something was amiss
at the hospital. I don’t recall any patient of mine who died unexpectedly at the hospital”. For him Stafford Hospital passed the granny test i.e. you could have no qualms about your grandmother being treated at the hospital.

Some GPs had received the odd complaint about cleanliness or service in the accident and emergency department but rarely sufficiently serious to raise the matter formally. The Local Medical Committee which represented general practice in the area never had occasion to discuss any problems. One GP said he had more patients telling him how good the hospital was than those who complained. Patients still wanted to be referred to the hospital even after the HCC report. They had accepted the poor coding explanation for the reported high mortality data.

There had been a somewhat scratchy relationship with the hospital about discharge letters going back some years which had led to some GPs challenging the competence of the Chief Executive of the hospital, but that was a long way in the past.

One GP had reported the hospital to the PCT after reading about the deaths of three young patients after laparoscopic operations. It seems, he said, that instead of taking out the gall bladder, which was appropriate, an artery had been cut by mistake as a result of which patients had died. Nothing much happened.

There were happy memories of GP fundholding but mixed feelings about PCTs and the future of GP commissioning.

Francis urged GPs to remember that their duty to their patient did not stop with a referral to a hospital.

**Primary Care Trusts**

Staffordshire had six primary care trusts from 2001 until 2006 when they were merged into two as a means of consolidating expertise and saving management costs. It was described in evidence as a very disruptive change process which took many months for new staffing structures to be approved and staff recruited. South Staffordshire PCT, which had the primary relationship with the Stafford Hospital Trust, was one of the largest in England. It began its work by trying to build a better relationship with the Trust than had existed when the Trust had struggled to relate to three PCTs with differing styles and contract requirements. In this endeavour they were not very successful.

One hospital doctor in evidence reflected “my experience of the PCT was that it was antagonistic and adversarial. The first time I went to a meeting with them I felt that I had opened a bar and that there was a brawl going on”. Finance was always the principal driver for the PCT. The engagement of GPs in the commissioning process was low. The PCT had supported the Trust’s bid for foundation status telling Monitor that the Trust had a good management team who were addressing the outstanding quality issues.

The PCT clinical audit team was focused on the governance structure at the Trust rather than the service itself. At this stage few concerns were being expressed about the Trust…poor clinical quality was not on the radar, perhaps because nobody was looking at it!
Quality schedules and standards had not been a part of NHS contracting at all in the early days and the PCT only began to try and negotiate some into contracts in 2008/9 albeit with considerable difficulty. PCTs were on a steep learning curve as far as commissioning was concerned.

The PCT did not pick up significant concerns about clinical quality until 2008 at about the same time as the HCC investigation started. The Chief Executive had attended a meeting with CURE at which harrowing patient stories had been related. He had been shocked and spoke the following morning to the Chief Executive of the Trust [who also claimed to be shocked] and then to the SHA. He reassured CURE that the HCC investigation would be thorough and independent. The PCT started unannounced visits to the Trust and particularly to the A and E Department which the HCC investigators had reported as being under strain.

When the HCC report came out the PCT came under some public pressure as the hospital’s main commissioner but the system produced mixed messages. Monitor effectively told the PCT to back off. It was not the PCT’s role to monitor governance at the Trust they claimed.

The PCT worked closely with the interim management team at the Trust and have played their part in the change and recovery process. They disappear in 2013.

On reflection the PCT regretted that the care it had commissioned from the hospital had fallen short of what was required. They did not have a skill base or the hard data to identify clinical quality problems. They were not close enough to the Trust to spot the problems from softer data. Like most others they accepted the poor coding explanation for the high mortality numbers. It was CURE who eventually persuaded them that there was a problem.

**Medical Examiners and the Coroner**

The South Staffordshire Coroner spent a full day in the witness box. Had he noticed a higher than expected mortality rate? No, he replied, he was always focused on the death in front of him and he had no data base that might highlight trends. If some evidence was presented that indicated action that might prevent another death in similar circumstances he could issue a Rule 43 report and seek a response from the appropriate agency or health authority. The example he gave was of a road sign on a bend but the Inquiry was clearly thinking about evidence of systemic failure in a hospital. The coroner had no capacity to follow up his Rule 43 reports or take account of concerns about staffing levels which was, in his view, a very complex area.

He had taken exception to a demand by the HCC under the Freedom of Information Act, for a list of all the inquests he had held on patients who had died after treatment at the Trust. It would have involved a manual search through thousands of records and he had no staff to do that. In any case the Act did not apply to Coroners!

He had good working relationships with the Trust and had appointed the Trust’s solicitor and one of the doctors to join his team. Neither would get involved with any cases involving the Stafford Trust. He denied getting too close.

The resourcing and organisation of the coroners service is very Dickensian. This dark and dusty corner of our society needs refurbishing which may start with the appointment of a Chief Coroner for England and Wales.
Medical Examiners are a new breed of expert who work with hospitals making sure that the right cases get referred to the coroner and that the right cause of death is included on death certificates.

It was one of the follow ups to the Shipman Inquiry. They might also be able to spot trends and patterns but usually have no resources to conduct inquiries. The expert giving evidence came from Sheffield which was one of a small number of national pilot schemes. Every Trust should have one. It will usually be a part time commitment for an existing consultant.

**Independent case review**

In July 2009 The Secretary of State announced that the PCT would offer an independent case note review to any families in Stafford who requested one. Although this was presented at the time as a new initiative it was not. It built upon a review commissioned by the Trust itself in April 2009. The right to an independent case review may well be a candidate for inclusion in the NHS constitution.

**Members of Parliament**

All the local MPs gave evidence to the second Inquiry. None had picked up systemic failures through their constituency clinics. One had worked at the hospital for a short time and spotted no serious problems. They all relied on the regulatory reports about the Trust and were shocked at the HCC report. Why did nobody blow the whistle they asked? Contact with hospital managers was relatively frequent and they clearly bought the coding explanation for high mortality numbers. At one point no doubt prompted by the Trust they made representations to ministers about the funding of the NHS in Staffordshire.

It was Bill Cash M.P who worked most closely with CURE, helping them with a submission to HCC and coming out early to demand a public inquiry. He presented worrying evidence that patients who had complained were still being “given retribution” by some nursing staff. He pinned the blame on senior managers at the top of the NHS, including Monitor, who had in his view been very complacent.

It became clear from the evidence that MPs have neither the skills nor the backup to hold local organisations to account. They have to rely on the regulators appointed for this purpose. For the most part they see themselves as supporting their constituents and local hospitals. Perhaps that is all we can expect of them.

It was Ben Bradshaw one of the ministers who gave evidence who wondered whether there was something special about the health economy and political landscape in Staffordshire that made it less likely that alarm bells would ring. Was everybody so concerned to protect their local hospital and its future that they were resistant to seeing their services as they really were? The answer to his rhetorical question must be yes.

**Strategic Health Authorities**

There were a number of Strategic Health authorities in place during the period covered by the Inquiry.

Stafford came within the ambit of the Shropshire and Staffordshire SHA until 2006 when they were all merged into the West Midlands SHA.
As can be seen the Strategic Health Authorities were in a state of constant change during the period covered by the inquiry. The role of the SHA was explored in some detail during the second Inquiry. The Department described their role as that of improving the NHS in their region and making sure that local health services were of a high quality and performed well. The Shropshire and Staffordshire SHA, who had Stafford on its patch, saw its role as developing partnership and stimulating improvement and this fitted the mood music of the day. SHAs were told by ministers to stop meddling with local providers as they moved to foundation trust status. They should stick to the strategic agenda and concentrate on building up commissioning capacity in the region. Peter Blythin the regional nurse made it plain in his evidence that micromanagement of individual trusts was not the primary role of the SHA. If they saw problems the action line lay through Primary Care Trusts.

The expansion to three SHAs in the West Midlands and then, after no time at all, reducing them back one again caused major disruption, staff movement and a diminution in corporate memory. In their final form the SHAs were much smaller than their predecessors with a maximum of 75 staff.

Although the Shropshire and Staffordshire SHA had viewed the Stafford Trust as having managerial problems with a difficult body of consultant medical staff they had picked up no early signs of poor clinical quality. A new Chair and Chief Executive had been appointed at the Trust in 2004/5 and appeared to be making progress. When the West Midlands SHA took over the region and looked at the Trust preparations for foundation status they saw progress...although they thought it might take a couple of years to get the Trust up to the mark. An SHA review for the year 2006 had scored the Stafford Trust level 4 which signified “normal risk” which demanded light touch monitoring. There were bigger problems elsewhere in the West Midlands witnesses explained.

Regional officers were again alerted to serious problems at the Trust in 2008, just as the HCC investigation was starting, by the Chief Executive of the PCT who had met CURE and listened to their patient stories. The Trust was now a foundation trust so the region had few powers to intervene other than put in whatever support they could....which they did.

The real problem for the SHA was their early reaction to the mortality data from Dr Foster which placed a number of the region’s hospitals at the wrong end of national league tables. They were surprised at the results and called in the Mid Staffordshire team for an explanation. The Trust argued that the completeness and the accuracy of coding and limited community provision of palliative care services may have contributed to the high scores. They convinced the SHA team that the problem lay in the data. The Trust had sought their own external advice which appeared to support their view.

The SHA decided to commission their own external study from a team at the University of Birmingham. When it became available it seemed to confirm their suspicions about the value of mortality data as an indicator of poor clinical care. An important conclusion in view of the number of West Midlands hospitals with poor results. What senior managers at the region did not fully appreciate was that they had entered an academic minefield where the experts disagreed with each other. They were not very supportive to the HCC inquiry team which in their view was slowing down
progress in effecting change at the hospital. Monitor told them that as the Trust had foundation status the SHA should have no role in the performance management of the Trust or in making sure that the HCC recommendations were implemented. Monitor was telling many of its colleagues in the NHS family to “get their tanks off my lawn”.

Some people in Stafford thought that the SHAs had been very supportive and helpful during difficult times but others including one senior consultant took a different view. “These people were like god. Nobody has seen god. Far removed from the real world, from workers at the coal face”.

The West Midlands SHA had a strong regional team and an experienced Chair. They had a reputation for competence and innovation. Their natural instinct was to support the Stafford Trust in resolving their problems rather than castigate them for failure. Unfortunately they found themselves, according to their counsel, in a perfect storm; a combination of events all coming together in a rare situation that aggravated an existing situation dramatically. The SHA shared the collective NHS sense of shame or what had happened in Stafford but like the Department of Health placed the final accountability firmly on the Stafford Trust board.

Francis thought that the SHA had missed important opportunities to detect and act on the failings at the Trust. They took false comfort from the notion that some potential causes of concern were not exceptional in the trusts under its oversight. It became, in his view, too remote from the patients it was there to serve. In common with the system as a whole at the time their focus was unduly directed at financial and organisational issues.

Strategic Health Authorities have been disbanded in the latest NHS reorganisation.

**Department of Health**

There were a number of Ministers at the Department of Health during the period covered by the Inquiry. The people at the top of the Department of Health were;

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<td>June 2003-May 2005</td>
<td>John Reid</td>
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<td>May 2003-June 2007</td>
<td>Patricia Hewitt</td>
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<td>June 2007-June 2009</td>
<td>Alan Johnson</td>
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<td>June 2009-May 2010</td>
<td>Andy Burnham</td>
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<td>May 2010 – Sept 2012</td>
<td>Andrew Lansley</td>
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<td>2001-2006</td>
<td>Nigel Crisp</td>
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<td>2006-2010</td>
<td>Hugh Taylor</td>
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Ministers claimed to know little about the problems in Stafford until they were presented with the HCC report in March 2009, which came as a shock. Stafford was not on anybody’s radar at the centre. There had been correspondence with CURE in the weeks leading up to the publication of the report but that failed to ring any serious alarm bells. When Alan Johnson saw a pre-publication copy of the report he was horrified. He asked that the references to 400 to 1200 deaths be omitted on the
grounds that they represented a statistical projection that could not be tracked back to actual patient deaths. [In a matter of hours the numbers were leaked to the press].

Alan Johnson and his colleagues described the events in Stafford as appalling and sent in two senior doctors Prof George Alberti and Dr Colin Thomé to review matters. Both confirmed that standards had dropped in Stafford but that corrective action had been initiated. CURE was not convinced and said as much.

Andy Burnham took over as Secretary of State in June 2009 and despite some “institutional resistance” announced that an independent Inquiry would be conducted by Robert Francis Q.C. He had resisted the pressure for it to be conducted as a public inquiry on the grounds that the priority was to make progress on improvements in Stafford which might be hampered by a lengthy public inquiry. In the event much of the evidence that was presented to the first Inquiry was made public. In presenting his first report Robert Francis stated “I am confident that many of the witnesses that have assisted the Inquiry by written or oral evidence would not have done so had the Inquiry been conducted in public.”

Twelve senior officials from the Department of Health were called to give evidence to the second Inquiry including Una O’Brien the Permanent Secretary and David Nicholson the Chief Executive of the NHS. This was an unprecedented opening up of a government department with all relevant internal papers and email traffic being made available to the Inquiry and the public including briefing notes for the Prime Minister. This fascinating glimpse into the secret world of government displayed both the strength of the civil service with sharp clear minds providing crisp, concise and thoughtful briefings for ministers and the small minded pettiness of individuals looking to defend their turf.

There were a number of primary pressure points in the cross examination.

First was the role the Department of Health had played in creating the wider culture in which the NHS operated. Had the determined pursuit of financial balance and the achievement of national performance targets encouraged a culture of corporate bullying? Many witnesses said that an aggressive target based culture had produced cheating, a focus on targets to the exclusion of other important priorities and attitudes which permeated some parts of the NHS based on “I don’t care how you do it….just hit the target”. The witnesses from the Department of Health strongly denied that such a culture existed although they acknowledged that tough targets had been set to secure financial balance as well as important service targets, such as waiting list reductions and better infection control. Were those managers who went over the top in the blind pursuit of single targets out of step with the top management of the NHS or were they caught up in system wide culture with bullying at its core? Were they simply following what they thought was a style set at the top as some witnesses argued? An external investigation commissioned by the Department of Health into the monitoring of quality standards, which reported in January 2008, had concluded that a” blame and shame culture pervaded the NHS and at least certain elements of the Department of Health”. This view had, the authors claimed, been confirmed by Healthcare Commission leaders who saw public humiliation and CEO fear of job loss as one of the NHS’s major quality improvement drivers. Few of the departmental witnesses had seen or heard of this report which had been fed into the Darzi review. Others thought its conclusions had been overstated. It was never made public.
Finding the correct boundary between bullying and robust managerial discipline is not easy. Francis concluded that the evidence did not justify a conclusion that there was a culture within the Department which could properly be described as one of bullying. However it seems clear that some managers and perhaps some civil servants crossed the acceptability line perhaps encouraged by Ministers who were themselves focused on sorting out what they regarded as a financial mess. They did after all sack Nigel Crisp the Permanent Secretary and Chief Executive of the NHS for not dealing adequately with the financial problem in the NHS.

The period covered by the inquiry was one of extraordinary growth following the NHS Plan in 2000 followed a few years later by a major overspend and demands from the Treasury for tighter financial discipline. In 2005/6 the NHS ran up a financial deficit of £547m with 179 individual NHS organisations reported to be in difficulty. Traditionally as long as the central NHS budget had balanced [it usually underspent] the Department left each of the Regional Health Authorities to manage problems in individual trusts. There was enough flexibility in the overall system to handle local problems. Those trusts in trouble were given loans to manage their way out of their problems, often with interest being charged. Some never did recover because the problems were deep rooted and demanded politically difficult solutions. The deeply entrenched problems simply rolled on.

However from 2005/6 the whole system began to tighten up and the Treasury began to demand that the escape routes be removed. Recovery loans had their payback period reduced or were called in altogether. Over ambitious cost improvement programmes were challenged and eventually exposed for what they were, fiction. Managers and their Boards were left in no doubt by both ministers and officials that balancing the books had to be top of the managerial agenda. In the view of the Department this did not demand a reduction in quality standards and some quality improvements such as reduced infection rates would, witnesses claimed, actually save money.

The NHS had to get more efficient. Service rationalisation as a way out of a financial crisis was a long and politically hazardous process when it entailed the closure of services or hospitals. Action was needed today not tomorrow. It was SHAs who fronted the pressure for financial balance acting as agents of the Department. This pressure eventually worked as the NHS fought its way back to financial balance in 2006/7.

This tightening financial environment impacted on Stafford as it did on the whole of the NHS and led to an increased cost improvement programme that incorporated a headcount reduction [mainly nurses]. But Stafford was never regarded as a Trust with desperate financial problems at a level that merited stern external oversight. It never became a turnaround trust.

With the NHS Plan and its huge investment came many targets, set by ministers, designed to channel the new money and demonstrate that it had been wisely spent. Target setting could clearly be justified on public expenditure grounds; the argument was how the targets were pursued.

The second pressure point was the decision making process that led to the Stafford hospital being granted foundation trust status in February 2008. The early assessment was undertaken by the Strategic Health Authority. Once they were satisfied that the Trust was ready, a formal application was made to the Secretary of State who had to give his blessing for the application to be forwarded to Monitor who made the final decision.
The Trust application arrived in the Department of Health in the summer of 2007 and was referred to a committee of officials [Applications Committee] who concluded that although the Mid Staffordshire Trust application was not strong it could go forward and this was their recommendation to Andy Burnham the Secretary of State who approved its submission to Monitor. The doubts expressed by some members of the Applications Committee were played down in the ministerial submission, which ministers subsequently complained about.

There was clearly some pressure to speed up the number of applicants going through to Monitor and a good deal of the questioning by the Inquiry team focused on whether the bar had been unreasonably or even recklessly lowered [initially from three stars to two stars]. An email exchange between the Department and Downing Street produced some evidence of pressure and the search for “clever tactics” to get the numbers up.

Officials preferred in their evidence to talk about widening the entry gates rather than reducing the bar. A clever but unconvincing explanation as other evidence suggested that the departmental view was that there should be no bar at all to making an application to Monitor.

Monitor and Departmental officials knew that a critical HCC report was in the pipeline at the time that the foundation status bid was being considered but appear to have accepted assurances from the Trust and the SHA that it would all be sorted out.

Monitor would claim that they took the Departmental screening very seriously indeed and assumed that the applications that came through to them had a clean bill of health. Matters were complicated by the tension that existed between the Department of Health and Monitor whose Chair and Chief Executive aggressively asserted his independence. One email exchange between Departmental officials, said to have been written in the heat of the moment, said “I would not believe a word they say, about what they did or did not consider...... don’t believe any of that bullshit about relying on the Secretary of State’s support for the application.”

With the benefit of hindsight one of the officials involved admitted that if the Application Committee had had all the facts that were now known the recommendation to ministers would have been very different.

The truth was that a weak application from a trust in trouble got through the system.

The third pressure point focused on the negative impact of the numerous organisational changes imposed on the NHS by successive ministers. Witnesses talked about the destabilising impact this had had on leadership and corporate memory. The Stafford trust operated in an environment in which organisational change was endemic.

Whilst the evidence was being taken ministers were driving the NHS through yet another round of organisational change which the Inquiry team were clearly interested in but which was almost certainly beyond their terms of reference. Their scepticism was badly disguised! Reorganisations are expensive and rarely produce the results that are predicted of them. To politicians and bureaucrats however they give the appearance of action and the illusion of progress. Francis agreed that reorganisation was too often counterproductive and made of point of arguing that another would not be required to implement his recommendations.
Regulation, the fourth pressure point, was an issue that the Department had been wrestling with for some years. The Labour government had decided to reduce the burden of regulation on both the public and private sectors. The number of Inspectorates for the public sector was to be reduced from 11 to 4. It was this policy that led to the creation of CQC which was an amalgamation of three former regulators. The Department had contemplated rolling Monitor into CQC but decided that this would be a bridge too far. A new body was created to oversee the professional practice regulators [medicine, nursing, pharmacy and the others]. Like everybody else in the wider economy NHS organisations had to account to other regulators such as the Health and Safety Executive. It was a jungle and not a very effective one. The NHS regulators were supposed to be independent of Ministers but the Department was their sponsor, had a direct influence on their budgets and retained very close contact. There was always a tension when ministers wanted to encourage stern inspection of services for which they were responsible—one former Chair of the CQC told the Inquiry. As the Inquiry rolled on the handling advice from inside the Department to ministers was to be careful about playing the blame game. There were many outstanding issues to be addressed in the field of regulation.

What the Department did not do very well was coordinate the work of the regulators or encourage them to share intelligence with each other about poor quality. This was a major failing on their part.

Quality had begun to rise up the Departmental agenda following the appointment of David Nicholson as Chief Executive and Dr Darzi as a minister although Liam Donaldson the CMO had been pushing the patient safety agenda for some years. Together they placed quality firmly on the managerial agenda and in 2008 created the National Quality Board in an attempt to align the key managerial and regulatory bodies. Their action may well have been, in part at least, an early reaction to the events in Stafford.

The Department acknowledged it’s final accountability for system failure in the NHS as a whole but argued that in this case the prime accountability lay with the Trust Board and the individual professional staff involved.

**Care Quality Commission; CQC**

The Inquiry spent many hours taking evidence from CQC and its predecessor body the HCC. The HCC investigation into Stafford had been completed just as they were about to be wound up and there was some suspicion that the report had been rushed out before it could be changed or toned down by CQC.

Although CQC was a non-departmental public body, accountable to Parliament, it was funded by the Department of Health who kept it on a very short rein. The Secretary of State appointed the Chair and had a big say in what standards were to be enforced. The stars inspection regime idea came from ministers. The Secretary of State’s power to order CQC to investigate a provider was used frequently. According to Barbara Young the first Chair of CQC the model of an independent regulator regulating services provided by a government minister was never a satisfactory model. Ministers were, she said in her evidence, always torn between wanting good strong independent regulation of healthcare and worrying that from time to time when things went wrong they would be in the dock and found wanting. In practice ministers were very safe. No minister in the long history of the NHS has ever resigned or been sacked for a service failure.
Hugh Taylor the Permanent Secretary at the time was phlegmatic about the tension in his evidence. If you are regulating in an area as sensitive and as politically charged as health you have to live with the tension. “It goes with the turf.”

CQC which was a merger of three former regulators had a smaller budget than that of its predecessors but a wider brief. They did protest to the Department of Health but no extra funding was available. They had to manage with what they had.

CQC regarded the HCC investigation reports as blunt instruments, slow to respond after the event and which took an adversarial approach to those being reported upon. The reports undermined public confidence in the ability of a trust to improve and build a higher quality future claimed one witness. The CQC had a range of sanctions available to it rather than simply “beating up a trust’s management in public”. CQC wanted to change both the style and methods of regulation by concentrating more on higher risk organisations and services and then operating a light touch with the others.

The star system, which was examined in great detail by the Inquiry clearly had major faults and the system of Annual Health Checks which was based on self-declaration was little better. CHQ who inherited this system regarded it as unreliable, bureaucratic, inflexible and out of date but struggled to persuade ministers to let them change it.

In addition to inspecting health and social care organisations CQC had the job of registering literally thousands of NHS and social care providers including dentists and other health professionals by 2010 [21,000 providers spread over more than 36,000 locations]. It’s national help line saw a 13% increase in calls, to a total of 345,000 in 2010/11. It was an enormous challenge which appeared to have been under estimated by all those involved including the Department of Health.

CQC had reservations about the Dr Foster mortality data, and so did others, but they clearly did indicate a problem that needed investigation. HCC had been right to pursue the mortality indicator.

The light touch approach came under increasing pressure as negative reports about hospitals and nursing home hit the press. In 2011 CQC moved to annual unannounced inspections. These were “inspections that crossed the threshold” not paper exercises.

The relationship between CQC and Monitor, was initially at least, distant and difficult. Monitor had argued that it should be the sole regulator of foundation trusts but had lost the argument. Monitor was very protective of its foundation trusts who had complained long and hard about over regulation and stifling bureaucracy. They rather liked light touch regulation.

Risk summits began to evolve in the regions as the Inquiry rolled on, which brought many of the regulators together, sometimes for the first time. They began to share intelligence. The regulation world was beginning to get its act together.

As the Inquiry unfolded CQC came under increased public pressure and attack from events well beyond Stafford which led to a performance review by the Department of Health. It concluded that whilst the CQC had made considerable progress since it had been established in 2009 it, and the Department, had underestimated the scale of the task it had been given. The Board needed to be strengthened. Cynthia Bower the Chief Executive [who had been Chief Executive of the West...
Midlands SHA] decided it was time to move on and resigned and in doing so followed the path of her former Chair Dame Barbara Young.

Towards the end of the public hearings of the Inquiry CQC had its own problems, with a whistle blower from their own Board ,who alleged that the Board strategy was driven by reputation management and personal survival. The Chair was prevented from sacking her by the Secretary of State, at least in advance of the public inquiry report. The chair herself resigned, ahead of the publication of the Inquiry report, with plaudits from the Department of Health but little credibility in the field.

During the whole of the period covered by the Inquiry the techniques of regulation and inspection had been evolving. Despite his criticism Francis wanted to see the role of CQC expanded to include the regulation of foundation trusts provided they were properly resourced to do so. He would also like them to investigate individual cases which will often throw up wider system failures.

The Prime Minister told CQC to appoint a Chief Inspector of Hospitals.

Monitor

Monitor had authorised Stafford as a Foundation Trust in February 2008. They had judged the Trust to be locally representative, legally constituted, well governed, financially viable and sustainable. The application for foundation status had arrived at Monitor in June 2007 with the support of the Secretary of State with no reference to the fact that it had been judged to be marginal. Monitor initiated its own review including many meetings with the Trust and it’s Board. When asked about problems the Board talked about recruiting a good finance director, devolving a new governance strategy, securing a high level of nursing care as well as delivering the cost improvement programme and coping with competition. The meeting of the Monitor Board and the Trust Board in December 2007 was straightforward. The Trust paperwork all seemed to be in order including action plans to deal with HCC reports on hygiene, maternity, heart failure and children’s services. When the staff from Monitor had visited the Trust nobody expressed any concerns about patient care. A patient survey appeared to show that 88% of patients received good or excellent care. A discordant staff survey which showed that less than 50% of staff wanted to be treated/cared for at the Trust was incongruous but being investigated by the trust managers. Meetings with clinical divisions were straightforward although nobody at the trust mentioned the critical reports from the Royal College of Surgeons. Nobody expressed concerns about patient care.

The SHA had confirmed its view that the Trust was ready for foundation status and that they had no concerns about the quality of care. The PCT told Monitor that the Trust had a good management team which was addressing the quality agenda. The Local Authority Oversight Committee was positive as was the Patient Forum. Monitor knew about the Dr Foster data but had been reassured by the Trust decision to secure a review by CKHS and clean up the data. The Trust had only secured a Fair score from the HCC for the quality of its patient care but that was within the minimum threshold for an application to be made.

With no loud alarm bells ringing Monitor approved the application in February 2008 but with an unpublished side letter expressing concerns about the Trust financial future and its ability to meet its
thrombolysis and A and E targets. Monitor had been focused firmly on finance and managerial performance rather than clinical performance and clinical outcomes.

When the HCC announced the investigation into the Trust just a few weeks later Monitor demanded that the investigation be completed quickly so as give the Trust space to deal with any problems. In this they were supported by the SHA. When the final report came out Monitor sought the resignation of the Chair and played a role in removing the Chief Executive. There was a major spat between William Moyes and David Nicholson about who would appoint the interim replacements which had to be patched up with a messy compromise.

In its early years Monitor’s relationship with other NHS organisations including the Department was scratchy and at times difficult as they sought to protect their independence and look after the foundation trust movement. At one point they refused to sign up to a concordat entered into by a number of other organisations including the HCC on the grounds that they did not undertake inspections. After the publication of the first Francis report they began to work more closely with the other regulators and in 2012 their role was expanded to include market regulation. Monitor is now concerned about clinical as well as financial viability.

From 2013 Monitor was able to put an administrator in to trusts who were judged to be in breach of their statutory obligations. It looks very much as if they will take such a step in the case of Stafford.

In their evidence Monitor saw its future, once all trusts had secured foundation status, as being the economic regulator for the health sector.

**General Medical and Nursing Councils.**

Both Councils gave evidence to the second Inquiry. Neither knew in advance of the HCC report that there were serious problems in Stafford. Both have started to deal with individual professionals criticised by the Inquiry.[probably forty doctors and forty nurses] The Nursing Council will have to face up to a torrent of criticism about the profession itself and its own performance as a regulator. A crucial outstanding issue is whether the professional regulators will actively seek out poor performance or wait for complaints to trigger an inquiry. Francis is clear that employers should not delay disciplinary action whilst the professional regulators carry out their investigations. The two processes can he says work in parallel. It will also help he says if the NMC introduce a system of validation for nurses like that operated by the General Medical Council.

Both regulators are encouraged to work more closely with the CQC and in appropriate circumstances mount joint investigations. Francis hints at a shared investigating committee for all the professional regulators.

**The Health and Safety Executive**

The HSE was very involved in Stafford although there was some overlap of functions with CQC which must now be sorted out. There is no current criminal sanction except that under the HSWA for failure in safety systems to protect patients unless they follow a warning notice by CQC. This is Francis says a regulatory gap that should be closed. Francis is not persuaded that a criminal sanction will inhibit candour and cooperation. In future the HSE will see all NHS Serious Untoward Incident Reports.
NHS Litigation Authority

This organisation is concerned with managing claims against NHS bodies. Membership is voluntary but most NHS Trusts are members and pay a fee. Francis recommends that membership of this scheme or others like it should be made compulsory as a contribution to overall patient safety. Their risk management reports should be made available to CQC. They should adjust their discount levels to reward high performance.

National Clinical Assessment Service

National Clinical Assessment Service is the body that advises NHS employers who are concerned about the conduct or performance of doctors, dentists and pharmacists. Eleven doctors, including six surgeons, from Stafford were referred to the service. Francis did not think it wise to extend its current role. There were already enough regulators and quality inspectors.

Health Protection Agency

The HPE had concerns about the Stafford Trust’s management of hospital acquired infections. They did not share their concerns with others. It will be subsumed by a new organisation Public Health England in 2013 which Francis hopes will work more closely with the NHS regulators. Their data about infection control is valuable both to the public and to regulators.

National Patient Safety Agency

The NPSA is a valuable resource, Francis judged, but they did not spot problems at Stafford. They did not share “cause for concern” letters with the NHS regulators. The agency will transfer to the NHS Commissioning Board but Francis would prefer that it be transferred to a systems regulator.

Trade Unions

A number of Trade Unions gave evidence including the Royal College of Nursing and Unison. Neither had known in advance about problems at Stafford despite having local representatives on the ground. The RCN was almost certainly too close to local managers. It was ineffective both as a professional representative organisation and as a Trade Union.

The others

An extraordinary wide range of organisations whose functions related in some way to Staffordshire were also called to give evidence. They included the NICE, Royal College of Surgeons, Post Graduate Medical Education Board, Keele and Staffordshire Universities and the NHS Information centre..

None had had Stafford hospital on their radar as a problem.

Accountability

Although the Inquiry was not about apportioning blame it had to deal with the question of accountability. The Trust Board and almost all the senior managers and nurses have now gone. Many will never work in the NHS again. They have all paid a heavy personal price and some will have deserved it. Martin Yeates the Chief Executive was never well enough to give evidence although this was disputed by CURE and others. He never had the breadth of experience needed for what was a
challenging post. He was too focused on delivering what the centre demanded [foundation status, financial balance] to deal with very real local problems that were rotting away quality standards at the trust. He fought hard to ignore and deny the mortality evidence.

The Inquiry is critical of all those organisations who missed the clues that should have led to earlier action like the SHA and the Regulators.” If it was ever true that the clanging of a bed pan in any hospital reverberated in Whitehall, as it was said was the expectation of Aneuryn Bevan the noise emanating from Stafford certainly did not reach the ears of the DH until it was too late to save untold suffering to large numbers of patients.” If all the NHS organisations had worked more closely together then the problems in Stafford might have emerged earlier than it did.

The Department of Health acknowledged in evidence their accountability for system failure but denied that they were in operational control of the NHS. Indeed the direction of political travel in the last twenty years had, they explained, been to move away from central control and devolve responsibility and accountability to local NHS organisations. In their closing submission to the Inquiry the Department drew a distinction between accountability to the public and practical responsibility for what happens at a local level. The Department does not, they claimed, manage individual hospitals on a routine basis, and it has limited interactions with individual trusts. NHS Foundation Trusts are not statutorily accountable to the Secretary of State or to David Nicholson the Chief Executive of the NHS. The NHS is not they claim a single organisation. Ministers are not actually in charge of the NHS although they do retain a final say in planning matters, such as for example the shape of health services in South London or the location of paediatric cardiac surgery units in England.

One senior witness was asked during the Inquiry why, in say matters of patient safety don’t you simply issue an instruction to NHS authorities? Well it would be easier if I could be sure that they would listen he replied! Tucked away in an annex is an interesting analysis of the question as to whether Foundation Trusts are bound by the NHS Constitution. The surprising conclusion is that they are not legally bound by the constitution and nor are other NHS organisations who only have an obligation to “have regard” to its principles.

The separation between the NHS and the Department of Health will go further on 1st April 2013 when the NHS Commissioning Board starts work with at least a degree of distance between themselves and ministers.

All of this does not sit well with grand NHS development plans so loved by politicians [although none are criticised by the Inquiry] or with the recommendations that the Department has a leadership role relating to the NHS. It may not itself have the powers to implement some of the recommendations in the report. It may have to stick to guidance about best practice. The Department of Health is firmly part of the civil service and will remain so.

This is not the first Inquiry to point to the leadership ambiguity at the top of the NHS and it seems unlikely that this will change or that ministers will be able to hold back when problems arise at individual NHS provider units. Their retention of the final decisions in contested planning decisions about health services draws them back in with a vengeance. The political risks of letting go are judged to be too high.
The public need to begin to think not about a great organisation called the NHS but a National Health System with a thousand parts.

**Stafford Hospital; The Future**

By the start of 2013 the hospital was still struggling to find a viable future although, according to Ernst and Young, services had improved sharply in recent years. However its debts had continued to accumulate and the Trust would need continued and substantial financial support from the Department of Health and a huge cost improvement programme [7%] for each of the next five years just to balance its books. Monitor was threatening special measures as its expert advisors reported that the hospital was clinically and financially unsustainable in its current form. There can be no doubt about the financial conclusion but the clinical assessment was based on recommended Royal College consultant staffing levels which would present a challenge to many DGHs in England. In the specialties of accident and emergency and paediatrics and in emergency surgery the Trust had only 50% of the recommended levels. A merger with the North Staffordshire Trust is still a possibility but fraught with dangers for both parties. Some joint appointments have already been made. A and E services have been revamped to reduce the risks at nights and weekends, but cancer services had come under critical review with all too familiar comments about dysfunctional clinical relationships with management. Dozens of external experts have been flown in to offer their advice!

The option of full integration with primary care in Stafford, which many GPs favoured has not been pursued with any vigour, despite being the obvious way forward. It is in the too difficult box.
Chapter Five

The Public Inquiry Conclusions and Recommendations.

The final report ran to nearly four thousand pages and had 290 detailed recommendations.

The principal conclusion was that the Mid Staffordshire NHS Foundation Trust and the wider NHS failed the families in Stafford. The system ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety. The trust that the public should be able to place in the NHS was betrayed.

- The Trust Board was weak and did not tackle the tolerance of poor standards. It was too focused on national targets, financial balance and securing foundation trust status.
- The patient voice was not heard or listened to. The arrangements for public and patient involvement and local authority scrutiny were a conspicuous failure. Local scrutiny groups were not equipped to understand or represent patient concerns or challenge reassuring statements issued by the Trust.
- The local medical community did not raise concerns until it was too late.
- The Primary Care Trusts did not effectively ensure the quality of the health services they were buying for their community. They did not have the tools to do the job properly.
- The SHA did not put patient safety and wellbeing at the forefront of its work. It defended NHS trusts rather than holding them to account on behalf of patients. It preferred to explain away concerns such as those about mortality rather than root out matters which would concern any patient.
- Monitor’s duty was to ensure that trusts were fit to be granted the independence of Foundation Trust status. It focussed on corporate governance and financial control without properly considering whether there were issues of patient safety and poor care.
- The Department of Health did not ensure that ministers were given the full picture when advising that the Trust’s application for Foundation status should be supported. It was remote from the reality of service at the front line.
- The Healthcare Commission did not have standards which could be used to adequately test the quality of care being provided. However their painstaking investigation did eventually bring the truth to light.
- CQC was constrained in fulfilling its statutory duties by the resources made available to it. It had an unhealthy culture concerned more with image than delivery. It focused on
registration at the expense of inspection. There was reluctance by those who had the power to do so to intervene urgently to protect patients.

- Other organisations, including health care professional regulators, training and professional representative organisations failed to uncover the lack of professionalism and take action to protect patients. They did not work closely together.

What caused such a widespread failure of the system was an institutional culture in which the business of the system was put ahead of the priority that should have been given to the protection of patients and the maintenance of public trust in the service.

His detailed recommendations were he said designed to change the culture and make sure that patients came first. The NHS needed a patient centred culture, no tolerance of noncompliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing, and useful and accurate information about services.

Implementing his recommendations would not require another major organisational change. Nor would a solution be found by a search for scapegoats.
Recommendations

Francis recommendations fall into five categories:

First a set of clearly understood core values and fundamental standards the most important of which should be embedded in the NHS Constitution. The fundamental standards should be rigorously enforced and to cause death or serious harm to a patient by noncompliance should be criminal offence.

Staff should put patients before themselves. Individuals who reported noncompliance should be protected. The standards should be policed by CQC who should eventually become the single regulator. The assessment process for foundation trust status, which should transfer to CQC, must include quality and patient safety standards.

The fundamental standards should apply to external contractors providing NHS care. Zero tolerance should be the standard. The government should define those outcomes to patients that must be avoided. Commissioners should develop enhanced quality standards above those defined as fundamental and ensure providers met them. The commissioners must have the final say. There should be lay members on commissioner boards which needed to be recognisable public bodies. There should be one regulator dealing with corporate governance, financial competence, viability and compliance with patient safety and quality standards.

Secondly there should be more openness, transparency and candour throughout the system. There should be a statutory duty of candour. The patient must be told when something has gone wrong. Staff must be obliged by statute to make their employers aware of incidents that might cause harm to patients.

Staff must be honest and open with patients regardless of the consequences for themselves. Gagging clauses in staff contracts should be banned. CQC should audit Trust Quality Accounts and work more closely with Local authority overview and scrutiny committees.

CQC should have greater powers to prosecute those who fail fundamental standards. Trusts who mislead their regulators should be committing a criminal offense. Coroners should send copies of any healthcare related reports to commissioners and CQC. More independent medical examiners should be appointed. The professional regulators should work more closely together and share intelligence.

NICE should recommend standard procedures for measuring compliance with fundamental standards which should go beyond clinical outcomes to include the suitability and competence of staff and the culture of organisations.

Before the Department of Health plan any future reorganisations they should first publish an impact and risk assessment.

Thirdly, improved support for compassionate care and committed nursing. There should be a new status as a registered older persons nurse. Nurse training must in future include more hands-on care, at least three months, and entrants to the profession must show, in an aptitude test, a
commitment to compassionate care. There should be stronger nursing leadership at a ward level. The NMC should appoint a Responsible Officer for nursing in each trust.

Healthcare support workers must be properly trained and regulated and work to a nationally determined code of conduct.

**Fourthly the NHS should have strong patient centred leadership.** The NHS should have a more effective complaints handling system.

An NHS Leadership staff college should be created. Leaders should have a common code of ethics. Leaders should in future be registered as “fit and proper persons”, a status they could lose and as a consequence be disqualified from office.

The role of Foundation Trust governors should be extended. Those providers who provide placements in nursing and medicine must in future demonstrate that they are properly resourced to do this with patient safety in mind. Managers should be accredited.

**Finally, accurate, useful and relevant information must become the lifeblood of an open transparent and candid culture.** There should be clear metrics on quality. Each provider organisation should have a Board level member with responsibility for information.

NHS information should be published in a form more readily useable by the public.
Chapter Six

End Note

The media reaction to the report when it was published was somewhat muted by the absence of scapegoats although this did not stop many of them calling for the dismissal of Sir David Nicholson the Chief Executive of the NHS. He got the support of the Prime Minister as his credit with the Coalition government was high as he had pulled the NHS back from a financial disaster and injected some managerial common sense into Andrew Lansley’s controversial reform package.

The horror of the patient stories were recounted in great detail and there was much talk about culture. The more expert commentators whilst agreeing with the Francis diagnosis were doubtful about some of his recommendations including the idea of a single regulator.

Behind the scenes a huge battle started as foundation trusts resisted the move to close down Monitor. Even CQC seemed to have doubts about whether it could cope with an extended role. Others had doubts about his recommended criminal penalties and the impact that this might have on a putative no blame culture. Some wondered if the Francis vision was strong enough to overcome the inertia, the self-interest and the inevitable resistance to change that was deeply rooted in the bones of the NHS. To use and then mangle a phase from the inquiry...is the NHS too old to change.

Changing the culture of an organisation like the NHS is an enormous challenge. It could be the biggest challenge any government in England has ever faced, and it may be well beyond their skill base. It will require years of relentless pressure and change as one sacred cow after another was slaughtered and previously intractable problems resolved. It would require steady, brilliant leadership at all levels of the service working to a shared vision and a common set of values. Doubters and cynics would have to be pushed to one side. It would take a generation or more.

The public inquiry was not set up as a trial so questions of individual guilt did not arise. However in later evidence to a parliamentary committee Robert Francis indicated that there were possibilities for criminal charges to be brought for individual manslaughter or offenses in relation to wilful neglect of vulnerable people. NHS staff should be held to account for their conduct he said.

Jeremy Hunt the Health Secretary also seemed to encourage criminal action. The Inquiry had, he said, put evidence in the public domain which should be investigated by the police. Staffordshire police announced their own review of what had happened at Stafford hospital. A review that went beyond the evidence gathered by the public inquiry.

One MP forecast another Hillsborough. This was never going to be a peaceful cultural revolution.

What also kept the story running was the disclosure that up to fourteen other NHS Trusts were to be investigated for higher than expected mortality rates which the Daily Telegraph claimed may have caused 2,800 patients to die unnecessarily.

The NHS was in for a tough time as ministers considered their response to the Francis report.
The Stafford story might be a positive cleansing experience for the NHS or it could be another step in the slow decline of a once great system of health care.

A final point for discussion is whether the events in Stafford could have been exposed and the lessons learnt without a lengthy and expensive public inquiry. There will be other occasions when aggrieved citizens will demand public inquiries to expose shortcomings in public services. Is there a better, a cheaper and a quicker way of responding to their wishes.

This is a challenge for Parliament.
## APPENDIX ONE

### WITNESS SCHEDULE

<table>
<thead>
<tr>
<th>WEEK</th>
<th>DATE</th>
<th>DAY</th>
<th>ORGANISATION/SUBJECT/ROLE OR FORMER ROLE</th>
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<td>Opening Statement by Chairman</td>
<td>Robert Francis QC</td>
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<td>Tom Kark QC</td>
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<td>Opening Statement: Cure the NHS</td>
<td>Jeremy Hyam</td>
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<td>Rachel Langdale QC</td>
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<td>Structure and Organisation of the NHS</td>
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<td>Patient Safety</td>
<td>Prof. Charles Vincent</td>
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<td>18/11/2010</td>
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<td>The Development of Healthcare Regulation</td>
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Eighty eight statements were read into the evidence including those made by Martin Yeates the former Chief Executive. Only patient statements are included in the above list.