THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

Chaired by Robert Francis QC

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Volume 1: Analysis of evidence and lessons learned (part 1)

HC 898-I

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February 2013

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Letter to the Secretary of State

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The Rt Hon Jeremy Hunt MP
Secretary of State for Health
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5 January 2013

Dear Secretary of State

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

As you know, I was appointed by your predecessor to chair a public inquiry under the Inquiries Act 2005 into the serious failings at the Mid Staffordshire NHS Foundation Trust. Under the Terms of Reference of the Inquiry, I now submit to you the final report.

Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even

after the start of the Healthcare Commission investigation, conducted because of the realisation that there was serious cause for concern, patients were, in my view, left at risk with inadequate intervention until after the completion of that investigation a year later. In short, a system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system.

The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

I have made a great many recommendations, no single one of which is on its own the solution to the many concerns identified. The essential aims of what I have suggested are to:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;

- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

In introducing the first report, I said that it should be patients – not numbers – which counted. That remains my view. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary. But it is not the system itself which will ensure that the patient is put first day in and day out. Any system should be capable of caring and delivering an acceptable level of care to each patient treated, but this report shows that this cannot be assumed to be happening.

The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed. This does not require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it.

Yours sincerely

Robert Francis QC
Inquiry Chairman

Introduction

Background

1 Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area. During this period this hospital was managed by a Board which succeeded in leading its Trust[1] (the Mid Staffordshire General Hospital NHS Trust) to foundation trust (FT) status. The Board was one which had largely replaced its predecessor because of concerns about the then NHS Trust's performance. In preparation for its application for FT status, the Trust had been scrutinised by the local Strategic Health Authority (SHA) and the Department of Health (DH). Monitor (the independent regulator of NHS foundation trusts) had subjected it to assessment. It appeared largely compliant with the then applicable standards regulated by the Healthcare Commission (HCC). It had been rated by the NHS Litigation Authority (NHSLA) for its risk management. Local scrutiny committees and public involvement groups detected no systemic failings. In the end, the truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them. This group wanted to know why they and their loved ones had been failed so badly.

2 The NHS is a service of which the country can be justly proud, offering as it does universal access to free medical care, often of the highest order. It is a service staffed by thousands of dedicated and committed staff and managers who have been shocked by what they heard of the events surrounding the Trust. It is inconceivable to many of them that conditions of the type described by so many patients can have been allowed to exist let alone persist. Those responsible for the oversight of the service, from Ministers to senior civil servants to those in charge of regulatory and commissioning bodies, have been bewildered at how this could have happened without it being discovered sooner.

3 Healthcare is not an activity short of systems intended to maintain and improve standards, regulate the conduct of staff, and report and scrutinise performance. Continuous efforts have been made to refine and improve the way these work. Yet none of them, from local groups to the national regulators, from local councillors to the Secretary of State, appreciated the scale of the deficiencies at Stafford and, therefore, over a period of years did anything effective to stop them.

4 As has been frequently pointed out to the Inquiry, the primary responsibility for allowing standards at an acute hospital trust to become unacceptable must lie with its Board, and the

1 In the time period looked at by the Inquiry, Mid Staffordshire General Hospitals NHS Trust was awarded Foundation Trust status and changed its name to the Mid Staffordshire NHS Foundation Trust. Throughout this report the term 'the Trust' has been used to denote both Mid Staffordshire General Hospitals NHS Trust and Mid Staffordshire NHS Foundation Trust.

Trust's professional staff. The system is designed for directors to lead and manage the provision of services within its allocated budget but in accordance with required standards, and for professional staff, informed by their ethical standards and commitment, to serve and protect their patients. If every board succeeded in that challenging task, and if all professional staff complied at all times with the ethics of their professions, there would have been no need for the plethora of organisations with commissioning and performance management responsibilities. It is because of the fact that not all boards are capable of maintaining acceptable standards or improving services at the required pace, or applying effective stewardship to the resources entrusted to them that healthcare systems regulators and performance managers exist. It is because not all professionals do live up to the high standards expected of them that we have professional regulators. All such organisations have the responsibility to detect and redress deficiencies in local management and performance where these occur. It does not need a public inquiry to recognise that this elaborate system failed dramatically in the case of Stafford. As a result, it is clear that not just the Trust's Board but the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital.

5 The enormity of what occurred at this Trust has been consistently acknowledged by both the previous and the present Governments.

6 When presenting the report of the HCC on the Trust to the House of Commons, the Secretary of State for Health, the Rt Hon Alan Johnson MP, said:

> *I apologise on behalf of the government and the NHS for the pain and anguish caused to so many patients and their families by the appalling standards of care at Stafford hospital, and for the failures highlighted in the report.*[2]

7 I was first commissioned in July 2009 by the then Secretary of State for Health, the Rt Hon Andy Burnham MP, to chair a non-statutory inquiry, the principal purpose of which was to give a voice to those who had suffered at Stafford and to consider what had gone wrong there.

8 In announcing the first inquiry, Mr Burnham said:

> *All of us who care passionately about the health service were appalled by the events at Mid Staffordshire, which are in stark contrast to the dedication and professionalism shown by NHS staff every day up and down the country.*

9 It was not within that inquiry's Terms of Reference to examine the involvement of the wider system in what went wrong. What I heard shocked me, and the descriptions of what had

2 Hansard, 18 March, 2009 Column 909

been endured shocked those who read about them in my report, published in February 2010. It was clear to me, as it had been to the victims who gave evidence to me, that there needed to be an investigation of the wider system to consider why these issues had not been detected earlier and to ensure that the necessary lessons were learned.

10 I recommended that such an inquiry be held, a recommendation which was accepted by Mr Burnham, who asked me to chair a further non-statutory inquiry. In announcing that inquiry Mr Burnham told the House of Commons:

> *Let me be clear: the care provided was totally unacceptable and a fundamental breach of the values of the NHS.*[3]

11 He repeated the apology previously given by the Prime Minister:

> *Last year, the Prime Minister apologised to the people of Staffordshire. On behalf of the Government and the NHS, I repeat that apology again today. They were badly let down. I pay tribute to the people who had the courage to come forward and tell their stories and to expose the failures of the past, in order that they could protect others in the future.*[4]

12 Following the general election, Mr Burnham's successor, the Rt Hon Andrew Lansley CBE MP, the first Secretary of State for Health of the Coalition Government, confirmed my appointment but decided that the Inquiry should be a public inquiry under the Inquiries Act 2005. He announced this Inquiry and its Terms of Reference to the House of Commons on 9 June 2010. He told the House:

> *So why another inquiry? We know only too well every harrowing detail of what happened at Mid Staffordshire and the failings of the trust, but we are still little closer to understanding how that was allowed to happen by the wider system. The families of those patients who suffered so dreadfully deserve to know, and so too does every NHS patient in this country.*
>
> *This was a failure of the trust first and foremost, but it was also a national failure of the regulatory and supervisory system, which should have secured the quality and safety of patient care. Why did it have to take a determined group of families to expose those failings and campaign tirelessly for answers? I pay tribute again to the work of Julie Bailey and Cure the NHS, rightly supported by Members in this House.*

3 Hansard, 24 February 2010, Col 309
4 Hansard, 24 February 2010, Col 312

Why did the primary care trust and strategic health authority not see what was happening and intervene earlier? How was the trust able to gain foundation status while clinical standards were so poor? Why did the regulatory bodies not act sooner to investigate a trust whose mortality rates had been significantly higher than the average since 2003 and whose record in dealing with serious complaints was so poor? The public deserve answers.

The previous reports are clear that the following existed: a culture of fear in which staff did not feel able to report concerns; a culture of secrecy in which the trust board shut itself off from what was happening in its hospital and ignored its patients; and a culture of bullying, which prevented people from doing their jobs properly. Yet how these conditions developed has not been satisfactorily addressed.[5]

13 This is the final report of the Inquiry.

Scope of the Inquiry

Terms of Reference

14 The setting up of the Mid Staffordshire NHS Foundation Trust Public Inquiry was announced to Parliament by the then Secretary of State for Health, the Rt Hon Andrew Lansley CBE MP, on 9 June 2010.

15 The Terms of Reference for this Inquiry are as follows:

- *To examine the operation of the 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 to examine why problems at the Trust were not identified sooner, and appropriate action taken. This includes, but is not limited to, examining, the actions of the Department of Health, the local strategic health authority, the local primary care trusts, the Independent Regulator of NHS Foundation Trusts (Monitor), the Care Quality Commission, the Health and Safety Executive, local scrutiny and public engagement bodies and the local Coroner;*[6]
- *Where appropriate, to build on the evidence given to the first inquiry and its conclusions, without duplicating the investigation already carried out, and to conduct the inquiry in a manner which minimises interference with the Mid Staffordshire NHS Foundation Trust's work in improving its service to patients;*

5 Hansard, 9 June 2010, Column 333

6 This list should also include predecessor bodies of these organisations, where relevant, in accordance with the time period the Inquiry is examining.

- *To identify the lessons to be drawn from that examination as to how in the future the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals or their services are identified as soon as is practicable;*
- *In identifying the relevant lessons, to have regard to the fact that the commissioning, supervisory and regulatory systems differ significantly from those in place previously and the need to consider the situation both then and now;*
- *To make recommendations to the Secretary of State for Health based on the lessons learned from the events at Mid Staffordshire; and to use best endeavours to issue a report to him by March 2011.*[7]

16 Because this Inquiry has, in accordance with its Terms of Reference, built on the conclusions and evidence of the first inquiry, it is important for this report to be read with the report of the first inquiry.

The first inquiry

17 As stated above, the Terms of Reference for this Inquiry include a requirement to build on the work and conclusions of the first inquiry into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009.

18 That first inquiry was set up by the Rt Hon Andy Burnham MP, the then Secretary of State for Health, when he announced, in a written statement to the House of Commons on 21 July 2009 that he had appointed me to chair an independent inquiry into Mid Staffordshire NHS Foundation Trust.

19 There were a number of events that led to that first inquiry:

- In 2007, concerns were raised about the Trust's mortality rate as compared with other similar trusts. Then in April 2008 the HCClaunched an investigation into the Trust, following what it regarded as a concerning reaction by the Trust to the mortality statistics and number of complaints. In March 2009 it published the report of its investigation, which was highly critical of the acute care provided by the Trust.
- During the course of the investigation, and following the publication of the HCC's report, there was an increasing public outcry led by a group of patients and patients' relatives who had experienced poor care at the hands of the Trust. This group, called Cure the NHS (CURE), was led by Julie Bailey, the daughter of Isabella Bailey, an elderly patient who had died in Stafford Hospital. CURE ensured that the issue of the standard of care provided by the Trust remained in the public consciousness, and it campaigned tirelessly for a public inquiry.

7 It was subsequently agreed with the Secretary of State that the extent of the material that had to be examined by the Inquiry made this completion date impractical.

- In a partial response to these publicly expressed concerns, over the course of 2009 the Trust set up an independent case notes review, led by Dr Mike Laker and subsequently managed by the primary care trust. The Secretary of State also commissioned his own reviews: by Dr David Colin-Thomé on the lessons to be learned in relation to commissioning of services; and by Professor Sir George Alberti on the specific issues surrounding emergency admissions at the Trust. Both prepared reports that were published at the end of April 2009.
- None of these reviews or reports satisfied the public concerns as represented by Julie Bailey and CURE, who continued to demand a public inquiry into the failings at the Trust.

20 Ministers did not at that stage agree to set up a public inquiry, but instead commissioned an independent inquiry into the care provided at the Trust. The terms of reference for the first inquiry were as follows:

- *To investigate any individual case relating to the care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008* [later amended to March 2009] *that, in its opinion, causes concern and to the extent that it considers appropriate;*
- *In the light of such investigation, to consider whether any additional lessons are to be learned beyond those identified by the inquiries conducted by the HCC, Professor Alberti and Dr Colin-Thomé; and, if so:*
  - *to consider what additional action is necessary for the new hospital management to ensure the Trust is delivering a sustainably good service to its local population;*
  - *to prepare and deliver to the Secretary of State a report of its findings.*

21 As stated by the then Secretary of State, in his Written Ministerial Statement to the House of Commons on 21 July 2009, the focus of the first inquiry was to be on:

> *... ensuring that patients or their families have an opportunity to raise their concerns. It is important, given the events of the past, for those who depend upon the care provided by the trust to be confident that they have been listened to and that any further lessons not already identified by the thorough inquiries that have already occurred be learned.*

22 During the course of the first inquiry, documentary material was obtained from a wide variety of sources, including the Trust, the primary care trust [PCT] and other NHS bodies, the Care Quality Commission (CQC), the strategic health authority (SHA), Monitor, CURE, the local authorities and the four local Members of Parliament. The first inquiry was contacted, directly or indirectly, by 966 individual members of the public and some 82 members of staff from the Trust, past and present, and between 2 November and 22 December 2009, the first inquiry heard oral evidence from 113 witnesses.

23 The first inquiry heard harrowing personal stories from patients and patients' families about the appalling care received at the Trust. On many occasions, the accounts received related to basic elements of care and the quality of the patient experience. These included cases where:

- Patients were left in excrement in soiled bed clothes for lengthy periods;
- Assistance was not provided with feeding for patients who could not eat without help;
- Water was left out of reach;
- In spite of persistent requests for help, patients were not assisted in their toileting;
- Wards and toilet facilities were left in a filthy condition;
- Privacy and dignity, even in death, were denied;
- Triage in A&E was undertaken by untrained staff;
- Staff treated patients and those close to them with what appeared to be callous indifference.

24 The first inquiry report was published on 24 February 2010. It contained damning criticism of the care provided by the Trust, drawing out a number of conclusions, including:

- There was a lack of basic care across a number of wards and departments at the Trust;
- The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear of adverse repercussions; a high priority was placed on the achievement of targets; the consultant body largely dissociated itself from management; there was low morale amongst staff; there was a lack of openness and an acceptance of poor standards;
- Management thinking during the period under review was dominated by financial pressures and achieving FT status, to the detriment of quality of care;
- There was a management failure to remedy the deficiencies in staff and governance that had existed for a long time, including an absence of effective clinical governance;
- There was a lack of urgency in the Board's approach to some problems, such as those in governance;
- Statistics and reports were preferred to patient experience data, with a focus on systems, not outcomes;
- There was a lack of internal and external transparency regarding the problems that existed at the Trust.

25 One of the key issues raised in the report was the role played by external organisations which had oversight of the Trust. The report noted that:

The Inquiry has received a considerable number of representations that there should be an investigation into the role of external organisations in the oversight of the Trust. Concern is expressed that none of them, from the PCT to the Healthcare Commission, or the local oversight and scrutiny committees, detected anything wrong with the Trust's performance until the HCC investigation. While such an investigation is beyond the scope of this Inquiry, local confidence in the Trust and the NHS is unlikely to be restored without some form of independent scrutiny of the actions and inactions of the various organisations to search for an explanation of why the appalling standards of care were not picked up. It is accepted that a public inquiry would be a way of conducting that investigation, but also accepted that there may be other credible ways of doing so.[8]

26 One of the key recommendations arising from the first inquiry report was:

> *52. Having considered the evidence and representations referred to in Section H, I conclude that there is a need for an independent examination of the operation of each commissioning, supervising and regulatory body, with respect to their monitoring function and capacity to identify hospitals failing to provide safe care: in particular:*
>
> - *what the commissioners, supervisory and regulatory bodies did or did not do at Stafford;*
> - *the methods of monitoring used, including the efficacy of the benchmarks used, the auditing of the information relied on, and whether there is a requirement for a greater emphasis on actual inspection rather than self-reporting;*
> - *whether recent changes, including the 'Memorandum of Understanding' between Monitor and the Care Quality Commission (CQC), Quality Accounts and the registration of trusts by CQC, will improve the process by which failing hospitals are identified;*
> - *what improvements are required to local scrutiny and public engagement arrangements; and*
> - *the resourcing and support of foundation trust governors.*
>
> *53. This Inquiry has received many demands that there should be a public inquiry. One of the elements of such an inquiry, it has been suggested, should be the investigation of the external bodies mentioned above. I do not consider it is appropriate for me to suggest that a public inquiry (in the sense of an Inquiries Act inquiry) is the only way in which these issues can be addressed, but it is certainly a way in which it could be done.*

8 *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009, Volume 1*, HC375-1 (24 Feb 2010), page 23, paragraph 75

Recommendation 16: The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.[9]

27 The DH and the Trust Board accepted the recommendations of the first inquiry in full.

28 In response, and to support all NHS organisations to learn from and respond to the recommendations of the report, the DH published three reports designed to help embed effective governance and detect and prevent such serious failures occurring again:

- *Review of Early Warning Systems in the NHS*, which described the systems and processes, and values and behaviours which make up a system for the early detection and prevention of serious failures in the NHS;[10]
- *Assuring the Quality of Senior NHS Managers*, which set out recommendations to further raise the standards of senior NHS managers;[11]
- *The Healthy NHS Board,* which set out guiding principles to allow NHS board members to understand the collective role of the board and individual role of board members, governance within the wider NHS and approaches that are most likely to improve board effectiveness.[12]

29 The Secretary of State accepted a recommendation to consider asking Monitor to de-authorise the Trust when the power came into effect.

30 The Secretary of State also accepted Recommendation 16 of the first inquiry report and proposed that I an inquiry on a non-statutory basis, with the presumption that it would sit in public.

What went wrong and where

31 As seen above, the Terms of Reference[13] require this Inquiry to examine the involvement of numerous agencies with the events at the Mid Staffordshire NHS Foundation Trust within a defined period: January 2005 to March 2009. In doing so, this report builds on the findings of the first inquiry and the previous report of the HCC, and only reconsiders what is said where new evidence has thrown more light on what occurred. While observations will be made about the conduct of the business of the Trust and on some of those responsible, this report does not amount to a complete rehearsal or review of what has been found not only by the

9 *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009, Volume 1*, HC375-1 (24 Feb 2010), page 415, paragraph 52
10 DH00000000628 *Review of Early Warning Systems in the NHS: Acute and community services*, (February 2010), National Quality Board
11 Assuring the Quality of Senior NHS Managers – Final Report (24 Feb 2010), PricewaterhouseCoopers LLP
12 EMB/1 WS0000022551
13 See Volume 3, Annex A: Terms of reference.

first inquiry but also the HCC investigation and other reports. To have conducted such a review would have led to an unnecessary and disproportionate extension to an already complicated and lengthy process.

32 The Inquiry has been helped considerably by evidence from the Trust's patients, and those close to them, and has heard many harrowing stories. The principal focus of this Inquiry in receiving their evidence has been to understand their experiences of the wider system of the NHS in pursuing their complaints and concerns. Another principal purpose of this Inquiry has been to look at the interactions between the Trust and the various agencies which had responsibility for oversight, commissioning and regulation of healthcare services and professionals at the relevant time. For this reason it was not considered necessary to obtain or have regard to evidence from as wide a range of witnesses from within the Trust as might have been the case if this had been an inquiry focused on a formal investigation of its internal workings.

33 The interaction of the Trust with various other organisations has also been looked at. These are bodies which, while having no statutory, managerial or regulatory responsibilities in relation to the Trust's activities, had access to information which might have been helpful in detecting what was going wrong there or may have a contribution to make with regard to improvements in culture, training and support of healthcare professionals and managers working there.

34 It must be emphasised that it has not been within the Inquiry's remit to examine alleged failures of the system with regard to other trusts and services. Unhappily, the Inquiry received more than one request that it should do so, and all have had to be declined. Arguments were on occasion advanced that examination of events at other places would throw light on what went wrong in Stafford or in other parts of the healthcare system. To have explored such arguments by evidence would have been speculative and would have led to lines of enquiry in respect of which, once they were embarked upon, it would be difficult to know when it was appropriate to stop. In other words, this would have become not just a long inquiry but an endless one. The inability of the Inquiry to look into such matters, however, should not be taken to mean that I have made any determination that the matters of this nature raised were of no substance. I have simply decided that they were not to be regarded as within my Terms of Reference. In passing, I should observe that many of those who wrote to me with requests to look at issues arising elsewhere were clearly deserving of great sympathy, and their need to approach me in some cases bore witness to their inability to obtain satisfaction from the complaints and redress systems available to them.

35 I deal with the issue of whether any inferences may properly be drawn as to the existence of similar problems elsewhere in the service later in this Introduction (see 'Extrapolation' below).

Geographical and institutional limitations

36 The disaster of Stafford Hospital occurred in an NHS acute hospital provider trust, and it is the lessons to be learned from that which I have been asked to identify. Of necessity, this Inquiry has focused on the NHS in England and the arrangements for directly provided NHS care. NHS hospital care is also provided by independent providers through NHS funding arrangements. NHS providers share a regulator with providers of independently funded care. Different arrangements apply in Wales, Scotland and Northern Ireland for NHS care. Primary care is subject to a different regime. This report will not specifically address how the lessons from Stafford might be applied to those different parts of the health economy, but there are likely to be implications in the lessons and recommendations for other sectors which must be borne in mind in implementing them by those charged with doing so.

Lessons

37 The other main duty imposed on the Inquiry by its Terms of Reference has been to identify the lessons to be learned from the Stafford experience for the future, having regard to the system as it is now constituted. This has required the Inquiry to inform itself about the changes that have taken place since 2009. Given the pace of reform and procedural change during the lifetime of the Inquiry, this has been no easy task. The Inquiry sought to inform itself of those which have taken place since the close of the oral hearings and which are in the public domain. Wherever it has been deemed relevant, reference has been made to them in the text. This report should not, however, be understood as intending to offer a comprehensive and up to the minute account of the current position.

38 A number of organisations in existence during the period 2005 to 2009 have been abolished since, and others have been created. It has not been within the remit of the Inquiry to investigate the workings of these new bodies except to the extent thought necessary to inform the Inquiry about how the system now operates. That consideration has not extended to examine whether specific interventions in respect of other trusts or even the Trust have been deficient or effective, although the Inquiry has been invited to do so. This would not have been within its remit. However, in some instances the culture within the new system has been looked at and observations will be made about it.

39 Clearly some of the changes that have taken place have been the subject of considerable controversy, in particular the reforms to commissioning now enacted in the Health and Social Care Act 2012. It has not been within the remit of the Inquiry to examine the merits of the arguments for or against these reforms. There are many differing opinions on the best way to provide healthcare to the public in accordance with the founding principles of the NHS, but the focus of this Inquiry has been relentlessly on the need to protect patients from unacceptable and unsafe care. That should be possible to achieve whatever the system of provision. In general, it is unlikely to be structural changes in the system which enhance safety, although there may be many other reasons for making them. Within any system there is a need to

ensure a relentless focus on ensuring patient safety and the provision of at least a minimum quality of care. That should not be too much to ask of any system.

Recommendations

40 There are 290 recommendations in this report. They occur at various places throughout the report but have been grouped according to themes identified by the Inquiry, and are presented in a table within the executive summary and at *Chapter 27: Table of recommendations*. They are also highlighted at the end of each chapter where they occur. Where possible, recommendations identify the organisation it is suggested should take them forward. Where, for whatever reason, this has not been thought possible it would be for the DH to ensure that they are taken forward. Some recommendations are of necessity high level and will require considerable further detailed work to enable them to be implemented. They seek to take account of the system as now structured. In correspondence with the Inquiry the DH confirmed that the recent reforms would not pre-empt consideration of them.

41 The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent. It is respectfully suggested that the subject matter of this Inquiry is too important for it be allowed to suffer a similar fate. The suffering of the patients and those close to them described in the first inquiry report requires a fully effective response and not merely expressions of regret, apology and promises of remedial action. They have already been at the receiving end of too many unfulfilled assurances for that to be acceptable. What is required is a means by which it is clear not only which of the recommendations has been accepted, by whom, and what progress is being made with implementation, but above all how the spirit behind the recommendations is being applied. All organisations that are or should be involved in implementation should account for their decisions and actions in this regard. While the implementation process could benefit from coordination by the DH, many recommendations can be directly implemented by other bodies. While the theme of the recommendations will be a need for a greater cohesion and unity of culture throughout the healthcare system, this will not be brought about by yet further "top down" pronouncements but by engagement of every single person serving patients in contributing to a safer, committed and compassionate and caring service. Therefore, the first recommendation of this report relates to the potential oversight of and accountability for implementation of its recommendations:

42 It is recommended that:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;

- Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;
- In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

Constitution of the Inquiry

Panel

43 No panel was appointed to sit with me. Accordingly the daunting task of fulfilling the Terms of Reference has been my responsibility and mine alone. Therefore, the narrative, analysis findings and recommendations are also mine and mine alone, arrived at having regard to all the evidence placed before the Inquiry.

Assessors

44 To assist me in that task I appointed a number of assessors, which I was entitled to do under Section 11 of the Inquiries Act 2005.[14] Their function has been to offer me advice on matters within their expertise. Three of the assessors assisted me during the first inquiry and therefore brought with them a direct experience of the issues exposed by it. One gave expert evidence at this Inquiry and, as did three other assessors, contributed to the seminars which formed part of the material gathered.

45 The assessors were appointed in two stages. The first group were involved from the outset of the Inquiry and were in a position to offer me explanations, context and advice on the evidence as it emerged allowing me a greater understanding of what I was being told. I have also benefited from their immense experience in various aspects of the healthcare and other systems in identifying the issues arising for the system. I did not invite them to attend the oral hearings, but they were provided with access to the transcripts. I did not think it necessary for the performance of their function to attend oral hearings, and it would in practice have been very difficult to find assessors of the authority and experience of this panel who would have been able to make the time available to attend the many weeks of hearings.

14 A list of assessors and a summary of their qualifications and backgrounds appears at Volume 3, Annex D.

46 The second group were appointed after the close of the oral hearings with the specific remit of advising me in relation to the likely effectiveness of recommendations I was proposing to make. Their task was not to propose any recommendations but to allow me to reflect with them on the extent to which the recommendations I wished to make would help to address the problems this sad story has revealed.

47 I have not thought it necessary or desirable to have prepared or to publish a note of my discussions with the assessors, and no written reports have been sought or provided. Their function has been to act as a sounding board and to challenge and advise me. It is not proposed to disclose the content of any advice, whether written or oral.

48 I must place on record my deep gratitude to the assessors for the patience and dedication with which they have gone about their tasks. I could not have completed the report without their assistance.

The legal team

49 Counsel to the Inquiry, Tom Kark QC, and his juniors, Ben Fitzgerald, Tom Baker and Joanna Hughes have performed with great distinction the onerous task of analysing the vast quantity of evidential material made available to the Inquiry and presenting evidence and submissions at the oral hearings. They have continued to assist me as legal advisers and have been of immense assistance in all the procedures that have been undertaken.

50 Both Counsel and I have been privileged to receive the constant help of the Solicitor to the Inquiry, Peter Watkin Jones, his principal assistants Sarah Garner, Luisa Gibbons, Catherine Henney and Isabelle Makeham and the rest of his team from Eversheds.[15] To them fell the task of the initial sorting and analysis of well over a million pages of raw material disclosed to the Inquiry by the core participants and others, approaching and interviewing witnesses, preparing witness statements and the general legal conduct of the Inquiry. They too are owed a huge debt of gratitude for making order out of potential chaos and allowing the Inquiry to be conducted in as orderly a fashion as possible.

51 This Inquiry, like most modern public inquiries, has been run on a strictly non-adversarial basis with the result that representatives of core participants were generally expected to propose lines of questioning they wanted to be pursued with the legal team. The core participants were entitled to raise with me any concerns and to apply to ask questions directly if not satisfied with the conduct of questioning by Counsel to the Inquiry. It is a significant tribute to the legal team that core participants felt it necessary to make such an application on extremely rare occasions.

15 A full list of the Solicitor's team, along with the rest of the Inquiry team, appears at Volume 3, Annex B.

The Secretariat

52 The Secretary to the Inquiry, Alan Robson, his deputy Catherine Pearson and his team have met the challenge of the setting up of the infrastructure, providing the face of the Inquiry to the public and coping with the myriad of tasks required to maintain and bring the process to a conclusion.[16] It may come as a surprise for some to appreciate that there is no effective established template for the setting up or administration of a public inquiry and, therefore, the team has had to start from scratch. I am sure I am not the first chair of an inquiry to wonder why it is necessary for the wheel to be reinvented in relation to the many administrative and logistical details without which an inquiry cannot function. However, Mr Robson and his team rose magnificently to this challenge. They deserve particular praise for their caring and sensitive support given to witnesses to the Inquiry, many of whom faced great difficulties in taking this step.

The core participants and their representatives

53 Thirteen organisations applied or were invited to be core participants. This status gave them access to evidential material in advance of it being adduced in evidence, and they were, as indicated above, able to suggest lines of inquiry to the legal team. They were entitled to be legally represented and to make submissions to the Inquiry. Without exception, they used these rights proportionately and constructively in a manner which was of great assistance.

Liaison between the Inquiry and the core participants and the public

54 The Inquiry, through the Solicitor and the Secretary's teams, sought to keep the core participants, and the wider public, informed of the conduct of its business as it has proceeded. This has largely been done through the Inquiry website, though there has been regular correspondence and meetings with core participants on procedural matters and with the wider public and press who have been in touch with the Inquiry Secretary's team in writing, in person and on the telephone. For the duration of the hearings, the whole Inquiry team was located and worked from the hearing venue at Stafford Borough Council Offices.

55 The website has also sought to inform relevant parties of the Inquiry's intentions and procedures as they have unfolded, rather than after the event. Procedural protocols and statements have been issued (after consultation as necessary) and posted to the Inquiry's website on issues such as procedures to be adopted, a media protocol, a protocol for seeking legal representation at public expense, a protocol on the issue of warning letters under Rule 13 of the Inquiry Rules 2006, together with other key documents, such as the issue of restriction notices, the circumstances of accepting new evidence after close of evidence, and the details of the Inquiry's costs.

16 A full list of the Secretariat appears at Volume 3, Annex B.

56 Evidence and submissions have also been made available online. All core participants were provided with advance notice through the Inquiry's database of the statements and exhibits of witnesses who were to give evidence and indeed of those with possibly relevant evidence to give, but where the Inquiry had decided not to call the witness in person. Schedules of the timetabling of witnesses to give oral evidence were made publicly available in advance of witnesses being called. The statements of witnesses and their exhibits have generally been made available to the public and press via the website on the day the witnesses gave oral evidence. A livenote transcript was taken of all evidence given and that was generally posted on the evening of the giving of evidence too. Submissions made by the legal representatives of the core participants and of Counsel to the Inquiry were also made available on the website.

Seminars

57 Following the end of the public hearings, I organised a series of seven seminars where invited speakers, attendees, members of the public and press had an opportunity to come and discuss various topics that I had set out on the Inquiry website. I commissioned papers and/or presentations from the invited speakers, and these are all available on the Inquiry website.

58 The seminars covered:

- Methods of regulation, which was held on 13 October 2011 in Manchester;
- The training and development of trust leaders, which was held on 18 October 2011 in Leeds;
- Information, which was held on 19 October 2011 in Leeds;
- Organisational culture, which was held on 25 October 2011 in London;
- Nursing, which was held on 31 October 2011 in London;
- Patient experience, which was held on 2 November 2011 in Stafford;
- Commissioning, which was held on 3 November 2011 in London.

59 All seven seminars were facilitated by Dr Sarah Harvey, who also produced a report of the seminars that was published in hard copy and is available on the Inquiry website.

60 I also undertook a small number of visits to healthcare organisations, and a list of those visited is set out at Annex E.

Witnesses

61 Some 164 witnesses gave oral evidence. In addition, a further 87 witness statements and 39 provisional statements were 'read' into the Inquiry's record and were accepted into evidence. The Inquiry took 352 individual witness statements in total but some of these were not deemed material or relevant to the Inquiry's business. Those who assisted the Inquiry by

re-living their experiences of poor care and poor handling of their complaints did so with great dignity, patience and care. I am indebted to them for their invaluable assistance and acknowledge the cost in suffering that must have been incurred by many of them in doing so.

62 The Inquiry also heard from a vast range of healthcare professionals, officials, politicians and others involved in the complexities of commissioning, performance management, oversight and regulation of the healthcare system. The experience will have been stressful for nearly all of them, but the Inquiry is grateful to all for their assistance. It would have been surprising if I had been able to agree with the recollections or views of every witness, but I am satisfied that without exception they were all doing their honest best to tell me the truth as they saw it.

63 Not all witnesses were asked to give oral evidence. In the main this was because what they had to say was sufficiently contained in a written statement and little additional benefit would have been obtained from oral examination. In one significant case, that of Mr Martin Yeates, the former Chief Executive of the Trust, he was excused from giving oral evidence for medical reasons, which I was satisfied, following receipt of a report of an independent medical examination commissioned by the Inquiry, rendered him unfit to attend to give oral evidence. He was, however, able to provide a substantial written statement to the Inquiry following an interview by the Solicitor to the Inquiry.

64 Two witnesses were excused, because of medical reasons, the normal requirement of giving their oral evidence in the Inquiry chamber in the presence of the public, but they were allowed to do so in a separate room and one from a separate location, with what they said being relayed live to the public.

65 The Inquiry also had the benefit of a range of expert evidence from witnesses appointed by the Inquiry as experts for this purpose. I would like to express my gratitude for their deep understanding of the system and its history that this evidence brought to the process.

Hindsight

66 Professor Sir Brian Jarman pointed out in his evidence to this Inquiry that at the Bristol Inquiry, in which he was a member of the inquiry panel, there were 120 mentions of the word "hindsight" in the evidence. The Bristol Inquiry report contained a section on hindsight. In the Foreword, the panel expressed the hope that the disaster that had been uncovered there would not be repeated:

It would be reassuring to believe that it could not happen again. We cannot give that reassurance. Unless lessons are learned, it certainly could happen again, if not in the area of paediatric cardiac surgery, then in some other area.[17]

67 Professor Jarman told this Inquiry that although he had doubts whether the DH would actually implement the recommendations of the Bristol Inquiry:

I did feel at least there would be no excuse in future for those responsible to continue to say, after the Bristol report was published, as they had said to us throughout the Bristol Inquiry, "with the benefit of hindsight".[18]

68 Unhappily, the word "hindsight" occurs at least 123 times in the transcript of the oral hearings of this Inquiry, and "benefit of hindsight" 378 times.

69 It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time now that the enormity of what was occurring in the Trust is better known.

70 There is, however, a difference between a judgement which is hindered by understandable ignorance of particular information and a judgement clouded or hindered by a failure to accord an appropriate weight to facts which were known.

71 It has been said before and must be said again; I do not for a moment believe that those in responsible positions in the Trust or elsewhere in the healthcare system went about their work knowing that by action or inaction they were contributing to or condoning the continuance of unsafe or poor care of patients. What is likely to be less comfortable for many of those in such posts at the time is the possibility, and sometimes the likelihood, that whatever they believed at the time, they were not being sufficiently sensitive to signs of which they were aware with regard to their implications for patient safety and the delivery of fundamental standards of care.

Extrapolation

72 Some of the responses to Rule 13 letters, ie letters warning of potential criticisms, have asserted that it is impermissible to extrapolate from the events at Stafford a conclusion that such deficiencies are to be found elsewhere. This Inquiry has not, of course, investigated the state of affairs at any other trust. I have received several requests to do so from distressed

17 Jarman WS0000042749, para 38
18 Jarman WS0000042749, para 38

members of the public, but to have done so would not have been within my Terms of Reference. Therefore, I have been offered arguments that it would be unsafe in the absence of evidence to assume that significant changes are necessary to detect or prevent another such catastrophe.

73 The first point to make is that even if it were true that there were no other provider within the healthcare system which displayed the combination of deficiencies found at the Trust, it is of very grave concern that the extensive system of checks and balances intended to detect and prevent such failures did not work. Large numbers of patients were left unprotected, exposed to risk, and subjected to quite unacceptable risks of harm and indignity over a period of years. Whatever else can be said, the deficiencies at Stafford were wide in scale and adversely affected considerable numbers of patients and those close to them.

74 The second point is that it has not escaped the Inquiry's notice that even since the HCC report on the Trust there have been a series of highly concerning reports of experiences elsewhere containing echoes of what was experienced within the Trust. In the Patient Association's (PA's) closing submission to the Inquiry, they make reference to a number of highly critical reports, including: their 2009 report *Patients Not Numbers, People Not Statistics*; the 2009 report published by National Confidential Enquiry for Patient Deaths (NCEPOD), which reviewed the care of patients who died within four days of admission; the Alzheimer's Society report *Counting the Cost;* and their own report from 2010, *Listening to Patients, Speaking up for Change*.[19] There have been others, too, such as the Care Quality Commission (CQC) report in 2011 on dignity and nutrition for older people[20] and the well documented events of appalling care provided at Winterbourne View to name but two. Even if all the instances contained in the reports just mentioned are in some way isolated ones dependant on particular circumstances, they are suggestive that there are places where unhealthy cultures, poor leadership, and an acceptance of poor standards are too prevalent.

75 The third point is that the failure of the system to detect the deficiencies at the Trust and take effective action soon enough means that the public is unlikely to have confidence that "another Stafford" does not exist, in the absence of being convincingly persuaded that sufficient change has taken place.

76 Therefore, Stafford was not an event of such rarity or improbability that it would be safe to assume that it has not been and will not be repeated or that the risk of a recurrence was so low that major preventative measures would be disproportionate. The consequences for patients are such that it would be quite wrong to use a belief that it was unique or very rare to justify inaction.

19 CL0000001209, *Patient's Association closing submissions*, pages 2–3
20 *Dignity and Nutrition Inspection Programme,* (October 2011), Care Quality Commission, www.cqc.org.uk/sites/default/files/media/documents/20111007_dignity_and_nutrition_inspection_report_final_update.pdf

Similarity to others

77 An opposite argument was used, sometimes by those also espousing the extrapolation argument in other contexts, to justify inaction or a lack of a response. This was that matters of potential concern at Stafford, such as outlying mortality rates, concerns about governance, and staffing issues, could be found at many other places, and therefore were justifiably regarded as not being of particular significance or of requiring exceptional action.

78 In some instances, such an argument betrays a failure to appreciate the impact on patients and those close to them, of the deficiency in question. It is the institutional equivalent of the tolerance of poor care all too frequently seen and not challenged on some wards at the Trust. The fact that it might be typical of what happened elsewhere is cause for increased concern not reassurance. It is an argument which evidences a culture of habituation and passivity in the face of issues which may indicate real suffering. It is an attitude which would be unlikely to be persisted in if those adopting it were constantly to place an empathy for the predicament of patients at the forefront of their mind.

Standard of proof

79 In arriving at conclusions with regard to the relevant facts, the panel of a public inquiry finds itself in a different position to a court of law, whether civil or criminal. A court of law is required to make specific findings in relation to allegations made or charges before it in accordance with the relevant law. Issues are decided after the presentation of evidence and argument by each opposing party. In a criminal court charges may not generally be found proved unless the court is satisfied on the evidence so that it is sure of that matter. In civil proceedings the rule is generally that a fact will only be found proved if the court is satisfied of it on the balance of probabilities. In civil proceedings the more serious the allegation the more cogent will be the evidence required to prove it.

80 By contrast, at a public inquiry such as this one the process is inquisitorial, in that it takes the form of an investigation led by the inquiry and not by any of the parties. There are Terms of Reference but no more closely defined allegations or issues which have to be determined. There are no parties entitled as of right to call evidence of their own. The task of the inquiry is not to determine an allegation or a charge, and its findings are not determinative of civil or criminal liability. It is required to examine events that have occurred and identify lessons which in its opinion can be drawn from those events. It may as a matter of judgement identify criticisms it considers can be made of individuals or organisations arising from those events, but such findings are not binding on those criticised.

81 The Inquiries Act 2005 and the Inquiry Rules 2006 offer no specific guidance on the subject of the standard of proof to follow, beyond Section 17 of the Act which provides that subject to any provision of the Act or the rules:

... the procedures and conduct of the Inquiry are to be such as the chairman of the inquiry may direct.

82 The overriding requirement of the Act, set out in section 17(3), is that in any decision made by the chairman as to procedure or conduct of the Inquiry:

... the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost ...

83 There is much legal authority on what is the appropriate standard of proof in civil and criminal proceedings, but this is of little relevance to an inquiry because of the differences in character between the public inquiry process and such proceedings mentioned above.

84 Some assistance can be gained from the rulings made by chairs of previous public inquiries on the issue.

85 In the Shipman Inquiry, Dame Janet Smith set out the approach of that inquiry to the standard of proof in her first report, in effect declining to be constrained by any one standard of proof:

9.43 In an inquiry such as this, there is no required standard of proof and no onus of proof. My objective in reaching decisions in the individual cases has been to provide an answer for the people who fear or suspect that Shipman might have killed their friend or relative. I have also sought to lay the foundation for Phase Two of the Inquiry. My decisions do not carry any sanctions. Shipman has been convicted of 15 cases of murder and sentenced appropriately. He will not be tried or punished in respect of any other deaths. Nor will my decisions result in the payment of compensation by Shipman. It is possible that relatives might recover damages from Shipman if they can show that Shipman has killed their loved one, but my decision that he has done so will not automatically result in an award of compensation against him. Accordingly, I have not felt constrained to reach my decisions in the individual cases by reference to any one standard of proof.[21]

86 At the Bloody Sunday Inquiry, Lord Saville of Newdigate rejected the application of the criminal standard of proof:[22]

8. In the context of the present Inquiry, there is no question of the Tribunal having any power to remove or diminish the rights, liberties or freedoms of anyone. It is not the function of an Inquiry of the present kind to determine rights and obligations of any nature. Its task, set by Parliament, is to inquire into and report upon the events on Sunday

21 *Shipman Inquiry First Report* (19 July 2002) chapter 9, www.shipman-inquiry.org.uk/fr_page.asp?ID=133
22 The Bloody Sunday Inquiry: Standard of Proof Ruling (11 October 2004)

30 January 1972 which led to loss of life in connection with the procession in Londonderry on that day, taking account of any new information relevant to events on that day. The Inquiry cannot be categorized as a trial of any description. Unlike the courts it cannot decide the guilt (or innocence) of any individual or make any order in its report. Our task is to investigate the events of Bloody Sunday, to do our best to discover what happened on that day and to report the results of our investigations. It accordingly follows that the considerations that led the courts in the cases cited to require proof to a very high standard before making orders that affected the rights, liberties and freedoms of individuals are no guide to the task entrusted to the Tribunal.

87 After referring to Dame Janet Smith's approach quoted above, Lord Saville went on:

10. We consider that these observations are apt in our consideration of the events of Bloody Sunday ...

17. In our view therefore the cases cited to us do not provide any support for the proposition that as a matter of principle we cannot make any findings implying criminality unless we are satisfied to the criminal standard of proof or of serious misconduct unless we are satisfied to the enhanced civil standard.

18. As we have said earlier, since we are an Inquiry and not a Court (criminal or civil) we cannot give a verdict or pass a judgement on the question whether an individual was guilty of a specific crime or legally recognised serious wrongdoing. For the same reason the terminology and requirements of the criminal or civil law are largely inapplicable. Thus it seems to us that we can and should reach conclusions without being bound by rules designed for court cases, such as who has the burden of proof and the strict rules of evidence ...

88 Referring to a judgment in a Canadian case[23] he said:

19. ... As he pointed out, the findings of a commission of inquiry relating to an investigation are simply findings of fact and statements of opinion reached by the commission at the end of the day; and though they may affect public opinion, they are not and cannot be findings of criminal or civil responsibility.

89 Lord Saville considered and rejected a submission that not to apply a high standard of proof would be unfair to the individuals concerned:

22. The Inquiry is indeed concerned with matters of the greatest seriousness. The question whether the shooting of civilians by soldiers was or was not justified is central. The very subject matter of the Inquiry raises the possibility that individuals may be the subject of

23 *Canada (Attorney-General) v Canada (Commission of Inquiry on the Blood System)* 1997 3 S.C.R. 440

the most serious criticism and there may well be wide publicity, though it should be noted that most of those concerned have been granted anonymity. But for the Tribunal to conclude that while it was not sure, nevertheless it seemed probable that a particular shooting was deliberate and unjustified (objectively and subjectively) could hardly create or increase a risk of prosecution; indeed it would be more likely to have the opposite effect. Furthermore, apart from the reference to the possible risk of prosecution, no attempt was made to explain what 'serious consequences' would follow were the Tribunal not to apply the suggested standards of proof, save that it was also suggested that the media would be likely to misrepresent the views of the Tribunal, and categorize the individual as being guilty without reference to the degree of confidence or certainty expressed by the Tribunal in making any findings implying criminality or serious misconduct. The fact (if such it be) that the media may misrepresent the views of the Tribunal does not seem to us to be a sound or satisfactory basis for requiring the Tribunal to refrain from expressing those views.

23. In our view, provided the Tribunal makes clear the degree of confidence or certainty with which it reaches any conclusion as to facts and matters that may imply or suggest criminality or serious misconduct of any individual, provided that there is evidence and reasoning that logically supports the conclusion to the degree of confidence or certainty expressed, and provided of course that those concerned have been given a proper opportunity to deal with allegations made against them, we see in the context of this Inquiry no unfairness to anyone nor any good reason to limit our findings in the manner suggested ...

24. It was also submitted that there would be no point in reaching conclusions on matters implying criminality or serious misconduct, unless we were sure beyond a reasonable doubt. We do not understand this submission. We are asked to investigate and report on an event that took place some three decades ago, where on any view soldiers of the British Army shot and killed (and wounded) a number of civilians on the streets of a city in the United Kingdom and where the question whether or not they were justified in doing so has been the subject of such debate ever since that it led to the institution of this (the second) Inquiry some thirty years later. It seems to us that it would be quite wrong to confine ourselves in relation to this central part of the Inquiry to making findings where we were certain what happened. On the contrary, it is in our view our duty to set out fully in our Report our reasoned conclusions on the evidence we have obtained and the degree of confidence or certainty with which we have reached those conclusions. We are not asked to report only on these central matters on which the evidence makes us certain.

27 ... we are not persuaded by the arguments that seek to impose on us the criminal or enhanced civil standard of proof in relation to findings implying criminality or serious misconduct falling short of criminality. We should emphasise, as we have made clear on numerous occasions during the course of the Inquiry, that this does not mean that we shall entertain or allow to be pursued allegations of this kind which have no sensible

foundation at all or in respect of which the individual concerned has not been given a proper opportunity to answer.

90 The effect of this ruling was that the inquiry could make findings of fact while describing the degree of confidence with which those were made. This was not thought to be unfair, provided there was a foundation of evidence and a logical basis for the finding and the individual to whom the finding was adverse was given a fair opportunity to answer the allegation.

91 It is right to note that both the Shipman and the Bloody Sunday inquiries were set up under the now repealed Tribunals of Inquiry (Evidence) Act 1921, but nothing appears to turn on this.

92 The Baha Mousa Public Inquiry was set up under the Inquiries Act 2005. Sir William Gage, after hearing submissions, gave a ruling on the standard of proof to be applied. He ruled that he would apply the civil standard of proof. His reasoning appears in the following passages:[24]

18 All counsel stressed that in making my findings I am required to act fairly. Of course, I am well aware of the need to be fair to soldiers and others whose reputations and careers may be affected by my findings. Throughout the Inquiry I have endeavoured with Counsel to the Inquiry to ensure that those who may be open to criticisms are treated fairly and I am grateful to Mr Singh for his endorsement that the level of natural justice afforded to those who may be criticised has been 'above and beyond' the strict requirements of the 2006 Rules.

19 I must also be fair to the detainees who, on any view of the evidence I have so far heard, suffered serious and traumatic injuries following their arrest and detention in the TDF at Battlegroup Main between 14 and 16 September 2003. In addition, this is a Public Inquiry and it is in the public interest that my findings in the Report are expressed in such a way as can be readily understood as my judgement on what occurred, who was responsible and why I have made recommendations. In my opinion, this can best be achieved by adopting the flexible and variable standard of proof as applied in the Shipman Inquiry.

20 I recognise that in relation to some issues in this Inquiry, the more serious the allegation the more cogent must be the evidence to support a finding of wrongdoing. I must as a matter of fairness bear in mind the consequences of an adverse finding to any individual against whom serious allegations are made. However, by section 2 of the 2005 Act, I have no power to determine criminal liability, and the mere fact that criminal culpability might be inferred from my findings, does not in my judgement mean that I must adopt the criminal standard in making findings of fact. On the contrary, I think that

24 *The Report of the Baha Mousa Inquiry: Volume 1*, HC 1452-I (8 September 2011), chapter 6

the usual starting point will be to apply the civil standard but taking account of the 'inherent improbability' concept where it properly applies.

21 There are some cases where criminal conduct is considered in the criminal courts applying the criminal standard of proof, the facts of which arise in later civil litigation where the balance of probabilities standard falls to be applied. In order properly to report who is responsible, in my judgement, I must reserve to myself the right to state, where I find the evidence sufficient, that I find a fact proved on a balance of probabilities. To do otherwise would necessarily be to limit my findings of responsibility to the high criminal standard.

22 This does not mean, however, that I shall disregard the criminal standard of proof. There may be factual issues involving allegations of serious misconduct against identifiable individuals, where I shall wish to make clear that although I am satisfied on the balance of probabilities that an individual was involved in misconduct, the evidence is not sufficient to establish that fact to the criminal standard. There may equally be factual issues where I am satisfied to the criminal standard either that an individual was involved in particular misconduct or that he can be exonerated of such misconduct. In such cases, I may again think it right to make clear in my report that I am able to reach those findings to the criminal standard. The important point is that where issues of misconduct are concerned, I must make clear the standard of proof (be it civil or criminal) to which I have been satisfied in making the relevant finding.

23 So far as all other allegations or factual disputes are concerned, in applying the balance of probabilities standard of proof the concepts of 'inherent improbabilities' and 'the commonsense approach' [sic] *when reaching findings are concepts with which all judges of fact at first instance are familiar. These are factors which I shall have well in mind when reaching findings of fact on a balance of probabilities.*

24 During the course of oral argument I canvassed with all counsel whether or not I am entitled to make comments expressing suspicion or, some other such phrase, that an allegation is true. Mr Singh submitted that I am entitled to do so; others disagreed. Mr Beer submitted that I have no power to do so because my power is only to determine the facts (s.24(1)(a) of the 2005 Act).

25 I do not accept that I may not make such comments. In my opinion the terms of s.24(1)(a) do not restrict me from doing so. In any event, as Mr Singh pointed out, s.24(1) of the 2005 Act provides that 'The report may also contain anything else that the panel considers relevant to the Terms of Reference'. I do, however, accept and stress that by making a comment of that nature I would not be making a finding of fact. I further accept that the power to make such a comment should be exercised sparingly. Circumstances in which I will feel constrained to do so will, I believe, be comparatively rare.

93 It is to be noted that although Sir William decided that in principle he would be applying the civil standard of proof, he considered he had power to make comments not amounting to findings of fact in the nature of expressions of suspicion.

94 Sir William appears to have understood the approach of the Shipman Inquiry to have been to apply the "flexible" civil standard of proof. The passages from the Shipman report quoted above suggest that a broader approach was taken; Dame Janet explicitly said she would not be constrained by the requirements of "any one" standard of proof.

95 Looking at the overall effect of how previous inquiries have approached the matter, together with the current Inquiries Act and Inquiry Rules, the following principles may be gleaned:

- It is for the chairman of the inquiry to decide on the approach to be taken to findings of fact, criticism and recommendations as part of his role in determining the procedure of the inquiry.
- Even in inquiries which have to address allegations of extremely serious crimes, there is no place for the application of the criminal standard of proof.
- The context of the task set for the inquiry is important in deciding what the proper approach to making findings may be.
- An inquiry should not be inhibited from setting out its findings and opinions based on those findings by adherence to particular standards of proof.
- An inquiry is free to express its findings as it sees fit, provided that they are logically founded on the evidence, the basis of the finding is made clear, and a person adversely affected by a finding has had a fair opportunity to deal with it.

96 While the present Inquiry concerns events which had caused untold distress to many patients and their families and considerable public concern about the standard of service in our hospitals, it is not an investigation into the alleged commission of criminal offences. It concerns the apparent deficiencies in a system which allowed poor care and treatment to be given which may have caused harm to numbers of patients. Inevitably, it is likely that large numbers of individuals had a part to play in this, none of whom individually could have prevented the totality of what occurred. In the course of analysing what happened and why, inevitably, it will be necessary to consider what could have been done better by individuals and organisations. This is a necessary part of identifying the lessons to be drawn.

97 One other important difference between this Inquiry and the others is that its Terms of Reference require it:

> *where appropriate to build on the evidence given to the first inquiry and its conclusions, without duplicating the investigation already carried out.*

98 Therefore, the Inquiry is required, where it considers it appropriate, to proceed on the basis of evidence already given and conclusions reached in a previously published report written by the same chairman.

99 As already stated, no findings of fact or criticism made in this report are determinative of any form of civil or criminal liability. The duty of the Inquiry is to set out its conclusions about what happened, along with any observations it may have on what happened by way of comment or criticism and to offer what in its opinion are relevant recommendations. It should not be inhibited from doing so by reason of any particular standard of proof. It must, however, only make comments and criticisms which it concludes are fair, and should not do so unless those affected by criticism have had a fair opportunity to deal with it through the Rule 13 process.

100 Taking all these considerations into account, I have concluded that:

- The Inquiry should make findings based on the evidence before it, taking into account the findings of the first inquiry. In all instances, the Inquiry's findings must be guided by what is fair.
- Much evidence of what happened has not been contradicted. Where such evidence is not contradicted the Inquiry is likely to accept it unless it is inherently improbable, in which case this will be made clear.
- Where there are issues in relation to what happened, all the evidence relevant to that issue will be considered and taken into account. No particular standard of proof will be applied, but the Inquiry will find the facts on the basis of the evidence that it has preferred. A common sense approach will be adopted whereby inherently improbable assertions will be regarded with more caution than inherently likely ones.
- Where it is decided in relation to an important event that it is only possible to say it may have occurred, this will be made clear. The narrative of the report will make clear what the Inquiry has concluded occurred and will refer to evidence supporting that conclusion. As this is a report not a court judgment, a full account of the reasons for preferring the evidence cited will not always be given.
- Although there are no strict rules of evidence other than the overriding requirement of fairness, I will bear in mind that different weight may have to be afforded to different types of evidence.
- Criticisms of organisations and individuals may appear either in the course of a narrative account of what happened or separately. They may either be made explicitly or be implied. Where a criticism is made or implied, this will be the result of the Inquiry forming an adverse opinion arising out of the finding of fact. That opinion and the resulting criticism are a matter of judgement and not a matter for which proof is required. An explanation of the significance of criticisms in this report appears below.

Responsibility and criticism

Procedure

101 Where the inclusion of a significant potential criticism of an individual or organisation was being considered by me, they were notified of this under Rule 13 of the Inquiry Rules 2006 and offered an opportunity to respond. The notice was accompanied by a schedule prepared by Counsel to the Inquiry summarising the nature of the criticism and giving references to the evidence thought to support such a criticism. The Inquiry Rules 2006 provide that a duty of confidentiality is owed by the Inquiry and the recipients of such notices to each other in respect of such notices. This means that each has a duty not to disclose the existence of or content of the notice without the permission of the other. Recipients were invited to apply to the Inquiry for a waiver permitting them to share notices with those from whom they wished to receive assistance in formulating their replies. A large number of such applications were made and almost all granted on condition that the third parties signed a form of undertaking to maintain the confidence.

102 The requirements of Rule 13 of the Inquiry Rules 2006 are such that sharing large extracts from the draft report would have been impracticable, distracting and undesirable. This had the unfortunate result that some potential criticism had the appearance of being more severe than was in fact the case once the criticism is seen in its context. Likewise some recipients were concerned that they may have been singled out for criticism that could equally apply to others, not knowing that similar notices had been sent to others.

103 Some of the recipients had not given evidence to the Inquiry and had not been asked to. A particular group in this category were former Ministers; in their case, notices were served at the specific suggestion of the DH, which considered that some proposed criticisms were in fact criticisms of them. I had not previously been of the view that these criticisms were of Ministers for the reasons given below. Having considered the helpful responses I received from former Ministers, I remain of that view.

104 Some recipients of notices, both among those who had given evidence and those who had not, complained that the matter of criticism had not been put to them during the hearing and therefore they had not had an opportunity to respond to it. This indicated a failure to understand the purpose of the Rule 13 process, which is to provide a very specific and fair opportunity to individuals and organisations to respond to proposed criticism. The process has demonstrated its value in this Inquiry. I received many thoughtful and well constructed responses offering an analysis of the evidence, and in some cases new evidence, relevant to potential criticisms. I paid very careful attention to all the responses and have taken them fully into account in my final conclusions. Many modifications were made to the draft report as a result.

105 Some recipients asked that they be given sight of any revision of the potential criticism before publication of the Inquiry report. I declined to do so; first because the Rules do not provide for such a facility, and second because it would have been impracticable and undesirable. Such a process would inevitably have led to a virtually endless exchange of drafts and submissions, making the Inquiry process even longer than it already had been. For better or for worse, it is I who have been charged with the task of assessing the evidence and drawing my conclusions and that is a task I must complete with fairness, due care, and within as reasonable a timescale as possible. Any new evidence taken in to account in this way has been published on the Inquiry website.

General observations

106 There is a tendency when a disaster strikes to try to seek out someone who can be blamed for what occurred, and a public expectation that those held responsible will be held to account. All too frequently there are insufficient mechanisms for this to be done effectively. A public inquiry is not a vehicle which is capable of fulfilling this purpose except in the limited sense of being able to require individuals and organisations to give an explanation for their actions or inaction.

107 The evidence to this Inquiry has shown that we have still not managed to move successfully away from the culture of blame which Professor Sir Liam Donaldson, in *Organisation with a Memory,*[25] and Professor Sir Ian Kennedy, in the report of the Bristol Inquiry,[26] were so keen to banish. The understandable human need to identify one or more people to be held to account means that whenever something goes wrong a hunt starts, and the larger the disaster the more pressure there is. Thus a factor in the pressure leading to this Inquiry was a wish to see people brought to account, whereas if an inquiry is to fulfil its main purpose it has to identify lessons to be applied.

108 On the whole, the purpose of identifying where individuals have fallen below relevant standards should be to show examples of conduct or judgements to be avoided in future. In a system failure as widespread as that identified in this Inquiry, it becomes a futile exercise to undertake; so many are in one sense accountable, it is far more effective to learn rather than to punish. To place too much emphasis on individual blame is to risk perpetuating the illusion that removal of particular individuals is all that is necessary. That is certainly not the case here. To focus, therefore, on blame will perpetuate the cycle of defensiveness, concealment, lessons not being identified and further harm.

25 LD/5 WS0000070414–5
26 *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995: Learning from Bristol* (July 2001) The Bristol Royal Infirmary Inquiry

Approach to criticism in this report

109 It must be remembered that the inquiry mechanism is not equipped to determine individual responsibility by way of anything akin to a "trial". Individuals and organisations may be called to provide evidence, may have legal representation and may have the opportunity to respond in accordance with the Inquiry Rules 2006 and procedure to potential criticisms, but they cannot defend themselves as they could in adversarial proceedings – by cross-examination of critical witnesses, or presentation of evidence they choose to call in their defence – and they only have a limited right to make representations to the Inquiry. An Inquiry does not and cannot determine civil or criminal liability. Therefore, where comments or conclusions are made which are or might be interpreted as being critical of individuals, these serious limitations arising out of the nature of the process must be borne in mind.

110 This Inquiry is charged to investigate the deficiencies in the system which allowed the events of Mid Staffordshire to pass unnoticed or without effective reaction for so long. This is not a case where it was ever going to be possible or permissible to find that an individual or a group of individuals was to blame for this. When examining what went wrong in the case of a systems failure as complex as that surrounding the events in Stafford, the temptation of offering up scapegoats is a dangerous one which must be resisted. To do this would be to create the fiction that the behaviour of one person, or a small group of people, would have made all the difference and conclude that the easy answer to the problem is to appoint better performing individuals. It was not a single rogue healthcare professional who delivered poor care in Stafford, or a single manager who ignored patient safety, who caused the extensive failure which has been identified. There was a combination of factors, of deficiencies throughout the complexity that is the NHS, which produced the vacuum in which the running of the Trust was allowed to deteriorate.

111 The principal factors concluded to have been involved in this systems failure are examined in the chapters which follow. It has been necessary to examine particular examples of performance of individuals and organisations to demonstrate the conclusions. Such conclusions have been arrived at after consideration of all the evidence before the Inquiry, including responses to warnings issued under Rule 13 of the Inquiry Rules 2006. It is not practical or proportionate, even in a report of this length, to recite all the evidence relevant to every point, but to the extent appropriate to the matters considered the evidential basis for those conclusions is made clear in the text. Other evidence could often have been identified. In many cases where critical comment is made, examples of others acting in a similar fashion could often have been found. The unpalatable truth is that there is much for all who work in healthcare to learn from the narrative in this report in terms of reflecting on their own work, attitudes and collective culture.

112 Therefore, critical comments will be made about individuals and organisations, policies and cultures. It is extremely important that these are seen with these matters in mind. Much will

be said about culture in this report. Individuals and indeed organisations acting in accordance with a culture, even a negative or unhealthy one, cannot always be held personally responsible for doing so.

113 The most important task of an inquiry such as this is to identify the lessons to be learned. Such lessons can include, and they do in this report, ways in which particular matters of administration, management, or implementation of policy could have been done better. Such points can be and often are illustrated by reference to the activities of particular individuals. Such a narrative may appear to be critical of the individuals or organisations concerned, but unless the context specifically states to the contrary, it should be borne in mind that this report is written with the benefit of hindsight, in full knowledge of the appalling care provided at the Trust and an appreciation of its consequences for patients. A statement in this report that something might or should have been done differently is not in itself a suggestion of negligence or of a breach of a duty existing at the time. Such critical comment is not intended, unless the contrary is clear from the context, to suggest that many others would not have acted in the same way if presented with the same set of circumstances at the time.

114 The fact that a critical comment is made about some action of an individual or an organisation does not necessarily mean that there are not many positive aspects to their work and contribution to healthcare. Many of those about whom some critical comment has been made have been involved in making significant changes for the better. Many have offered notable insight to the Inquiry, and have evidenced a genuine desire to effect improvements in the service and the system providing it, often through thoughtful contributions about possible changes for the future. This makes it all the more important for the report to be read as a whole. What are perceived to be critical comments should not be taken out of context or in isolation from the rest of the report. In an inquiry required to focus on what went wrong and what needs to be changed it is simply inappropriate to qualify every critical comment with a reference to unrelated positive points. It is the unhappy task of an inquiry to focus on what went wrong, and not on what went right.

115 The report also contains more general observations about the effect of certain policies and their implementation. If there is one central message to emerge from this Inquiry it is that the safety of patients and the requirements of fundamental standards are obligations which need to transcend particular policies and to permeate all considerations within the system. Nothing in this report is meant to question or analyse the wisdom or appropriateness of individual policies, ranging from the creation of the FT concept through to the Coalition Government's present reforms. It is not intended to suggest that any Government or any Secretary of State for Health, or any of their junior Ministers did not intend to maintain standards of safety and minimum care. Clearly there are many different ways in which healthcare can be delivered to the public, and it is well beyond the remit of this Inquiry to debate the respective merits of the various approaches taken by different Governments. It is in any event unrealistic to lay personally at the door of Ministers responsibility for the detail of ensuring that the implementation of a policy does not prejudice safety or effective delivery of minimum standards, unless they have received advice on that subject which they ignore. The DH is a remarkable combination of policy making, administration and executive NHS management, which makes recognition of the reality of the practical limits of Ministerial responsibility important, whatever may be the constitutional theory.

The structure and style of the report

116 Given the complexity of the system, it has been the task of the Inquiry to examine the overlapping functions of the various organisations within it, and there has been no single obvious way in which to structure the report. The approach taken has been to start with a consideration of warning signs (*Chapter 1: Warning signs*) that in retrospect existed and could have suggested that the Trust was the subject of serious deficiencies in relation to the provision of a safe and effective service. This chapter seeks to proceed in roughly chronological order, but, where a strict date order of events might not assist, some themes are pursued as a whole.

117 The report then proceeds to pick out some matters concerning the governance and culture of the Trust. It must be emphasised that this is not intended to be a comprehensive examination of all that went wrong there: this report must be read with the report of the first inquiry and the report of the HCC for a full understanding of that.

118 There follows an examination of the role played by local scrutiny and patient and public involvement groups, the commissioners, the SHA, and the regulators with a view to establishing what went wrong, followed by a consideration of the involvement of other agencies.

119 Finally, there follows a section dealing with themes for the present and future, arising out of what went wrong.

120 Of necessity, some events and evidence are referred to in more than one chapter. While an attempt has been made to keep repetition to a minimum, it is necessary in some contexts to assist in understanding.

121 Evidential references are given for all statements of fact and quotations in the report. In general unless the context makes the contrary clear, I have accepted the evidence recited. While I have had regard to all the evidence admitted and the submissions made, this already long report would have been unmanageable if all evidence relevant to each point were recited or referenced or if a fully reasoned decision was given for each issue of fact requiring determination. On the few occasions where there have been significant disputes about fact I have sought to give a fuller analysis for my conclusion. It is important when considering my recitation of facts, comments, criticisms and conclusions to read them in context, just as the report must be read as a whole.

Summary of recommendations

Recommendation 1

It is recommended that:

- All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
- Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;
- In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

Chapter 1
Warning signs

Key themes

- Chronological analysis shows that for many years there were numerous causes for concern about the Trust's standard of service, governance, finances and staffing.
- These concerns taken cumulatively, and in some cases individually, had implications in relation to patient safety and the Trust's ability to deliver a minimum acceptable standard of care.
- Known serious concerns were not addressed effectively.

Introduction

1.1 During the course of both the previous inquiry and this Inquiry there has been a constant refrain from those charged with managing, leading, overseeing or regulating the Trust's provision of services that no cause for concern was drawn to their attention, or that no-one spoke up about concerns. A few examples will suffice to make the point:

- The Primary Care Trust (PCT) submitted that:

  it is now clear that there was not a culture of openness and transparency throughout the [Trust]. *Incidences of poor care were not formally fed through the system and they were not supplied to commissioners or regulators ...*[1]

  ... it remains striking that between October 2006 and March 2008, the most obvious local indicators did not reflect the true problems within the trust. No GP, clinician, MP or local politician suggested that they complained to the PCT about systemic poor standards of care at the trust ... this degree of silence in the face of catastrophic failing of care is unprecedented and remains surprising.[2]

1 PCT oral closing submissions T135.39
2 PCT oral closing submissions T135.35

- On behalf of the Healthcare Commission (HCC) Counsel submitted that:

  The deficiencies within this important element of clinical governance [audit] *... were not detected by the inspection team. But equally, they were not given a copy of this audit, despite its clear relevance to the issues under study. If the report had been shared with the inspectors they could have asked probing questions ...*[3]

- In its closing submissions Monitor asserted:

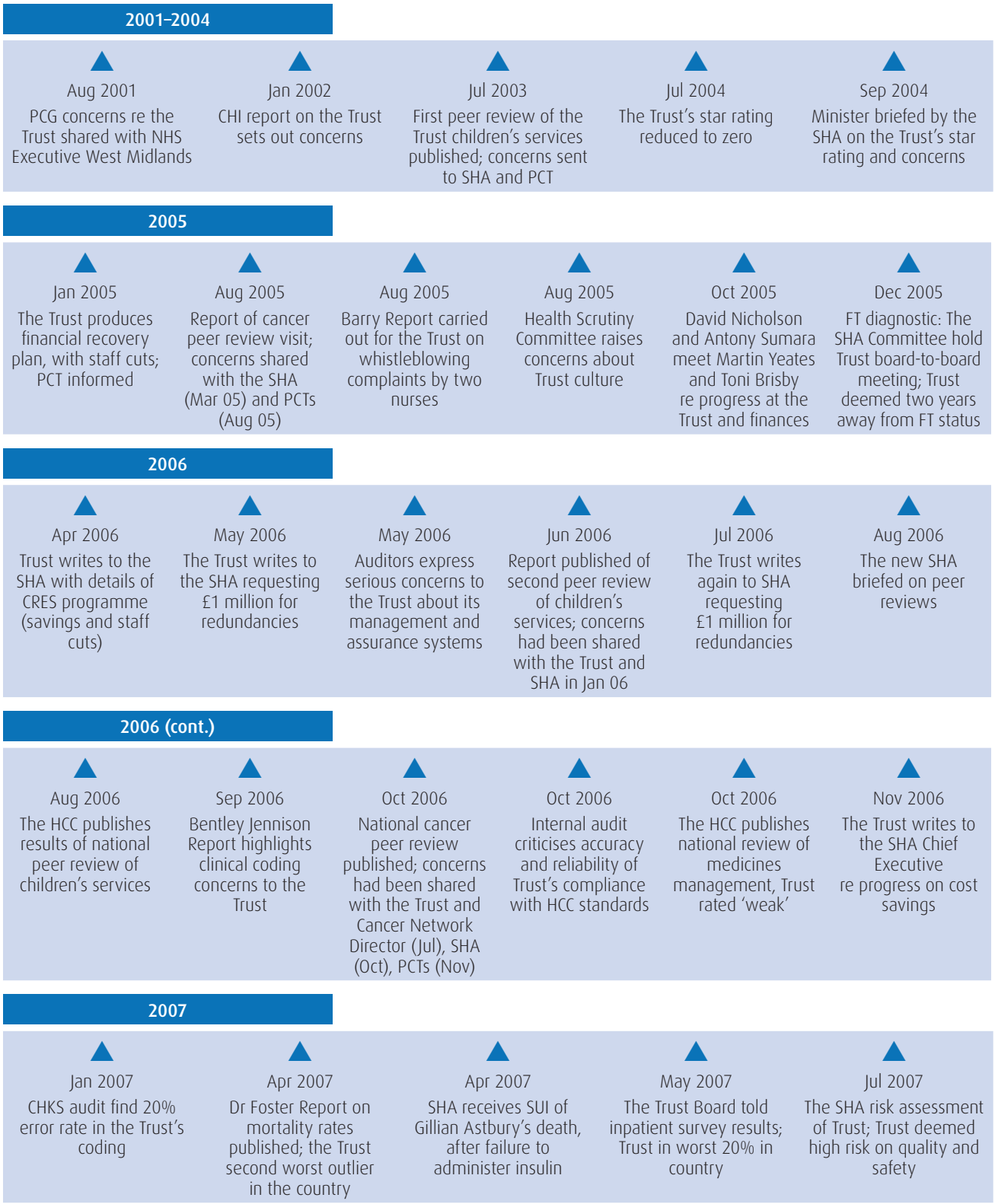
  Few stakeholders identified any concerns about the quality of care at the Trust (notwithstanding a 12 week period of consultation) at or about the time of its [FT] *authorisation.*[4]

  None of the clinicians brought any concerns to Monitor's attention ...[5]

1.2 This report will examine in subsequent chapters precisely what each organisation knew which might have been expected to give cause for concern or further enquiry, but this chapter will consider some of the more significant issues which were identified or identifiable throughout the period leading up to the publication of the HCC report. Figure 1 sets out a timeline showing the main events described in this chapter. The mortality alerts sent to the Trust during this period are set out in detail at Table 5.6 in *Chapter 5: Mortality statistics*. In summary, 12 alerts were sent to the Trust by the Dr Foster Unit and the HCC between April 2007 and December 2008. The resulting picture is one of a pattern of concerns which taken together, and in some cases even singly, showed that there were serious systemic issues at the Trust requiring a degree of urgent and effective attention which they were not receiving. This chapter does not include the history of mortality alerts and concerns and the reaction to them as they require a chapter to themselves. Relevant events in relation to mortality concerns are included in the timeline, from which it can be seen that the matters being considered here were occurring against the drumbeat of increasing anxiety about the mortality rates at this Trust. Events are dealt with roughly in chronological order, following through themes that appeared each year.

3 CLO000001594, *Healthcare Commission closing submissions*, p74
4 CLO000001074, *Monitor closing submissions*, pp52–53
5 CLO000001074, *Monitor closing submissions*, p56

Figure 1.1: Timeline of key warning signs



2007 (cont.)

Sep 2007
Helen Moss raises concerns about nurse staffing with the SHA

Oct 2007
The Trust solicitor's report on death of Mrs Astbury shows serious concerns re quality of care

Oct 2007
Nurse Donnelly lodges whistleblowing complaint re A&E

Oct 2007
Royal College of Surgeons report describes surgical department as dysfunctional

2008

Jan 2008
The HCC inform the SHA it is considering investigation into the Trust

1 Feb 2008
The Trust awarded FT status

5 Feb 2008
The HCC informs Monitor of its interest in the Trust and asks for any information

19 Mar 2008
The HCC launches investigation into the Trust

Mar 2008
The Trust Board receives report of skill mix review

Mar 2008
The Trust Board given 2007 inpatient survey results; the Trust among worst 20% on several points

2008 (cont.)

Apr 2008
The Trust report to the PCT sets out serious concerns re A&E

23 May 2008
The HCC writes to the Trust with concerns about A&E

May 2008
Dr Turner first raises concerns about A&E with the SHA Deanery

7 Jul 2008
The HCC writes to Trust re concerns about basic nursing care

Jul 2008
Audit Commission report finds inaccuracies in Trust coding

Jul 2008
The HPA raises concerns about handling of *C. difficile* cases by the Trust

2008 (cont.) and 2009

Sep 2008
The Trust receives report of external review of A&E by Heart of England NHS FT; confirms several deficiencies

1 Oct 2008
The PCT sends the Trust formal performance notice re A&E target; copied to Monitor

15 Oct 2008
The HCC writes to the Trust with concerns about unsafe care; copy also sent to the SHA, the PCT, Monitor and the DH

Oct 2008
Third peer review on children's services; concerns had been shared with the PCT (July) and the SHA (Oct)

4 Nov 2008
The PCT issues second performance notice to Trust

Mar 2009
The HPA peer review of *C. difficile* outbreak at Trust shows failure to institute effective measures

2001

Concerns of the Primary Care Group

1.3 As early as 2001 the Primary Care Group (PCG) expressed concerns about the management of the Trust, to the extent that it provided a paper to the then South Staffordshire Health Authority expressing the view that the then Chief Executive should be replaced.[6] Among the reasons for the dissatisfaction were:

- Lack of engagement and leadership of clinicians in the Trust;
- Lack of engagement with the whole health economy;
- Failure to implement agreements.

1.4 These concerns and the report were shared with the Director of Performance Improvement at the NHS Executive West Midlands in August 2001.[7] The report referred among other things to:

- A mis-allocation of resources which could have been directed to specialties experiencing "enormous pressures";
- The Trust was losing "good consultants";
- Interviews with key staff cited lack of management support, inadequate equipment, poor theatre management, over-reliance on agency nurses and waiting list initiatives implemented at short notice.

1.5 Through subsequent years and changes in Trust leadership it will be seen that comparable concerns have continued.

2001–2002

The Commission for Health Improvement report

1.6 This clinical governance review resulted from an inspection carried out between April and August 2001 and was published in January 2002.[8] The report identified serious cause for concern in a number of areas, including:

- Staffing levels, particularly in nursing and senior medical positions, were low – the Commission for Health Improvement (CHI) recommended an urgent skill mix review which was proposed to begin in September 2001;
- The quality of most clinical data was poor, largely due to poor IT;
- There was no patient involvement strategy and the Trust had not done a patient survey;

6 Price WS0000016117, para 57, WP/1 WS0000016136
7 WP/1 WS0000016136–51
8 HCC0016000108, *Report of a clinical governance review of Mid Staffordshire NHS Trust* (January 2002), Commission for Health Improvement

- While the Trust aspired to have an open learning culture it:

  was not strong enough to reassure staff that everyone reporting an incident would be treated the same way;[9]

- Staff morale was low and sickness absence was rising;
- Staff below corporate level believed that targets and control of finances took priority over clinical governance and their own morale;
- There were delays in accident and emergency (A&E) and a feeling among staff that they lacked management support;
- Patients on wards reported episodes of inappropriate attitude by staff and examples of this were observed by the reviewers;
- Poor standards of cleanliness were observed in some areas – a patient was recorded as commenting:

  Cleaning of the room was very poor. Occasionally it would just be the flick of a mop by the door. My locker and all the top surfaces hardly got a touch;[10]

- Staff were observed not following proper hygiene procedures;
- The extent to which clinical governance issues were discussed at the Board was unclear from the minutes; financial matters appeared to predominate.

1.7 On the positive side:

- Complaints handling was said to be good;
- The Trust was performing well on existing performance indicators and was significantly below comparable trusts for mortality within 30 days of surgery after emergency admission for a fractured hip. However, the data quality for these indicators was described as "mediocre" and therefore it was suggested that the results be treated with caution.

1.8 It was accepted by Mr Brereton – former Chair of the Shropshire and Staffordshire Strategic Health Authority (SaSSHA) – that if a board had no effective clinical governance then SaSSHA could not be sure that patients were being treated safely.[11] Professor Cumming, Chief Executive of SaSSHA's successor, the West Midlands Strategic Health Authority (WMSHA), at the time of his oral evidence to the Inquiry, thought that in retrospect this report showed that the staffing problems at the Trust were deep seated and of long standing:

9 HCC0016000115, *Report of a clincial governance review of Mid Staffordshire NHS Trust* (January 2002), Commission for Health Improvement, pvii
10 HCC0016000135, *Report of a clinical governance review of Mid Staffordshire NHS Trust* (January 2002), Commission for Health Improvement
11 Brereton T97.42–43

And I think ... that is the point I was making. I mean ... my belief, looking back retrospectively on this organisation, is that this is a hospital that has been short of nurses for a long time and it didn't suddenly – it potentially got slightly worse in the period we're talking about, but I think ... it's a deep-seated underlying problem that there had been for some time.[12]

2003

Children's service peer review report

1.9 In 2001 the West Midlands Regional Strategic Oversight Group for Specialised Services (SOGSS) commissioned the production of standards for the care of critically ill and injured children in the West Midlands.[13] The standards were prepared by a group of professional leaders in the field within the West Midlands, after extensive consultation. The first version of these was published in January 2002.[14] The standards covered:

- Support for critically ill children and their families;
- Reception of critically ill children;
- Paediatric high-dependency care and initiating paediatric intensive care;
- Retrieval and transfer of the most critically ill children;
- Organisation of care for critically ill children.

1.10 They sought to draw on published work and professional consensus, and aimed at describing a "reasonable level of care or clinical practice, rather than clinically proven fact", and claimed to express "a minimum acceptable standard of care".[15] Given that description, it might be of concern that the authors accepted that the standards would not be met in full:

It is also clear that the Standards as published will not be currently met by institutions undertaking acute paediatric care in the entirety, but it is intended that they form the benchmark against which service configuration can be developed for the improvement of paediatric care overall.[16]

1.11 Clearly an area addressing the needs of such a vulnerable group of patients was worthy of the most anxious attention by those commissioning the standards and the service, and by the SHA as overall performance manager of providers. The approach taken was to encourage providers to comply with the standards by supportive peer reviews, backed by reports circulated, not only to the provider concerned, but also to the commissioning group and the SHA.

12 Cumming T67.126–7
13 CJE/1 WS0000022938
14 CJE/1 WS0000022941
15 CJE/1 WS0000022947
16 CJE/1 WS0000022947

1.12 The SHA hosted a number of peer review exercises sponsored in the region by PCTs collectively. One of these was a review into children's services and was led by Jane Eminson; it took place on 20 May 2003. A draft report was sent to the Trust very quickly for comment, and, pending a response, Ms Eminson, the Peer Review Director, wrote to the Trust by a letter dated 29 May 2003, copied to the Director of the West Midlands Specialised Services Agency, notifying it that the draft report identified:

> *as immediate risks to clinical safety or clinical outcomes:*
>
> *There is no triage of children who arrive in A&E by their own transport. The visiting team considered that the moderately ill child may be at risk in this situation.*[17]

1.13 At the time such letters were not copied to the PCT direct as it was intended to allow the Trust to put its house in order before any potential intervention. It was hoped that by the time the report was published remedial action would already have been taken:

> *... hopefully the provider or the commissioner concerned will have dealt with what they can do, can then say "This is the report. We've dealt with this, this, and this and here is our action plan for dealing with that.*[18]

1.14 The letter may also have gone to the peer review steering group on which Mr Jon Cook sat, who was an officer of the Birmingham and the Black Country Strategic Health Authority (BBCSHA), which later became the WMSHA,[19] but the evidence before the Inquiry was not sufficient to establish whether Mr Cook transmitted information about the report or the letter to others at the SHA.[20]

1.15 The review report was published on 16 July 2003.[21] A number of positive points were noted, including the observation that:

> *The service has developed considerably over the last five years and the quality of the care provided has clearly improved over this time.*[22]

17 Eminson WS0000022922, para 25; CJE/3 WS0000023024
18 Eminson T96.148
19 Eminson WS0000023923, para 25
20 Ms Eminson in oral evidence suggested that Mr Cook's involvement would have been in 2006, ie after these events – see Eminson T96.95–6
21 CJE/2 WS0000023003
22 CJE/2 WS0000023021

1.16 However, the following were among the concerns reported:

- The standard requirement that all relevant medical staff in A&E should have appropriate, up-to-date resuscitation and high-dependency training was not met.[23]
- Contrary to the required standard, only one nurse in A&E had the relevant paediatric life support training and another was about to receive it. Support if required had to be called by the crash bleep.[24]
- There were no dedicated cubicles for children in A&E as required.[25]
- There was no end-tidal (exhaled) CO_2 monitoring on the paediatric ward.[26]
- There were no clear procedures in place for alerting the appropriate hospital team of the imminent arrival of a critically ill child, and, as mentioned above, no triage system for children arriving other than by ambulance.[27] There was no evidence of agreed protocols between A&E and paediatricians on matters such as admissions and treatment of major conditions.[28]
- High-dependency care was provided to some children, although not for extended periods of time. It was unclear to the peer review team where such care would be provided as they were given different views on this. They found that the arrangements for ensuring the necessary nursing support were not robust.[29]
- Concern was expressed to the team about incident reporting:

  Several members of staff expressed concerns about the system for feedback on critical incidents. The lack of confidence in this system appeared to be leading to forms not being filled in and separate systems being developed. Staff did not perceive a mechanism for ensuring a Trust-wide overview of incidents involving children or a mechanism for influencing other specialties who may be involved with the care of children;[30]

- Concerns were identified about surgical coordination:

  Surgeons are caring for children without the involvement of paediatric medical staff. There are proposals for a system of shared care but this has not yet been agreed or implemented.[31]

1.17 In spite of the positive points found, the concerns noted added up to a catalogue of worrying issues where the Trust was falling below the minimum standards required for children, particularly, but not exclusively, in A&E. These included matters such as deficient arrangements for the provision of emergency resuscitation and lack of coordination over the treatment of surgical patients. Even without the benefit of hindsight, these matters should have raised

23 CJE/2 WS0000023007
24 CJE/2 WS0000023008
25 CJE/2 WS0000023006
26 CJE/2 WS0000023009
27 CJE/2 WS0000023009
28 CJE/2 WS0000023010
29 CJE/2 WS0000023015
30 CJE/2 WS0000023020
31 CJE/2 WS0000023020

important questions about the performance of the management team which had allowed such matters, important to the safety of a group of vulnerable patients, to occur. Although a later edition of the same standards, published in 2004, was expressed in more aspirational terms, the matters of concern raised in 2002–2003 would have been considered as falling below acceptable standards at the time.[32]

1.18 The report was sent by a letter dated 24 July 2003 to the Trust, Rob Willoughby, Children's Lead at SaSSHA, and William Price, Chief Executive of South Western Staffordshire PCT (SWSPCT).[33] The letter suggested that Mr Willoughby would be in contact with the Trust to follow up the action taken on the concerns listed. Ms Eminson stated that an action plan was received by the peer review group, but it is not apparent that any further follow up occurred.[34]

2004

Follow-up of Commission for Health Improvement and children's service peer review reports of 2002–2003

1.19 Professor Ian Cumming was unaware of any indication that the CHI report issues had been followed up.[35] However, the evidence shows that some action was taken. In May 2002 the Trust produced a clinical governance development plan.[36] This was updated in December 2002.[37] This was in effect an action plan listing actions designed to address the issues raised by CHI. A report by Dr Paulette Myers, Deputy Director of Strategy and Head of Clinical Governance at SaSSHA, on CHI's findings was submitted to the Board of SaSSHA at its meeting on 18 March 2004 as part of an end-of-year (2003/04) review,[38] and this noted that the Trust had not submitted, as required, a clinical governance development plan for this year.[39] The concerns listed as requiring discussion with the Trust included:

- The Trust had submitted few serious untoward incidents (SUIs) during 2003–2004;
- Information was required on what progress was being made in implementing the children's service peer review recommendations;

32 The introduction to the standards, republished in 2004, stated: "The philosophy of the document is ... one that expresses an acceptable standard of care, which the Steering Group believes all institutions caring for acutely ill children should aim to achieve. It is also clear that the standards as published will not currently be met in their entirety by institutions undertaking acute paediatric care. They are intended as a benchmark towards which services should be working and which are achievable by all hospitals in due course ..."
33 Eminson WS0000022923, para 26; CJE/4 WS0000023026
34 Eminson WS0000022923, para 27
35 Cumming T67.44
36 SHA00000000065; IRC/21 WS0000017156; BJC/1 WS0000042041
37 SHA0001000403; IRC/21 WS0000017166
38 SHA0024000183; IRC20 WS0000017151
39 ESI00147839 SaSSHA Board minutes; SHA0024000184; IRC/20 WS0000017151; PM/3 WS0000037107

- Information was still required on whether the key issues in the CHI 2002 report had been addressed and:

  If not, what are the restraints in achieving this and when are these scheduled to be completed?[40]

1.20 The fact that she was recording them in 2004 indicated that they were still matters of concern.[41] In a note of the end-of-year (2003/04) review meeting between SaSSHA and the Trust, which Dr Myers recollected took place in June 2004, Dr Myers was recorded as saying that:

> *Based on previous evidence there was a fair degree of confidence that the structures and process for Clinical Governance within the Trust were robust ... it was noted that the Trust had not submitted a Clinical Governance development plan for 2003/04.*[42]

1.21 In her oral evidence Dr Myers explained what this meant about the reassurance SaSSHA would have felt about the issues at that time:

> *I think that says there was a fair degree of confidence. That's not a high degree of confidence, it's fair, and that would mean that there was patchy evidence ... there would have been some evidence to suggest they were putting systems in place, and some of that would have been progress on the CHI action plan. But the fact that obviously not everything had been completed and particularly the peer review report, meant that we could only say fair.*[43]

1.22 Jan Harry, the then Director of Nursing at the Trust, was recorded as stating that the development plan had been submitted late owing to timetabling issues. It was in fact this omission which contributed to the subsequent downgrading of the Trust's star rating status to zero.[44] She also stated with reference to the issues raised in the children's services peer review report that:

> *... some of the issues raised in the report had no resonance with her ...*[45]

1.23 Dr Myers considered that this showed a lack of insight, although in fairness she made the point that that was not the normal response of the Trust to expressions of concern.[46]

40 IRC/20 WS0000017153
41 Myers T100.57
42 SHA0001000340; PM/4 WS0000037114; Myers T100.57–59
43 Myers T100.59
44 Myers T100.60
45 PM/4 WS0000037114
46 Myers T100.61

1.24 Ms Harry was recorded as asserting that in relation to children's waiting times they were fast tracked "wherever possible", and that the availability of qualified children's nurses meant it was not always possible to have one on duty in A&E. She said a "self assessment" had been carried out that year and that an action plan had been set up.[47]

1.25 In further evidence to the Inquiry, Ms Harry explained that her firm recollection was that the report she was referring to as containing points which had "no resonance" was the cancer services peer review. The context of the remark as recorded in Dr Myers's contemporaneous note persuades me that it was referring to the children's service peer review. In that context Ms Harry's apparent rejection of at least part of its outcome does display a lack of insight as suggested by Dr Myers.

1.26 Mr Brereton told the Inquiry that the indications up to this point suggested concerns, but that there would have been an assumption that with appropriate leadership they were being addressed:

> *I don't believe we thought we were failing to follow-up. I believe we were slightly surprised that this was an organisation which, having generated an action plan and commitment, hadn't carried it out, because it is my experience that that is not usual. The NHS is full of really very able people who care about what they do and action plans, generally speaking, are delivered. I suspect that the view we took again was leadership issue, the board isn't ensuring that the undertakings they've given are being carried out, and the board needs refreshing ...*[48]
>
> *... I think one can only say that this report at the time clearly was not interpreted in the SHA as being a culture about to crack. It was interpreted as being a culture that needed support and better leadership and change. And I repeat, in the period through 2005 substantial change in that board took place.*[49]

Loss of star rating

1.27 In July 2004 the Trust star rating was reduced to zero. This would have been a development known to the SHA in advance and would naturally have been a cause for concern. Professor Cumming put it this way:

> *Q. But back in 2004, when the trust lost all of its stars that surely would have alerted somebody at the SHA to potential problems?*

47 PM/4 WS0000037114
48 Brereton T97.48
49 Brereton T97.49–50

A. The SHA would, of course, have known in advance of the star rating being published that – they may not have known exactly what was going to happen because we never completely knew the formula behind which the star rating was calculated ... But clearly, if a trust is failing its waiting targets for elective surgery, if a trust is not meeting its outpatient waiting targets, if a trust is not meeting cancer times and if a trust is not financially performing, those are all issues that the SHA would have known about well in advance of the star ratings actually coming out, and I would certainly have expected there to be performance conversations taking place.[50]

1.28 On 15 September 2004, the Minister of State John Hutton MP (now Lord Hutton) met with local MPs, prior to which he had been briefed by the SHA.[51] Following this meeting he wrote to Dr Tony Wright MP indicating that he had asked the SHA to keep him apprised of the matter. Following this meeting, the Minister was given a briefing[52] from Phil Taylor, Finance Director of SaSSHA, on the Trust and on its loss of a star rating, among other concerns. This stated that "inevitably" the SHA would be "working closely" with ("and actively managing") the Trust and other agencies to address the issues causing this to happen. The issues said to have caused the removal of the stars were:

- Breaches of the inpatient waiting standard, in the main said to be due to the implementation of a new patient administration system but also due to poor systems failing to identify this problem sufficiently early;
- Breaches of the outpatient waiting standard for similar reasons;
- Failure to achieve the cancer waiting standard;
- A financial deficit attributed to implementation of the new consultant contract.

Mr Taylor reported that a substantial proportion of the underperformance related to problems in the introduction of a new patient administration system which resulted in the trust losing track of waiting times. Subsequent performance was said to have improved.[53]

1.29 Actions being taken included a referral to the Modernisation Agency and performance management of the executive team. Confidentially, the Minister was informed that the competence and capability of the executive team were being reviewed. The Chair had resigned and as an interim measure an experienced SHA Board member was put in to assess the problems. The Minister was assured that:

The SHA will [following the preparation of a Trust improvement plan and an assessment of the abilities of the executive team] *ensure delivery against the Improvement Plan and all national standards and targets.*[54]

50 Cumming T67.48
51 DK/8 WS0000002841
52 SHA0002000188; PT/18 WS0005000603
53 PT/18 WS0005000603
54 SHA0002000189; PT/18 WS0005000604

1.30 At that stage, therefore, neither SaSSHA nor the DH, up to ministerial level, can have been in any doubt that there were potentially serious managerial issues, particularly in relation to finance, and record systems, at the Trust and that close supervision of its performance was necessary.

1.31 The measures which made up the star rating were not on the whole direct measurements of clinical performance and this system has been criticised for being a blunt tool for assessing trust performance. There has also been criticism of the imposition of targets, but they were the only quality measures available at this early stage in the development of measureable standards, and therefore it might have been expected that this level of deviation would have attracted serious concern, and it did. The "balanced scorecard" for the year 2003/04 had been superficially more encouraging. The Trust scored in the middle band for patient focus, and in the top band for clinical focus, based on the assessment by the NHS Litigation Authority for its Clinical Negligence Scheme for Trusts (CNST) rating.[55]

1.32 It cannot be suggested that no action was taken in response to this poor star rating. Much attention was paid to the Trust as a result. What does not seem to have occurred to anyone was that the deficiencies being identified could have implications for the safety of patients and the minimum standard of care to which they were entitled, or that management changes in themselves were no assurance that such implications had been or would be effectively addressed within an acceptable timescale. No suggestion was made to the Minister to this effect and in the absence of such advice he cannot be held responsible for not drawing out that concern for himself. It was not detected by the MPs, the meeting with whom was the occasion for the briefing note.

1.33 A "star recovery plan" was produced by the Trust in November 2004.[56] This analysed the reasons for the change. The Trust had significantly underperformed in relation to two out of nine key targets (outpatient and elective waiting times) in three months of 2003. Thereafter, the plan stated, an action plan resulted in those targets being met for the rest of the year. The Trust had also underachieved in two other targets (cancer two-week waiting times and financial balance). However, the Trust was said to have done well on the items in the "balanced scorecard", where it achieved an average or above average score on all but five of the 36 items. The items where the Trust had underachieved were stroke care (it had no acute stroke unit, but one was planned), complaints (the complaints department was now being managed directly by the Chief Executive), consultant appraisal (it was suggested that the recording process was not complete) and the waiting time issues referred to above.[57]

1.34 The SHA's reaction to this issue is considered in *Chapter 8: Performance management and the strategic health authorities*.

55 PT/1 WS000500450, *Trust Star Recovery Plan* (November 2004), Mid Staffordshire General Hospitals Trust, para 2.5
56 PT/1 WS000500447, *Trust Star Recovery Plan* (November 2004), Mid Staffordshire General Hospitals Trust
57 PT/1 WS00050048–50, *Trust Star Recovery Plan* (November 2004), Mid Staffordshire General Hospitals Trust

2005

Financial recovery plan

1.35 In January 2005 a financial recovery plan was produced. The financial "gap" was identified as being £7,032,000. In response, a plan was produced by the Trust which included a proposal to reduce the workforce by 180 whole-time equivalents (WTEs), of which 98 were to be part of an establishment review approved by the Board in January and a further 82 through a review to be completed by September. A vacancy scrutiny programme was instituted.[58]

1.36 This programme was the result of a requirement by SaSSHA, as part of the national financial recovery plan, that all organisations were to be brought into financial balance. There is evidence that the PCT was aware of this plan and was informed that most of the posts concerned were already vacant.[59]

1.37 These savings in staff costs were being made in an organisation that was already identified as having serious problems in delivering a service of adequate quality and complying with minimum standards. Yet no thought seems to have been given in any part of the system that was aware of the proposals as to the potential impact on patient safety and quality. A moment's thought ought to have provoked a question mark over the Trust's ability to provide a safe and effective service. There is no evidence that any effective questioning of this nature was undertaken. This is not to judge those responsible with hindsight, but by reference to common sense.

The national cancer service peer review

1.38 The Trust was part of the North West Midlands Cancer Network, which was part of a national scheme. A peer review visit took place on 23 and 24 March 2005 and a report published on 8 August the same year.[60] The review was of compliance with national standards for cancer services.

1.39 Although the report recognised that the Trust continued to provide patient-focused care of a high quality, it identified a number of concerns, including:[61]

- A shortage of oncologist support for the service within the Trust, in particular insufficient sessional time from visiting oncologists;
- A lack of shared protocols between consultants;
- No rapid referral system to oncologists, and one oncologist refused to accept faxed referrals;

58 SCC00050000038
59 Fisher WS0000042309; para 48
60 CJE/5 WS0000023028
61 CJE/5 WS0000023032

- A lack of administrative support, and coordinators;
- A lack of commitment to improving outcomes in accordance with the outcomes guidance;
- Although patients were in general very complimentary about the service, they:

  ... commented that they felt quite vulnerable when admitted to wards whose staff may not be familiar with their problems. This feeling of vulnerability is exacerbated at weekends and holiday times, when the staff absences and shortages are more noticeable to patients;[62]

- An immediate risk in the radiology service in what was described as the "excessive" workload of the consultant radiologists, leading to "potential for error and for the welfare of staff to suffer".[63]

1.40 A principal theme of concerns in each area of the service was the lack of staff to support it.

1.41 A report was published in August 2006 summarising the peer review visits to a number of organisations during 2005, including the one to the Trust mentioned above. The delay was due to the need to consolidate the results of the many reviews that took place nationally.[64] The delay should not have prevented action being taken by the Trust in 2005 as they would have been aware of the original report.[65] Although based on the same review, a number of points were made more forcefully:

6.2 Locality 2: Mid Staffordshire General Hospitals NHS Trust

6.2.1 Locality summary

It is disappointing that several of these themes were also apparent in 2001 and have not yet been resolved.

Concerns

- *Shortage of oncologist support to cancer services within the Trust*
- *Four of the 7 MDTs* [multi-disciplinary teams] *reviewed had no or insufficient oncologist support. For two MDTs this was considered to be an immediate risk to clinical safety or clinical outcomes because of the lack of agreed referral guidelines for oncological opinion.*[66]

62 CJE/5 WS0000023034
63 CJE/5 WS0000023040
64 Eminson WS0000022925, para 34
65 Eminson WS0000022925, para 34
66 CJE/6 WS0000023121

1.42 The concerns described above were repeated in relation to palliative care. It was observed that:

> *Nurse staffing (1.6 wte) is insufficient for a hospital of this size. It would be reasonable to expect at least 2 WTE for this workload. As a result there is no palliative care team input to the lung or upper GI MDTs.*
>
> *The team does not appear to be effectively linked to the network palliative care group and several of the network related measures have not yet been met ...*
>
> *... The team does not appear well integrated to Trust-wide decision-making arrangements.*[67]

1.43 Ms Eminson, commenting on the report, remarked that the Trust seemed to have less insight than others in the region:

> *... there was not always the same degree of insight into their problems as there was in other organisations. The peer review team worked with the clinicians in the department being reviewed. In 2001, we did a comparison between the results of the peer review visits and the self assessments across the trusts in the Midlands. The Trust had the biggest gap between its self assessment and the results of the peer review. The Trust saw itself as achieving more than other people believed that it did to an extent greater than other trusts in the West Midlands. Until recently, one of the other characteristics of the Trust which we saw as a peer review team was that it did not accept the findings of the reviews as readily as other trusts. As a result the reports may have underestimated our concerns about the Trust because we were trying to produce a final report which was a fair reflection of the reviewers' findings and acceptable to the Trust. The focus of the Trust seemed to be on getting a "yes" rather than looking deeper at the services being provided and the concerns that we were raising.*[68]

1.44 The immediate concerns expressed in the 2005 report were communicated to the Trust in a letter to the Chief Executive Officer (CEO) dated 30 March 2005.[69] The letter was copied to, among others, the cancer lead at BBCSHA, who would have been known to the Trust. The final report of the review was sent to the Trust in a letter of 9 August 2005. Copies were sent at the same time to the CEOs of the Cannock and South Western PCT. The Trust was warned that the HCC would be considering whether an overall assessment of the cancer services should be included in its overall assessment of the Trust's services, although it had been agreed that this would not be the case for visits undertaken in 2005. A right of appeal was offered against adverse findings.

67 CJE/6 WS0000023129
68 Eminson WS0000022924, para 30
69 CJE/7 WS0000023163

1.45 This review made clear that there were grounds for concern about the level of staffing at the Trust and the impact this was having on the quality of care being offered in a sensitive area. It was sufficient to raise questions about the management capability and pointed to a need for urgent corrective action for the protection of patients.

The Barry Report

1.46 In August 2005 Robina Barry, a clinical psychologist, who was Director of Psychological Therapies for South Staffordshire Healthcare NHS Trust, produced a report following an investigation conducted at the request of John Newsham, Acting Chief Executive at the Trust, into a whistleblowing complaint by two nurses about nursing conduct on Ward 3, a trauma ward.[70] The copy of the report seen by the Inquiry is addressed in manuscript to Mrs Brisby (the Chair of the Trust) and Mr Newsham.

1.47 The report was extremely damaging, more than justifying the complaints that had been made. The report noted that:

> *Ward 3 is known by reputation to have had long-standing problems (many years) in standards of patient care which are generally put down to the heavy workload and poor staffing.*[71]

1.48 Matters of concern accepted in the report included:

- Recording medication as having been given before it was;
- An incident of failing to notify relatives of a death;
- Aggressive, inappropriate and inefficient management style on the part of the ward sister. This was said to reflect a system failure rather than the individual conduct of any one person. However, Mr Newsham accepted that the allegation amounted to one of bullying;[72]
- Poor nursing care. The report found that there was a:

  ... lack of systematic provision of nursing care. Staff talk about poor staffing levels, disproportionate use of bank staff and difficulty in recruiting and retaining staff.[73]

- Lack of appraisals and professional support. The report noted that the Trust did not have in place a system for auditing or monitoring appraisals, thus giving staff the message that it was not important;
- A lack of ward meetings;
- A lack of systems to ensure good practice and to identify poor practice;

70 CURE0001000001; Brisby WS0008000073, para 274–6; TB/77 WS00070000796; Newsham WS0000011920, T60.10; para 12; JN/1 WS0000011961
71 CURE0001000004
72 Newsham T60.14
73 CURE0001000012

- Deficient note keeping. The report accepted that there was evidence of a culture of poor record keeping. For example, it was found that basic information about continence and washing was missing from notes examined. It appeared that this level of information was not handed over at handovers, resulting in important aspects of care being missed;
- Inadequate handovers;
- Failures to record pressure ulcers. An audit of just over a year's worth of returns on incidences of pressure ulcers found that only two out of a possible 53 returns had been made. While it was the responsibility of the ward manager to make the returns, the report recognised that this evidenced a systemic failure as the non-compliance with this policy should have been picked up and acted on. Of perhaps even greater concern was the finding that the clinical nurse specialist had been called to the ward on occasions to see patients whose wounds had deteriorated because her advice had not been followed in matters as simple as the daily changing of dressings. It appeared that:

  this advice is often not passed on, or is ignored by some staff.[74]

- A failure to change dressings. The report found that in notes looked at there was no evidence that dressing care was recorded in care pathways or plans. Other wards had charts for dressings and turning frequency. In this ward handovers did not appear to include information on what patients' nursing needs were. What was necessary was left to each nurse's judgement;
- A possibility that incident reporting was discouraged. The investigators received varying reports from staff about this but they agreed that feedback when incident reports were filed was rare;
- Poor governance arrangements:

  The investigation has highlighted poor governance arrangements across the Directorate and Trust. The clinical governance plan highlights record keeping and appraisal as priority areas, and talks about auditing areas of clinical concern. Yet nobody at Directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care needs are met. Nobody acted upon the knowledge that Ward 3 was failing to submit pressure ulcer forms or that there were concerns about the levels of pressure ulcers including several public complaints about pressure ulcers or nursing care. There appears to be a lack of commitment at the highest level in the Trust to tackle these problems.[75]

1.49 In a later communication to Cure the NHS (CURE), Ms Barry said that she had thought at the time that there had been a "closing of the ranks" among staff which limited the evidence she was able to act on.[76] In a letter to the Staffordshire Newsletter of 25 March 2009 she reported that the staff who had made the complaints which led to her investigation had been suspended pending the Inquiry and were so traumatised that they had since left the Trust to

74 CURE0001000010
75 CURE0001000014
76 CURE00330003803

work elsewhere.[77] Clearly if her report had been discussed with her at the time she could have expanded on it and perhaps assisted in addressing the issues which had been raised. Yet she heard nothing further from the Trust after submitting her report, apart from a note of thanks.

1.50 It was difficult to establish precisely what happened to this report. Mr Newsham accepted he read the report when he received it,[78] and claimed that he handed it to Mr Yeates who was appointed at around this time.[79] He believed that Mr Yeates took this report very seriously,[80] but there does not appear to have been any follow up. Mr Newsham told the Inquiry that he was sure he would have discussed this in the meetings he had with Mr Yeates and he saw changes taking place in the governance arrangements.[81] However he admitted that the report was not discussed by the Board.[82] Mr Newsham's response in evidence to what the report meant was little short of supine. He told the Inquiry:

> *The complaints in 2005 in relation to Ward 3 did not highlight to me that there were any wider concerns about the general level of nursing care at the Trust. A few months before the whistle was blown in 2005, the functionality of Ward 3 had changed from an elective orthopaedic/trauma ward to a more medical based ward, and this presented different care requirements and different problems. There was also a high staff turnover on Ward 3, including senior ward management, and therefore, the issues they were experiencing did not raise any wider concerns.*[83]

1.51 This is difficult to accept on any reading of the report. For example, it included the following conclusion:

> *The investigation has found evidence of poor leadership and management and of poor nursing care on Ward 3 ... There is a strong view on the Ward that failings are due to the poor staffing levels and therefore excusable. The culture on the ward appears to allow for support of this view ... Nobody at directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care needs are met ... There appears to be a lack of commitment at the highest level in the Trust to tackle these problems.*[84]

1.52 Regrettably, this Inquiry has to conclude that Mr Newsham's response rather proved this point. While his primary responsibility was as Director of Finance, as a Board member he had a

77 CURE00330003805
78 Newsham T60.12
79 Newsham WS0000011921, para 16
80 Newsham T60.24–5
81 Newsham T60.27
82 Newsham T60.28
83 Newsham WS0000011921–2, para 18
84 JN/1 WS0000011974

responsibility to ensure that the report he had commissioned was acted on. The Inquiry is satisfied on the evidence that he failed in that responsibility. It is clear that no effective action was taken on the serious findings of this report. There was merely a general assumption that the changes being made in governance would address such issues.

1.53 Although Jan Harry may have had discussions about the complaint and what should be done about investigating it, in her witness statement she told the Inquiry she could not recollect seeing the report itself.[85] The report was not made known to her successor, Dr Helen Moss, when she arrived at the Trust over a year later in 2006.[86] It might have helped her understand the nature of the problems she had to deal with, how longstanding they were, and the urgency of the need to rectify staffing deficiencies.

1.54 Mrs Brisby who did see the report and accepted that it raised serious concerns,[87] did not consider it was the role of herself or the Board to become involved, as the issues were "operational":

> *What seemed very clear to me at the time – and still does – is that these are operational issues. In other words, they're matters for the executives and others to deal with. The board's role is to make sure that the governance arrangements are right so that this sort of thing actually gets picked up properly by the board processes ... John Newsham was acting chief executive at the time. He and I discussed it. It seemed very clear to me that the job of the chair was to make sure that the governance processes were robust enough to make sure that issues like this would actually come to the board in an appropriate form, not in the operational detail but in a form that meant the board could actually address it properly.*

1.55 She did not accept it was the duty of the Board not only to put in place governance arrangements but to ensure that something was actually done about it. Indeed she was adamant about this:

> *THE CHAIRMAN: ... if you see something like this happening and your reaction is, it's the chief executive's job to deal with it, why the public and the patients should consider that's a sufficient reaction?*
>
> *A. I think it's the only sensible reaction. In this case what we did was to appoint a chief executive, and over a period of time an entire new executive team revised all the governance arrangements, as it happened through the foundation trust process, because that seemed a helpful way of doing it, so that between this period, 2005, which was when I was still relatively new to the trust, and 2009, when I left, I would argue there*

85 Harry WS0000010712, para 50
86 Moss T62.8
87 Brisby T129.30

was a really dramatic change, and I reference a document in my statement, produced by Stephen Moss ... where he lists the achievements of the trust in the final year of my chairmanship. I also think it's probably worth saying that it takes a long time to turn a big organisation round, and I'm not just talking about the health service, which is – tends to be cumbersome anyway but any organisation takes a long time to turn round. And actually, I think if people are clear about their roles and do what they need to do, then there's a chance of doing it. If they're not clear about their roles, then I think that way chaos lies.[88]

1.56 The report of the first inquiry concluded that the Board under Mrs Brisby's chairmanship resorted to a distinction between strategic and operational issues which led them not to grapple with really important matters. Her failure to bring this report to the Board's attention or to pursue with Mr Yeates what he was doing are further examples of what I regard to be a dangerous abrogation of directors' fundamental duty to protect the safety of those who come to the Trust for care and treatment. Her reference to changes in governance systems misses the point entirely.

1.57 While the Inquiry is satisfied that Mr Yeates received a copy of this report, it has no evidence about what, if anything, he did about it. For the reasons explained in the Introduction it was not possible to examine him, and this was not an area he covered in his statement. Therefore, it is not possible to make any observations about his management of the issue.

1.58 This report foreshadowed the type of problem which was eventually brought to light four years later in the HCC report. While it may have reached Mr Yeates, and have been known to Mrs Brisby and Mr Newsham, it was not drawn to the Board's attention or disclosed to any external agency. Had it been, there is at least the possibility that more effective action would have followed. Mr Newsham accepted that had the report been shared with the PCT it was possible that some action would have followed.[89] It raises a serious question about what obligation there should be to disseminate this sort of information to ensure that action is taken on it.

Concerns expressed at Staffordshire Health Scrutiny Committee

1.59 At a meeting on 17 August 2005 of the Staffordshire Health Scrutiny Committee (SHSC), Councillor Colin Wilkinson expressed concerns that staff at the Trust "don't feel able to be open and honest with management about their concerns". The feeling was also expressed at the meeting that members were not being given the full picture about the changes that were being proposed.[90] Councillor Wilkinson was a Borough Councillor whose views were thought to be of particular weight because he had been the Director of Nursing at the hospital up

88 Brisby T129.33
89 Newsham T60.31
90 SCC00050000215–6

until 2000.[91] These concerns were conveyed by Councillor Susan Woodward, Chair of the Committee, in a letter the following day to Mrs Brisby and Mr Yeates. Mr Yeates had taken over very recently as Chief Executive.[92] The letter, in effect, conveyed concern from members that they were not being given a full and accurate picture of the changes proposed by the Trust as part of its financial recovery plan. Councillor Wilkinson in particular had raised several issues about the Trust's plans and the assurances given about the impact on patient care. This followed on from previously expressed concerns that the Trust did not undertake adequate consultation about changes,[93] which will be explored in more detail in *Chapter 6: Patient and public local involvement and scrutiny*.

1.60 Mr Yeates wrote to Councillor Woodward on 30 August 2005,[94] addressing the concerns raised. He accepted that there may have been a lack of appropriate communication with the committee in the past and undertook to remedy this. He sought to address Councillor Wilkinson's report of staff concerns:

> *I believe that a number of my team, and I personally, have addressed some of the concerns being raised by staff referred to by Councillor Wilkinson. I am confident that the staff I have met and spoken to do believe they have the opportunity to discuss their current concerns, and are being supported through the process of change that we have now put in place.*

1.61 Mr Yeates and Ms Harry attended a meeting of the SHSC on 28 September 2005 and gave a detailed presentation about proposed changes.[95] They were subjected to detailed questioning about various aspects of this, and the committee concluded that Mr Yeates was committed to "bringing about a sea change in the way they engaged with the local community." However, the issue of the staff concerns does not appear to have been pursued.

1.62 A report that staff felt unable to raise concerns was a concerning indication of the unhealthy culture which was persisting when identified by the HCC. If it had substance it revealed a state of affairs that required remedying by strong leadership. Mr Yeates's letter, quoted above, while reassuring in the sense that he recognised the issue, was hardly sufficient to provide reassurance that it had been successfully tackled. There does not seem to have been any identification of what the issues were on which the staff felt they were not being heard. In fairness to Mr Yeates he was, at that point, very new to the Trust and to the post of Chief Executive, and was doubtless on a steep learning curve.

1.63 This evidence also contradicts the assertion often heard at this Inquiry that the staff were silent about concerns.

91 Jones T36.169
92 SCC00050000215
93 Eagland T41.45–46; Thompson T35.100
94 SCC00060000009
95 SCC00060000034

General awareness of leadership issues

1.64 In his statement to the Inquiry Mr Yeates said that before his appointment as Interim Chief Executive Officer he had been aware of many issues affecting the Trust, including its deficit, a lack of governance, lack of managerial structures and a perception that the Trust was "introverted".[96] These issues were clearly also ones of which SaSSHA was aware. That was why the departure of David O'Neill as Chief Executive and the appointment of Mr Yeates had been engineered. Indeed on 27 October 2005 Antony Sumara, then Managing Director of SaSSHA, and David Nicholson, then Interim Chief Executive of SaSSHA (in addition to his other roles of Interim Chief Executive of the WMSHA and BBCSHA), met Mr Yeates and Mrs Brisby to review their progress in making changes. It was noted that a financial recovery plan was in place and that the Trust was expected to break even in 2005/06.[97] Various steps intended to bring this about were listed, including a reduction in the workforce and a reconfiguration of the surgical wards. As we now know, both these changes contributed to the poor care delivered in the period which followed. No detailed scrutiny of the possible impact of such changes on patient care seems to have been conducted by SaSSHA. Mr Yeates says that, at the time, he was aware that there were "huge organisational and cultural issues" but he was confident they could be addressed "over time".[98]

1.65 David Nicholson was Interim Chief Executive of SaSSHA, which was the SHA responsible for the Trust. He was in this role at the time that the Trust had been suffering from these leadership problems.[99] He was also aware, even before he met Mr Yeates, having been told by him, that there were problems at the Trust "engaging the clinicians in the work of the Trust". He recognised this was an important problem:

> *He was saying that one of his difficulties was getting the clinicians engaged in the work of the trust. So I knew that before I came to that meeting, and it is significant. It's something which is essential for an organisation to take any kind of change forward, for that to happen. Certainly in my experience of running hospitals over many years was that it was vital.*[100]

1.66 Therefore, senior officers within SaSSHA knew that the Trust had suffered long-standing leadership problems, organisational and cultural issues, that the clinical staff were disengaged, and that there were serious financial challenges requiring the Trust to consider workforce reductions.

1.67 As Sir David Nicholson accepted, the performance management system at the time was not focused on, or sensitive to, issues of quality. If patient safety had been considered, it ought to

96 Yeates WS0000074923, paras 9–10
97 Yeates MY/1 WS0000074973–4; DN/17 WS0000068177–186
98 Yeates WS0000074924, para 11
99 Nicholson T127.85
100 Nicholson T127.89

have been apparent that the Trust was, at the very least, vulnerable to these issues resulting in a reduction of the standard of care to an unacceptable level. It ought also to have been apparent that even with competent leadership it could take a significant length of time to remedy these problems, particularly in a time of financial stringency.

The Foundation Trust diagnostic

1.68 In October 2005 the Trust was subjected to the diagnostic process being conducted nationally to establish what needed to be done and over what timescale to enable NHS trusts to become Foundation Trusts (FTs). The process is described in more detail in *Chapter 4: The foundation trust authorisation process*. Members of the diagnostic team attended a Trust Board meeting on 1 December 2005.[101] Among the items discussed were:

- The Trust's financial recovery plan.[102] Concern was expressed that there had been a £100,000 deterioration in the financial position in the previous month;
- The clinical floors project.[103] Ms Harry gave a presentation on the Short Stay Surgical Unit Project which was said to be part of a programme for the organisation of clinical care to improve the patient's "journey" across the Trust. It was reported at the meeting that this project was to be in two phases: firstly, the opening of the Emergency Admissions Unit (EAU) and a Transitional Observation and Discharge Unit in September 2004, and, secondly, a reconfiguration of the clinical floors, which was to be "looked at", and the opening of a pre-discharge unit in August 2005. It was anticipated that the first phase would be completed over Easter 2006, and the whole programme by June 2006.

  Ms Harry was recorded as confirming that:

  ... these changes would reduce the patient journey and that the more complex cases would go direct to the specialist beds. A sensitivity analysis would be undertaken, and the qualitative issues would also be considered. It was noted that surgical teams and senior nurse colleagues had been involved during the planning process, and the support of all concerned during the implementation process was important.[104]

  The Board agreed to support the continued implementation of the Clinical Floors Programme.

  Ms Harry told the Inquiry that, under this project, there were programme boards which were attended by representatives of the SHA and the PCT. Clinicians also attended, some supported the project, others were neutral:

101 CURE00330000457, Minutes of the Trust Board meeting (1 December 2005)
102 CURE00330000458, Minutes of the Trust Board meeting (1 December 2005)
103 CURE00330000458–9, Minutes of the Trust Board meeting (1 December 2005)
104 CURE00330000458–9, Minutes of the Trust Board meeting (1 December 2005)

Some consultants did not like the EAU; however one would have to ask them to explain their reasoning. In organisations, people go a long way to maintain the status quo and put an effort into stopping things happening. There was scepticism to start with about EAU. We would always get people who would stand on the sidelines and be critical.[105]

While there was mention of staff involvement and "support", it might have struck an outside observer as odd that the Board was prepared, at this meeting, to resolve to support the continued implementation of such a significant project when there was no evidence presented to them of the level of professional staff support, particularly as quality issues were yet to be considered.

In fairness to Ms Harry it must be pointed out that she had left the Trust before the full implementation of this project, and that it is impossible to tell whether the final form of the project would have been the same had she remained – she told the Inquiry that the clinical floors, as actually implemented, were not what she envisaged (see below). However, it remains the position that the Board was presented with little more than assurances that staff had been or would be consulted, and it does not appear that any great weight was accorded to concerns raised by staff. While Ms Harry may question the reasoning of any staff objections, there is little contemporaneous evidence of the reasons of either herself or the Board for apparently discounting them.

The same can be said of the next Board meeting on 12 January 2006.[106] Ms Harry presented a business outline case for the surgical floor, including a Short Stay Unit and options for implementation. The floor was to incorporate pre-assessment, day surgery, short stay medical and surgical beds, emergency surgical and trauma beds, and a Post-Surgery Unit. She:

highlighted the significant staff involvement throughout the planning stages of this project, with weekly Programme Board meetings and contribution from implementation groups, including Directorate Managers and Ward Managers.[107]

The model was said to have been tested and was feasible; the need to be aware of infection control risks was recognised. Ms Harry "confirmed" to the meeting that the appropriate skills and competencies were already held within the existing staff establishment.[108] However, staff from Ward 14 were present at the meeting and expressed staff and patient concerns, including infection control, privacy and dignity in mixed sex

105 Harry WS0000010706–707, paras 30–31, 36
106 CURE0036000080, Minutes of the Trust Board meeting (12 January 2006)
107 CURE0036000080, Minutes of the Trust Board meeting (12 January 2006)
108 In contrast, Ms Harry told the Inquiry in her written evidence on the clinical floors project that, with regard to the nursing skill base at the Trust, she had "not quite reached the point where *[sic]* we needed by the time I left." Her expectation had been, she said, that the Trust would have continued to build up nursing skills and expertise so that cohorts of skilled staff could be allocated to the floors in two or three years time. She denied that the floors actually put in place were part of her plans. Harry WS0000010704, para 23

ward areas, the mix of specialties, and the possibility of medical patients being temporarily placed in these beds. Ms Harry thanked the staff for their input. She "emphasised" that there had already been "heavy input" from staff in the production of the business case and that staff and patients would be involved at all stages of establishment of the operational policy for this area. The Board agreed to support the option proposed. The impression is therefore that the claim of staff involvement and, by implication, support, was not evidence based. As stated in the first inquiry report, there is no documentary evidence known to the Inquiry of a risk assessment in relation to these proposed changes:

- Performance: here it was noted at the Board meeting of 1 December 2005 that:

  Issues had been identified within the Acute Hospital Portfolio and Data Quality work and it was noted that the Trust had been slow to respond to issues raised within the Theatres Management Review. However, assurances have now been received that matters will be addressed.[109]

1.69 The assessment of the diagnostic team was unfavourable. It was anticipated that it would take the Trust more than two years to be ready for FT status. The findings contained a number of matters of serious concern:

- The overall conclusion was that:

  Service strategy not agreed or costed, although development was in place. Significant gaps in internal controls to manage operations and finances to attend rapid progression to FT status;[110]

- A "lack of robustness" was identified in budget-setting and cost improvement delivery processes;
- "considerable improvement" in performance was required before an application could succeed, given a 1 star performance due to underachievement on cancer and finance measures;
- It was thought that the:

  Trust's future depends on establishing a robust service model. This is currently not in place, and therefore cannot be agreed or costed;[111]

- There was inadequate risk assessment:

  Risks are not adequately considered as part of the strategy development and decision-making processes;

- Information provided to the board was described as "weak" and there was an insufficient focus on performance;

109 CURE00330000460, Minutes of the Trust Board meeting (1 December 2005)
110 TRU0005000008, *Foundation Trust Diagnostic* (Dec 2005) the Trust, p4
111 TRU0005000009, *Foundation Trust Diagnostic* (Dec 2005) the Trust, p5

- There was no system of integrated governance, alignment of strategic and operational risks in board reporting.

1.70 This view was confirmed following the board-to-board challenge which took place on 22 December 2005. It was conducted by David Nicholson and Antony Sumara. Sir David Nicholson in evidence recollected having concerns at the meeting including that:[112]

- Not one Board member had thought about what to do with the Cannock site;
- The Board did not appear to have a strategy for the clinical direction of the organisation and he could not see any clinical engagement to drive a specific strategy.[113] However, he accepted that this had been difficult in the absence of a permanent appointment as CEO;[114]
- He was struck by the lack of local connections with other organisations.

1.71 Sir David stated that there was no discussion about the proposed workforce reductions. On looking now at what various papers said about the proposal, he did not think they would have rung alarm bells. The proposed reductions in posts seemed to him to be consistent with the proposed reduction in beds.[115] He felt his directors of Nursing and Workforce would have been helping support and challenge the Trust in advance of this meeting and would have raised any concerns about workforce issues if he had had them.[116]

1.72 Mrs Brisby agreed with Mr Sumara's description of the Board's presentation as being:

> *flamboyant although it did not appear to have much substance behind it;*[117]

1.73 She herself described the Board's performance as:

> *... dismal. Our presentation was vague, aspirational and did not show a proper understanding of financial risk assessment. It was clear at this meeting we still had a long way to go to get to the standard needed for Foundation Trust status.*[118]

1.74 The diagnostic team confirmed their earlier pessimistic view of the Trust's current position. In the letter to the Trust summing up the conclusions of the diagnostic team, David Nicholson gave the opinion that the Trust was at least two years away from being ready for FT status. Among the reasons given were doubts about the ability of the Trust to deliver recurrent cost

112 Nicholson WS0000067673, paras 138–139
113 Nicholson T127.93–95
114 Nicholson T127.95–96
115 Nicholson WS0000067675, para 145; Nicholson T127.100
116 Nicholson WS000006767, para 145
117 Brisby WS0008000035, para 136
118 Brisby WS0008000034, para 132

improvements at about 5% of turnover year on year, and the need for better governance in view of the gaps in control and accountability.[119]

1.75 While the FT process of assessment was, it is now accepted, largely focused on financial rather than quality issues, the concerns that were made apparent by it had potential implications for the standard of care delivered. As we shall see, the senior leadership of the SHA were aware of the diagnostic findings, and yet did not look at whether a Trust with such problems was actually delivering safe and acceptable care. In failing to make such a link, it may be that they reacted as any other senior NHS manager or leader would have done at the time. If that is so, it is of course a sad commentary on the collective state of mind of the leadership. What it amounts to is a failure to think first, foremost and constantly of the effect on patients of what was done or not done. Further, there was no sense of urgency evinced by the SHA leadership with regard to the need for the newly installed management to make and evidence significant improvements. They took reassurance from the appointment of a new leadership team and their apparent readiness to implement change.

1.76 During the course of the financial year 2005/06, the DH commissioned McKinsey to review the cost improvement plans of all trusts in the country. In relation to the Trust, this highlighted various risks including that there was a high risk to the delivery of its plan, when assessed against historic benchmarks. It recommended a large number of actions.[120] While the report was focused on financial issues, and noted that the Trust had action plans in place to address them, this finding tends to confirm that the Trust was under significant pressure and that the implications for the safety and quality of the service provided needed consideration.

2006

Care of critically ill and critically injured children's review

1.77 In January 2006 the Care of Critically Ill and Critically Injured Children's Peer Review Group inspected the Trust. As in 2003 (see above) it found cause for serious concern.

1.78 The findings can be seen in the final report, which was produced in June 2006.[121] A letter accompanying the final report shows that it was sent to the Trust and suggests that it was copied to William Price of SWSPCT and Jean-Pierre Parsons of Cannock Chase PCT (CCPCT).[122] It noted the following, among other findings:

- The Trust's compliance with the relevant standards was only 51.4%. A&E compliance was a mere 40%, the paediatric ward was 55.6%, and there was 43.8% compliance in paediatric

119 TRU0005000047, Letter from David Nicholson to Toni Brisby (6 January 2006)
120 Nicholson WS0000067680, para 160; DN/25 WS0000068312
121 SHA0023000146, Report of the peer review visit to Mid Staffordshire General Hospitals NHS Trust (June 2006), SHA
122 SHA0041000468–9, Letter to Martin Yeates regarding the outcome of the peer review (June 2006), SHA

anaesthesia. A total of 52 core standards (out of a total of 143) were found not to be met;[123]

- A number of "immediate risks" were identified, including:
  - Low levels of medical and other staff trained in paediatric life support. In A&E "for much of the day there will therefore be no one within the department with training in paediatric life support." There was no one on duty in the paediatric ward with the relevant training at night;
  - The absence of a formally agreed protocol for resuscitation, stabilisation, maintenance and transfer of critically ill children;
  - There was "insufficient senior medical cover within A&E" and insufficient middle grade cover;
  - There were insufficient nursing staff in A&E;
  - No nurse was available to triage patients who "may wait for up to two hours having been seen only by the receptionist";
- Further, lower-level concerns noted included:
  - A&E staff were "not aware of arrangements for feedback from critical incidents and do not appear to be involved in learning from incidents that have occurred";
  - Protocols for resuscitation, stabilisation, maintenance and transfer of critically ill children in the A&E department were not in a format suitable for use in emergencies;
  - Some anaesthetists on the emergency rota did not have regular involvement in the care of children and might not be maintaining their skills in that area;
  - Staff with the appropriate training were not always available in theatre and recovery areas.

1.79 Although some of this non-compliance might arguably be overlooked as the standards were to some extent developmental,[124] those identifying fundamental staffing issues and lack of life support training and clear policies should have been seen as signs of serious deficiencies in leadership, management and governance. Staffing issues had been identified in the cancer peer review previously and therefore appeared to be continuing, albeit in a different area. The matters identified as "immediate risks" should have been identified and acted on by all concerned as matters giving rise to serious risks to the safety of a vulnerable patient group.

1.80 The concerns were apparent and shared with the Trust long before the report was finalised. Ms Eminson told the Inquiry that at this time the peer review group retained responsibility for following up findings until the final report was prepared, when it would be passed to the PCT.

123 The core standards referred to here are not the HCC core standards, but those specified in the *Standards for the Care of Critically Ill and Injured Children in the West Midlands (Version 2)* (SHA0023000148–151). These were developed by a specialist multi disciplinary group of the West Midlands Specialised Services Commissioning Group after consultation and published in May 2004. This document described the standards as "being written as the result of the consensus view of the Steering Group and constitute a reasonable level of care or clinical practice, rather than clinically proven fact."

124 SHA0023000148–151, *Standards for the Care of Critically Ill and Injured Children in the West Midlands (Version 2)* (11 January 2006), Peer Review Team

Therefore, she would expect to ask for and see the action plan prepared by a trust in response to such a report but not oversee its implementation.[125] She was asked why that was so:

> *Q. And why was that? Was that a matter of resources or a different kind of policy decision?*
>
> *A. I think in general, I work on the basis that if I say I'm going to do something, I do it. So I think we trusted, that if there was a reasonable action plan, if they said – so long as we checked that they had understood, that then we trusted that they would do it.*[126]

1.81 In pursuit of that understanding of her responsibility, Ms Eminson had sent a letter dated 18 January 2006 to the Trust, copied to Rob Willoughby of SaSSHA, among others, immediately after the peer review visit expressing the team's concerns about "immediate risks",[127] notifying Mr Yeates, and through Mr Willoughby, the SaSSHA, of the fact that the draft report had identified issues:

> *... as immediate risks to clinical safety or clinical outcomes.*

1.82 These were essentially the issues described above. The letter stated that the responsibility for follow up was "being clarified" but in the meantime requested the Trust's action plan by 15 February.

1.83 The Trust sent its action plan back under cover of a letter from Mr Yeates to Ms Eminson on 14 February.[128] The letter expressed the hope that the plan would show that the Trust was taking the appropriate action. It did not, in fact, suggest that immediate steps were being taken to deal with matters which were potentially life threatening to children arriving in A&E. For example, in response to the concerns about paediatric life support, it stated:

> *PAEDIATRIC LIFE SUPPORT*
>
> *A&E Department*
>
> *The A&E Department will shortly transfer to the Medical Directorate. It has been agreed that APLS and PLS training will be identified within the training plan for the area for the next year using the criteria that shift leaders will have the APLS training and other senior staff will have PLS training ...*

125 Eminson T96.156–157
126 Eminson T96.157
127 CJE/11 WS0000023244
128 CJE/12 WS0000023247

1.84 This conveyed no sense of urgency. Ms Eminson, however, thought that the plan was sufficient:

> *[I]t ... looked like the Trust was taking appropriate action in response to the immediate risks identified by the visiting team. I do not recall raising any further concerns with the Trust about this action plan.*[129]

1.85 She accepted, but only with hindsight and in the light of the knowledge now possessed, that more could have been done to follow up the action plan.[130]

1.86 As Counsel to the Inquiry pointed out in his closing submissions, the Clinical Governance Lead of SaSSHA, Dr Paulette Myers, who was on leave at the time and had not seen the report, thought in retrospect that it was inadequate:

- The actions mentioned were not specific.
- There was no lead name attached to them.
- There were no milestones or end dates.
- There was insufficient detail to enable a judgement of whether the proposed action would solve the problem identified.

1.87 Therefore, she felt that if this had been her responsibility:

> *... if it was a topic that was relevant to my role and we received an action plan like that, we would have sent that back and followed that up with a phone call and a – a letter, and they would have had to have resubmitted them. We would have been very clear what the weaknesses were and what we wanted to see addressed and we would expect a response.*[131]

1.88 Ms Myers was also asked whether it was the SHA's responsibility to follow up matters of this nature even if a primary responsibility for doing so lay with the PCT:

> *Q. We've heard some evidence from Ms Eminson that she considered that the primary care trusts had responsibility for the follow-up of peer reviews in 2006, although that appears to be contradicted by some other Documentation. At this stage, was there any doubt in your mind that it was still the SHA's responsibility to follow-up on things like this?*

129 Eminson WS0000022928, para 42
130 Eminson T96.158, 174
131 Myers T100.86–7

A. I think even if the PCT had responsibility, if something comes to your attention, the approach that I would certainly take would be to check that people were doing what they should. So as I said, I think in a previous question, we would still speak to the PCT to check that they were in sight of the report, if some of the issues related to the way they commissioned services, for example, because ... they would be part of the solution. So they would have to be involved in the action plan to address it.[132]

1.89 The Chair of the peer review steering group (Dr Ralston) obviously remained concerned. On 19 April 2006 he wrote directly to Mr Yeates complaining about an incident which had come to his attention.[133] The terms in which he did so shows that he was concerned, not just about an incident involving an individual clinician, but also about a long-standing problem at the Trust in understanding the requirements and standards of paediatric care:

Following the 2003 visits, the Steering Group, which I chair, discussed serious personal/professional concerns about a small number of Trusts and a very small number of individuals. [The Trust] *fell into both categories ... In summary these* [concerns] *were that a) the Trust did not appear to understand the relevance of the standards and peer review process and have mechanisms in place to make the necessary changes and b)* [Dr X]*, in particular, did not appreciate the importance of the issues and the changes that needed to be made ...*

... Following the most recent visit ... Jane Eminson wrote to you on 18 January 2006 confirming the immediate risks identified by the visiting team including, among several other issues, the lack of a formally agreed protocol for the resuscitation, stabilisation, maintenance and transfer of critically ill children. [Dr X] *... would have been well aware of the standards that should be met.*[134]

1.90 Dr Ralston went on to describe a serious incident reported to him which he thought raised questions about what Dr X had done about it:

Without the benefit of a full investigation, this incident causes me concern at three levels: firstly, that [Dr X]*'s actions were not consistent with basic safe practice in this instance; secondly, that a consultant who had responsibility for preparing the Trust for review against the Standards for the Care of Critically Ill and Critically Injured Children in the West Midlands appears not to understand and appreciate the importance of these issues, and, thirdly, that whatever action Dr Gibson took following his meeting with Jane Eminson in October 2003 appears not to have altered* [Dr X]*'s clinical approach.*[135]

132 Myers T100.83–84
133 Eminson WS0000022928 para 44; CJE/13 WS0000023251–2; Eminson T96.166
134 CJE/13 WS0000023251
135 CJE/13 WS0000023252

1.91 He called for a clinical governance review of the case, but clearly raised the issue of why problems identified in 2003 had not been successfully tackled by 2006.

1.92 Although Ms Eminson was not, openly at least, copied in on this letter, she told the Inquiry she was aware of the issue and had been involved in the drafting of the letter.[136] She did not personally follow up this issue at the time; this was regarded by her as a matter for Dr Ralston to follow up as a clinician at the hospital which had received the child concerned. The implication was that the incident revealed the Trust's inability to grapple successfully with serious safety issues of immediate concern. This problem does not seem to have been addressed.

1.93 Ms Eminson herself candidly accepted that with hindsight more should have been done sooner. Asked what that "more" was, she replied:

> *We ... could have followed up had the action plan been implemented. We could have alerted ... an SHA more. We – we did have some discussion at this point about whether we should* [refer] *to a professional body ... my recollection is we thought about that. You know, what were our responsibilities at this time? So, ... we could have done more, but they aren't terribly obvious. But especially with hindsight, I think one's always left with a very uncomfortable feeling of, as we come to later, should we have done more?*[137]

1.94 The receipt of this report did not prevent Mr Yeates writing to Stuart Poynor, then Chief Executive of the East Staffordshire PCT, on 30 August 2006 in relation to an unfavourable score from the HCC review of children's services (see below):

> *I am sure you know that our hospitals and staff provide an excellent service to children and young people ...*

1.95 After accepting that in one respect there was scope for improvement he said:

> *In the meantime I assure you that you can continue to have confidence in the high quality services we provide for children and young people.*[138]

1.96 The overview report, which was produced by the peer review group, expressed "particular concern" about three unidentified trusts for lack of arrangements across their services and a lack of progress since the 2002–2003 review. It would not have been possible for a reader to

136 Eminson T96.171
137 Eminson T96.174–175
138 TRU00010007163–4, Letter from Martin Yeates to Stuart Poynor (August 2006)

discern that one of the poorly performing trusts was the Trust. According to Ms Eminson, once this report was produced in June 2006, responsibility for follow up passed to the PCT.[139]

1.97 Mr Price, Chief Executive of SWSPCT, could not recall anything about this report. Therefore he was unable to explain what, if anything, was done about it, and why it was not included in the handover information given to Mr Poynor on the transfer to the South Staffordshire PCT (SSPCT). Accepting that, if the PCT did indeed receive a copy, it was the PCT's responsibility to see that the concerns raised in the report were addressed he told the Inquiry:

> *I haven't got a clue then why it is we haven't picked this up, and why I'm so vague. And having followed the inquiry on the website, when I saw this come up at earlier question sessions, Jean-Pierre[140] and I have spoken about it and we're ... as vague as each other. And ... I honestly cannot understand it or explain it. And given as well the context which you reminded me of in terms of the specialised services, and where I sat in that arrangement ... that's very odd to me ... I really ... don't know. So, yes, it says it's been copied to me but for some reason the report itself is not ringing bells at all. Whether or not it was because it was in that strange period when some shadow arrangements were already starting for the new PCT, I don't know ... as a report, doesn't ring any bells.*[141]

1.98 Hypothetically, he accepted that he would have regarded it as the PCT's responsibility to become involved in concerns of this nature whatever the formal expectations:

> *I'm not overly bothered what the guidance actually said. Do I accept responsibility as a PCT? That's something that impacts on my population, yes. Therefore, if I'm aware of that sort of thing, I want to be involved with it. And some of this about arguing behind the scenes, isn't it, whether or not the SHA ... or another part of the organisation has formal accountability, but ultimately I had accountability for the whole of the service that was in my patch anyway. So I would want to be in on it. And I think this is indicative of another problem, in terms of, you know, people accepting responsibility ... for what is reasonably theirs. And that was my attitude, that that was, you know, part of what's going on in my patch. I wanted in on it. So I would accept that.*[142]

1.99 Mr Poynor did not think, to the best of his recollection, that he had ever seen the 2006 peer review report, although he would have expected it to have been brought to his attention.[143]

1.100 In fairness to Mr Price, Mr Poynor, Mr Parsons and the PCTs, the Inquiry was unable to locate any reference to this report in the PCT documentation available to it. Therefore there is no

139 Eminson WS0000022919–20, para 14
140 Parsons WS0000077444, para 101
141 Price T94.73
142 Price T94.73
143 Poynor T64.111–112

evidence that they did, in fact, receive it other than the inclusion of these individuals in the list of people copied in on the covering letter, which was sent, along with the report, to the Trust. It is therefore unclear whether it was received and ignored or whether it was in fact, in error, not sent to them. Either way this important report was not drawn to the attention of those in charge of the PCTs.

1.101 Ms Eminson briefed Eamonn Kelly on the implications of the children's peer review programme generally on 14 or 16 August 2006.[144] Having previously worked for a PCT, Mr Kelly had started in post as Acting Director of Commissioning and Performance of the WMSHA on 1 July 2006. He assumed the substantive post on 25 August. He had direct line managerial responsibility for Jonathan Lloyd from then on until 1 December 2006, although Mr Lloyd reported on Trust performance issues in practice to Cynthia Bower.[145] Mr Kelly does not recollect if the Trust was specifically discussed.[146] On 6 December 2006 Ms Eminson wrote to him, following a meeting on the same subject on 14 November, referring him to the overview report.[147] Ms Eminson told the Inquiry that she wrote it because Mr Kelly had asked her to do so in relation to any trusts about which she was particularly concerned. He had said he would discuss them with Mr Lloyd, the head of performance, and follow the matter up in performance discussions with the relevant PCTs.[148] Mr Kelly accepted that it is likely he made this request.[149] Ms Eminson identified the Trust as one of those found to have a lack of robust Trust-wide arrangements and a lack of progress since the 2002/03 review.

1.102 Mr Kelly feels sure he would have shared this letter with colleagues but is unable to find any correspondence confirming that. Therefore, potentially relevant emails have been lost, for which he apologised to the Inquiry.[150] However, having re-read Ms Eminson's letter, he suggested it would not have caused him concern:

> *I do not believe that the letter would have caused me significant concern about* [the Trust] *at the time. If the letter, together with any other issues that Jane raised with me, had caused me significant concern, I would have spoken to Cynthia Bower … As peer review was part of a quality improvement process, I would have expected that I would have taken steps to ensure that the matters raised in the letter were followed up. With hindsight, it is now clear to me that if the letter had been triangulated with other information about* [the Trust] *I would have been more concerned.*[151]

1.103 In his oral evidence he emphasised that:

144 Eminson WS0000022929, para 49; Kelly WS0000021725, para 104; EAK/14 WS0000022154; T75.101–103
145 Kelly WS0000021698, para 6; Kelly WS0000021700, para 11
146 Kelly WS0000021726, para 105
147 SHA0023000144–5, Letter to Eamon Kelly from Jane Eminson (Dec 2006), Kelly WS0000021726, para 106; EAK/54 WS0000022165
148 Eminson T96.185–186
149 Kelly T75.110
150 Kelly WS0000021726 para 106
151 Kelly WS0000021726 para 107

And at no point – and although I can't recall the discussions in detail, at no point did I have any indication ... or did I interpret any indication that this was a serious matter that required a higher level of escalation than subsequently happened.[152]

1.104 And later:

If we thought that a higher and more urgent level of escalation was needed, then we wouldn't have agreed to pass the letter to Jonathan Lloyd. That wouldn't have been appropriate. It would have been more appropriate to have escalated it potentially to the chief executive ... and also my other SHA colleagues. What I do accept, sir, is that the information should have been better triangulated within the organisation. But ... I can assure you that at – that no time did I leave any of those meetings with any serious concerns about any hospital.[153]

1.105 He did not think he actually read the peer review report at the time. Having done so for the purpose of the Inquiry he thought it raised concerns that should have been followed up by the Trust, and that with hindsight, when taken with other evidence, common themes emerged.[154] Although he was new to his role at the time, it is surprising that he did not consider it necessary to read a report about which Ms Eminson had approached him because of her specific concerns for this Trust.

1.106 Mr Kelly felt, however, that if Ms Eminson had had serious concerns at the time of the peer review in January, these should have been raised then and not in December.[155] She accepted that, following her December letter, she took no steps to find out what, if anything, had been done about it. Following her discussion with Mr Kelly she was led to understand that this was not part of the peer group's responsibility.[156]

1.107 The peer reviews were organised by the West Midlands Quality Review Service (WMQRS), effectively a consortium of PCTs, including SWSPCT or its predecessors. It was not primarily the SHA, although, confusingly, the peer review team used SHA notepaper. It is clear that Ms Eminson lacked a clear understanding of who had responsibility for following up peer review reports and sought to do something about that. However, the alternatives were limited to the PCT or the SHA or both. This uncertainty appears not to have been resolved satisfactorily, a matter for which the SHA must bear responsibility.

1.108 While some documentation was received by the SHA and the PCT, Ms Eminson did not communicate even in general terms the serious concerns expressed by Dr Ralston in his April

152 Kelly T75.110
153 Kelly T75.113
154 Kelly T75.115
155 Kelly WS0000021726–7, para 108
156 Eminson T96.187–188

letter, which could not justifiably be regarded simply as a matter of professional discipline of one practitioner at the Trust. A deficiency that had survived for three years required the urgent attention of the Trust's performance managers, particularly where it raised safety concerns for child patients. Again, the lack of clarity about the location of responsibility for follow up on issues of concern may explain this.

1.109 From the evidence referred to above it appears that the peer review report, and the concerns in it, were intended to be conveyed to the SWSPCT and CCPCT before the merger. It is accepted that, if they received a copy of this report, the SWSPCT had a responsibility to follow up the concerns, but this did not occur. It is unclear on the evidence whether the report was actually received by the PCTs, but either way the matter became lost in the system. The relevant information was not, the Inquiry accepts, handed over to Mr Poynor at the time of the merger. It is clear from his evidence that knowledge of the report would have prompted more questions and less ready acceptance of the assurances given by Mr Yeates concerning children's services in August 2006. At this distance in time it is not possible to attribute responsibility, but the fact remains that through a failure of communication no steps were taken locally to address serious concerns about children's services at the Trust.

1.110 So far as the SHA is concerned the Inquiry considers that although the report was received by Mr Kelly it is unlikely that it, or knowledge of it, was circulated any wider within the organisation. While it appears that some documentation originating around the relevant time has gone missing, the Inquiry considers that it is inconceivable that if the matter had been accorded importance, and any follow up of what the PCT was doing undertaken, that there would be no surviving documentary evidence of that. It is more likely that, as Mr Kelly says, the letter did not cause him significant concern and therefore he put the matter to the back of his mind. Mr Kelly has effectively accepted with the benefit of hindsight that more should have been done, but does point to the fine balance to be drawn between taking action over concerns and encouraging peer review on a voluntary basis. It might be argued that Ms Eminson should have escalated the matter to the SHA with more urgency than she showed but the Inquiry accepts that there is no evidence that she would have met with any different reaction.

1.111 The Inquiry rejects any suggestion that it is only with hindsight that the need for more robust action over the concerns raised in this report could be detected. The peer review report raised serious concerns without the need for confirmation from other evidence, however desirable it might have been to look for that in any event. Ms Eminson specifically drew Mr Kelly's attention to the problems at the Trust because she had particular concerns about it. Mr Kelly's request to her to inform him of such cases can only have been in the context that, as Director of Commissioning and Performance of the SHA, he would seek to ensure that appropriate action was taken by the Trust and the PCT. Not only did he fail to do that, he did not even pass on the information to them. It might have helped if he had taken the trouble to read the

report. Ms Eminson did what she reasonably could in circumstances where, through no fault of her own, responsibilities were not well defined.

The Health Care Commission review of children's services

1.112 In October 2006, independently and coincidentally, the HCC published its own national review of children's services, including that of the Trust.[157] The criteria included sufficiency in numbers and training of staff.[158] This was classed as "weak". The report was blunt as to its assessment:

> *The performance of this organisation does not meet minimum requirements or the reasonable expectations of patients and public.*[159]

1.113 The matter was raised by Elizabeth Buggins, Chair of the WMSHA, in a meeting with Mrs Brisby on 16 April 2007. She was told this was due partly to a lack of data submitted, and that an action plan for improvement had been developed.[160] She appears to have accepted that assurance at the time.[161] The same message was given in a press statement issued by Mr Yeates at about the same time.[162] Mr Yeates had previously written to Mr Poynor in the terms quoted above, offering an assurance that the service was safe, although the evidence on which this assertion could be based was less than clear.

1.114 It would appear that the conclusions of this review were consistent with the West Midlands peer review. Ms Buggins herself was not aware of this review at the time,[163] or that the Trust's consideration of the actual standard of service being delivered had not gone beyond looking at the deficit in the documentation required by the HCC.

1.115 The question ought to have occurred to the informed observer as to whether the Chair and Chief Executive of the Trust were displaying a lack of insight into a serious matter potentially putting a vulnerable group of patients at risk.

1.116 In her evidence, Ms Buggins accepted that, had all the information now known been available, different judgements might have been made:

157 WS0000024200, *Mid Staffordshire General Hospitals NHS Trust – Improvement review of services for children in hospital* (undated), Healthcare Commission
158 PCT00280003374, *Improvement Review, Services for Children in Hospital, Management Summary* (May 2005), PCT
159 Buggins T74.114
160 Buggins WS0000022527, para 43; EMB/5 WS0000022630
161 Buggins WS0000022533, para 59; EMB/5 WS0000022630
162 TRU00010008795, Press statement (Oct 2006), The Trust
163 Buggins T74.82

One is we wouldn't want to do anything to discourage trusts or service commissioners undertaking peer reviews by putting something around which they feel may reflect adversely should they have to disclose it. So I'd far rather people at the very lowest possible level at the clinical level, take responsibility for the quality of care and doing everything they can to improve it, rather than relying on the policeman. Having said that, I do fully accept that if all of the information that has now come to light about this organisation, including the peer reviews, had been clear to one body, such as the health authority, then the judgements we made would have been different.[164]

West Midlands national cancer peer review of haematology services

1.117 Under the national cancer peer review scheme a peer review of the Trust's haematology services took place in June 2006 and the report was published in October the same year.[165] This found that although medical staffing had improved it remained a matter of "very serious concern". It found that there were insufficient consultants in the specialty, and no evidence was found of the development of a pan-Staffordshire multi disciplinary team. The nurse staffing ratio was inadequate for the number of designated beds in this area. The staffing issues were identified as an "immediate risk" of which the Trust was notified in a letter of 20 July 2006 to Mr Yeates as Chief Executive.[166] This letter was copied to the Network Director but not the WMSHA. An action plan addressing the concerns was requested to be sent by 11 August 2006. On 23 October Ms Eminson wrote to the Network Director of the Greater Midlands Cancer Network (GMCN) notifying her of the concerns in the draft report about staffing at a number of named trusts, including the Trust.[167] The letter was copied to Mr Lloyd, Director of Performance at the WMSHA,[168] as well as Mr Yeates as Chair of the Network. A later letter sent by Ms Eminson in November 2006, enclosing the final report, requested an action plan to be sent to the GMCN by 1 December.[169] This letter was copied to the WMSHA and PCT Chief Executives, among others.

Lack of governance

1.118 In May 2006, the Trust's independent auditors, Bentley Jennison Risk Management Ltd, reported to the Trust Audit Committee that they had serious concerns about deficiencies in its risk management and assurance systems for the year ending March 2006.[170] The auditor's opinion was that:

164 Buggins T74.86
165 Eminson WS0000022926, para 38; CJE/15 WS0000023257–82
166 CJE/16 WS0000023284–5
167 SHA0048000608, Letter from Jane Eminson to Ruth Serrell (Oct 2006)
168 Mr Lloyd does not mention this review in his statement, although he recollected receiving a report concerning the review into critically ill and critically injured children in June 2007, Lloyd WS0000022352, para 31. Mr Lloyd did not give oral evidence owing to illness.
169 CJE/17 WS0000023287
170 SHA0001000380, Internal Audit annual report (31 March 2006), Bentley Jennison Risk Management Ltd

Limited assurance can be given as weaknesses in the design and inconsistent application of controls put the achievement of the organisation's objectives at risk in a number of the areas reviewed.[171]

1.119 The reasons for this opinion included:

- A failure to update the assurance framework with no regular flow of assurances to the Board during the year. This meant that there was not in place:

  Reasonable assurance that there is an effective system of internal control to manage the principal risks across all the main business activities within the Trust

- There were "fundamental weaknesses" in the risk management processes;
- Common themes had been identified through reviews during 2005/06 including a lack of adequate policies and procedures, their inadequate monitoring, leading to inconsistent delivery of internal control across the directorates;
- Limited progress was identified in the follow-up to previous recommendations;
- While progress was noted in improving the process whereby the Standards for Better Health Declaration was made, further work was required in various areas, most notably a need:

  to ensure that changes in the degree of compliance reported are due to real improvement and not an increase in the level of risk the Trust Board considers it is willing to accept as well as providing sound evidence should the Trust be inspected.[172]

1.120 A report of the Audit Commission on the accounts for 2005/06 came to a similar conclusion.[173] It found the Trust to be below minimum requirements in relation to:

- Financial reporting, largely because of incomplete working papers being available;
- Internal control, in part through lack of a documented risk management policy and a failure of the Board to review risk registers.

1.121 It should be noted that this was the second year in which such concerns had been expressed. At the end of 2004/05 the auditors had reported that:

Although we acknowledge that the Trust has undertaken work in this area and has updated the Financial Recovery Plan, there remain significant risks associated with the delivery of the plan and ultimately the objective of achieving financial balance in 2005/6.

171 SHA0001000383, Internal Audit annual report (31 March 2006), Bentley Jennison Risk Management Ltd
172 SHA0001000386; see also AC00000000148, External audit: Annual audit letter (Oct 2006), The Audit Commission
173 AC00000000172, Auditors local Evaluation Assessments (2005/06), Audit Commission

During the year there were also a number of breaches of the Trust's Standing Financial Instructions ... it is critical that the integrity of the internal control framework is restored ... The Trust's financial standing remains an area of significant concern ...[174]

1.122 Concerns about governance had been expressed in 2002 and this report offered no reassurance that the problems had been corrected. In fairness it should be recorded that by the time of the review of the 2006/07 year, KPMG, the Trust's external auditor, reported that it had successfully delivered on the action plan to remedy these concerns.[175]

Report on Clinical Coding

1.123 In September 2006 Bentley Jennison delivered a final report on an internal audit of clinical coding at the Trust.[176] This concluded that the controls systems in place were insufficient to assure the Trust that the system was achieving the required objectives. In particular:

- Procedures for coding had not been formally approved;
- There was a lack of training in the procedures;
- There was no formal procedure for coding outpatient episodes.

1.124 As we shall see the Trust and the system as a whole depended on the reliability of hospital statistics, derived from clinical coding returns, not only for calculating payments to the Trust for services provided, but for mortality and other measurements of patient safety. This report suggests that the Trust had cause to be improving its coding well before the unfavourable Dr Foster report of 2007. It is not clear from the evidence what steps were taken before 2007 to address this important matter affecting the ability of the Trust and others to detect deficient and unsafe provision.

Internal Audit into the process of monitoring performance under Standards for Better Health

1.125 In October 2006 Bentley Jennison produced a draft report titled *Standards for Better Health – Review of the Process for the Continual Monitoring of Performance*.[177] The auditors made serious criticisms which called into question the accuracy and reliability of the Trust's declaration of compliance with the standards:

174 AC00000000116, Annual Audit Letter 2004/05 – Mid Staffordshire General Hospitals NHS Trust (Nov 2005), KPMG
175 AC00000000163, External Audit – Annual Audit Letter 2006/07 – Mid Staffordshire General Hospitals NHS Trust (31 October 2007), KPMG
176 MON00030011603
177 MON00030011625

- In relation to the four directorates to which they were referred to seek evidence:

  ... despite numerous attempts, Internal Audit was unable to evidence any supporting documentation from the four Directorates reviewed. It is of concern that no operational evidence has been gathered and retained to support the Board's declaration. The lack of supporting evidence on which the declaration has been made must question the robustness of the levels of compliance with the core standards that have been published. Discussions with the Trust's officers during the review have highlighted their concerns with the accuracy of some of the declarations made ...[178]

  ... none of the [officers contacted in three directorates, Surgery, Medical, and Support Services]*, were aware of the requirements to gather, reference, collate and maintain substantiating evidence in terms of the Standards for Better Health declaration. Furthermore none of the three officers have been able to provide Internal Audit with any operational data or information to support the declarations made by the Board in terms of the Trust's compliance with the core standards. These officers also confirmed to Internal Audit that they were uncertain of the accuracy of the level of compliance made for some of the declarations published.*[179]

- The action plan arising out of non-compliance found at the time of the April 2006 declaration was deficient in that in one instance no implementation dates were identified. Also no testing of action of 26 of 37 other action points could be undertaken due to lack of evidence;[180]
- The action plan had not, at the date of the audit, been reviewed by any board, committee or group;[181]
- The auditors expressed the concern that:

  If the Healthcare Commission instigated an inspection of the Trust at short notice, officers would therefore find it difficult to provide sufficient supporting evidence.[182]

  ... the process for the gathering, referencing and retention of operational evidence to support the Trust's final declaration and ... the monitoring of compliance with the actions to be taken to address areas of non-compliance is inadequate.[183]

1.126 To any reasonably informed reader the findings of this report would or should have called into question the competence of senior management and leadership at the Trust. The findings would or should have been of serious concern to the HCC and, in the context of an application for FT status, to Monitor and the DH.

178 MON00030011627, para 1.1
179 MON00030011631, para 3.2.3
180 MON00030011633, para 3.2.3
181 MON00030011634, para 3.4.1
182 MON00030011627, para 1.1
183 MON00030011628, para 1.1

1.127 At its meeting in October 2006 the Trust's Audit Committee was informed by Ms Landon, Acting Director of Nursing, that:

> *... there was little evidence during 2005/6 on this topic as directorates/divisions were not aware.*

1.128 She reported that she had ensured that the divisions were now fully aware of the standards:

> *as this is now one of the main topics of the new Governance arrangements for 2006/2007.*[184]

1.129 At the meeting in February 2007 the committee was given a detailed report on all the internal reviews, including this one, which had been conducted in the previous year. Action sheets were presented.[185] At its meeting in March 2007 the committee went through in some detail their views on compliance for the Standards declaration for 2006/07.[186] This will be commented on in more detail in *Chapter 2: The Trust*, but the approach appears to have been to examine proposed declarations of non-compliance for accuracy rather than those where a declaration of compliance was proposed.

1.130 The HCC were informed of the contents of the October 2006 report via an engagement form, and it is possible that this was part of the background leading to the core standards inspection in 2007. As will be seen, however, this did not uncover the serious issues which were persisting at the Trust and which were eventually uncovered by the HCC investigation.

1.131 In May 2007 Bentley Jennison presented an annual internal audit report to the Trust. Its overall conclusion was that:

> *Based on the work undertaken in 2006/7 significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. However some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk.*[187]

1.132 It reported that in the course of the year Bentley Jennison had provided "substantial" or "adequate" assurance in a number of reviews, but only "limited" assurance in 5 out of 16 reviews. They did not, however, consider that these had a significant impact on the overall opinion quoted above. They had made 16 "fundamental" recommendations, and 78

184 MON000400010807, para A(06)51
185 CURE0037000110, para A(07)05
186 MON000400010244
187 DH/37 WS0000038805

"significant" ones, all of which had been accepted by the Trust. However they identified a number of areas where failure to act on them could "adversely impact on the achievement of the organisation's objectives". These areas included clinical coding and A&E followup. They noted a number of common weaknesses in the course of the year, including:

> *... a lack of adequate monitoring of the Trust's policies and procedures, which has led to inconsistent delivery of internal control across the directorates.*[188]

1.133 The report was more encouraging with regard to progress in relation to the governance around the *Standards for Better Health* and the Trust's self declaration:

> *The trust has made considerable progress since our review in October 2006 and it was evident that the process is continuing to develop and evolve particularly in the area of supportive evidence being held for the core standards declaration. Whilst we have identified a small number of areas where the Trust can make improvement as a result of our work we consider that the trust has a reasonable process to support the preparation of its 2006/2007 declaration.*[189]

1.134 In May 2007 the auditor reported to the committee that he thought progress had been made but that there was more to be done.[190] The committee thought that "considerable progress" had been made, "particularly in the area of supporting evidence".

1.135 Therefore it does appear that there was a reaction to the critical nature of the October 2006 report, but it is not clear that any outside agency was aware of it at the time. The only persons external to the Trust present at audit committee meetings were representatives of the internal and external auditors. Deficiencies in this area meant that the limited assurance offered by the monitoring of standards that took place at the time was not necessarily reliable even within its own context.

1.136 In October 2007, in the course of its assessment of the Trust's application for FT status, Monitor officials met the internal auditors and examined all their reports prepared during 2006/07 including those referred to above. The auditors did not flag up any major concerns. It was observed that following the critical report of October 2006 on the process for monitoring performance against the *Standards for Better Health* considerable progress had been reported in May 2007 and that the Trust had a reasonable process in place to support the 2006/07 declaration.

188 DH/37 WS0000038806
189 DH/37 WS0000038808
190 TRU00010014424, para 5.1

1.137 Monitor took further reassurance from other audit reports, for example:

- Limited assurance had been provided with regard to clinical coding, but the Trust appeared to Monitor to be following this up;
- Following a critical report on clinical audit in May 2007 an action plan had been developed and that the Medical Director (Dr Suarez) was keen to address the detected deficiencies;
- A report on recommendation tracking in May 2007 had concluded that little progress had been made on this, but Monitor were satisfied the Trust was following this up.[191]

1.138 Reflecting on Monitor's consideration of the internal audit information in retrospect, David Hill, one of the assessors, told the Inquiry that he did not think that Monitor considered the clinical audit in as much detail then as it did now.[192] This seems to be a fair view of Monitor's consideration of the concerning features of the internal audit reports. They were assured that the Trust had made progress in correcting perceived deficiencies, but in retrospect might have considered why such deficiencies had come about in the first place.

Staff cuts at the Trust

1.139 The Trust planned to make considerable financial savings in the financial year 2006/07. Financial performance in previous years had been as follows:[193]

Table 1.1: The Trust's financial performance 2003–2006 (RAB adjusted figures)

2003/04	£509,000 deficit
2004/05	£1,649,000 deficit (down from £2,158,00 deficit in the final accounts)
2005/06	£2,149,000 surplus (up from £478,000 surplus in the final accounts)

1.140 As recently as September 2005 there had been a projected overspend of £3 million. The recurrent cost improvement programme for the year 2006/07 was said to be £10 million.

1.141 A target workforce reduction of 166.81 WTE was established and distributed on a 2:1 clinical support staff to clinical staff ratio. The funded establishment as at 1 April 2006 was 2,395.9 WTE (with 89.87 vacancies), as compared with 2,515.81 WTE on 1 April 2005. Projected vacancies as of 31 May were 105 WTE.

1.142 Phil Taylor, then Director of Performance and Finance and Deputy Chief Executive of SaSSHA,[194] would have been aware of the plan and would have gone through it in detail with Mr Newsham.[195] Mr Taylor's assessment was that £1.1 million of the projected savings were

191 Hill WS0000037903–908, paras 39–48
192 Hill WS0000037907, para 44
193 TRU00010008049, Figures taken from the paper attached to the letter to Mr Spilsbury (31 May 2006)
194 Taylor WS0005000425, para 3 From July 2004 to June 2006
195 Taylor WS0005000435, para 43

for staffing reductions related to service rationalisation, £3.2 million was from "other staffing efficiencies" and £400,000 was to be saved by adjustments in the skill mix. A total of £4.3 million was to be saved from staff wages.[196] He considered that the plan represented a reduction in staff numbers of 5%, but thought that only 20 of these would be from clinical posts. He would have expected any concerns of SaSSHA's Workforce and Clinical Governance Directorate about the effect on patient care to have been addressed before the plan was approved.[197] The Trust's plan, 8% of turnover, was for the highest level of savings of any trust in the West Midlands, the average for NHS trusts generally being 5% for that year. However, there were other trusts whose projected savings came close to those of Mid Staffordshire General Hospitals NHS Trust (the former name of the Trust). Mr Taylor accepted that this represented a "huge challenge" but pointed out that this was a year when high levels of savings were being made across the NHS.[198] This report looks at the financial pressures prevailing in the Trust.

1.143 On 6 April 2006 Mr Yeates wrote to Mr Taylor, giving details of the Cash Releasing Efficiency Savings (CRES) programme for 2006/07. [199] It was being proposed to produce £2,245,000 non-recurrent savings by the workforce reduction in front line service and by process redesign. A further £2,202,000 was intended to be saved by workforce reductions in back office functions.

1.144 On 31 May 2006 Mr Yeates wrote to Peter Spilsbury, Director of Health Policy and Strategy at BBCSHA, repeating a request for £1 million support from the SHA, effectively to fund proposed redundancies and staff reductions. Attached to the letter was a paper containing the figures summarised above.[200]

1.145 The paper noted that the projected overspend of £3 million had been overcome and that "major steps" had been taken including "rigid" agency bank and overtime control procedures, and "rigorous" vacancy recruitment processes.

1.146 Whatever Mr Yeates's explanations and optimism, this paper showed that the Trust must have made substantial cuts to arrive at the end of year surplus, and had already lost a significant number of established posts before embarking on the staff cuts for which the loan was being sought.

196 These figures are taken from Mr Taylor's witness statement – Taylor WS0005000435, para 44. It is difficult to match them with either the Trust's plan documents or his exhibit PT/14 WS0005000588, but the differences are not considered significant for the purposes of this Inquiry.
197 Taylor WS0005000435, para 45. These figures are taken from Mr Taylor's witness statement – Taylor WS0005000435, para 44. It is difficult to match them with either the Trust's plan documents or his exhibit PT/14 WS0005000588, but the differences are not considered significant for the purposes of this Inquiry.
198 Taylor WS0005000435, para 47
199 TRU00010008053
200 TRU00010008049

1.147 In a paper issued in July 2006 for a meeting of the Trust's Joint Negotiating and Consultative Committee (JNCC) Mr Yeates outlined the plans for costs savings.[201] This referred to plans announced in March for a reduction of about 150 posts. It was now proposed to reduce the workforce by 166.81 posts to save £4,447,838. A position was said to have been agreed with the Staff Side on 10 July 2006. An interest in voluntary redundancy had been expressed by 180 staff, of whom 70 confirmed an interest in pursuing the offers being made. The Trust had accepted 50 of these with other offers for reducing hours.

1.148 On 21 July 2006 Mr Yeates wrote to Mr Spilsbury, again requesting a loan or underwriting to a maximum of £1 million to meet redundancy costs.[202] He reported that the Trust had already agreed to 50 staff taking early retirement or voluntary redundancy but there was a need to "remove more staff". A breakdown of numbers was enclosed and he claimed to be mindful of the need to deliver good standards of clinical care as well as reduce costs.

1.149 On 3 November 2006 Mr Yeates wrote to Ms Bower, CEO of the WMSHA, reporting on progress with cost savings.[203] He said that the Trust was currently in surplus in its management accounts and that the "challenging" workforce reduction programme had been "fully delivered". It was no longer necessary to call on the £1 million support which had been requested previously. The letter contained workforce figures which appear to have been at variance to those given in the earlier correspondence referred to above. The funded establishment for March 2006 was said to have been 2,502.29 WTE (as opposed to the 2,395.9 WTE mentioned in April). This was reported to have been reduced by September to 2,243.56, a reduction of 258.73 WTE. The reduction of WTE in post was said to be 130.33 between March and September. The reduction in head count was 143 over the same period.

1.150 The £10 million cost improvement plan amounted to 8% of the Trust's turnover. The plan was the second highest proposed in the West Midlands and, according to Mr Taylor, was £1 million more than it might have been as the plan was to bring in a £1 million surplus. The fact that the Trust had been in surplus for 2005/06 decreased the level of surveillance the SHA thought to be necessary.[204] Mr Taylor accepted that it was somewhat strange that an organisation which had a small financial deficit was scrutinised more heavily than one which stayed in balance by making huge cuts. However, he would have expected such an organisation to be causing concern on other performance measures:

201 TRU00010008057
202 TRU00010008047
203 TRU00010008336
204 Taylor WS0005000434, paras 38–39; T71.192–193

... if they'd put in place huge cuts, that would have reflected in the various performance measures that were in place. And if we just take some of the fairly simple ones. If you [cut] *a lot of surgical capacity, for example, your 18-week waits are going to go out of the window. So I think ... if an organisation did that, it would reflect somewhere else ... it might not reflect immediately if it was a very short-term measure, but I'm sure it would have reflected somewhere ... at the end of the day, and probably in a number of places.*[205]

1.151 Mr Taylor accepted that an 8% cost improvement plan represented a "huge" or "enormous" challenge.[206]

The financial recovery plan from which these projected savings came was considered by the SHA. It contained a methodology for the assessment of risk, but, certainly in terms of clinical risk, contained no evidence of the outcome of any risk assessment exercise.[207]

1.152 Therefore, the position was that the Trust was facing a very challenging financial demand, which it was seeking to meet to a significant extent by economies in staffing, against a background where reviews of services had already identified difficulties caused by short staffing, and governance arrangements were unlikely to be reliable.

Medicines management

1.153 In October 2006 the HCC published a national review of medicines management in acute provider trusts. This was conducted by way of independent audit and was intended:

to take a view about what needed to be done for good quality of service in that particular area and then measured trusts against that.[208]

1.154 The Trust was scored as weak, with a poor performance rating in 13 out of 21 indicators and above average scores in only 3.[209] Andrea Gordon of the HCC recalls that a pharmacist at the SHA took these results "very seriously"[210] and it was assumed at the HCC that the SHA would performance manage the Trust on the issue. What is less clear is the extent to which it gave the HCC any pause for thought as to the competence of the Trust management or the impact this might have on the safety and standards of care being delivered to patients.

205 Taylor T71.193–194
206 Taylor WS0005000435, para 47; T72.21
207 Taylor T72.1–4
208 Walker T83.80
209 Gordon WS0000024102, para 65; AG/9 WS0000024231
210 Gordon T78.13

2007

Case note audit

1.155 The findings of the earlier internal audit of coding referred to above were confirmed and expanded on in a report in January 2007 by CHKS, a provider of comparative information and quality improvement services for healthcare professionals.[211] CHKS found an error rate of about 20% in the coding resulting in adverse financial consequences.[212]

1.156 The report also included an audit of case notes which revealed at least one reason why the coding was inaccurate. CHKS found that those notes audited would not meet the CNST core standard for secure filing, and generally the records viewed would not meet the requirements for supporting clinical governance.[213] The report would have been very worrying reading for anyone concerned with patient safety:

> *A number of case notes contained loose documents, papers were mixed up in the chronological order and sheets were attached in apparent random order. Different episodes of care were recorded on the same sheet but not in chronological order. The correspondence section rarely contained any correspondence and then not a complete record as would have been expected ...*
>
> *The anaesthetic record was often the best source of information to identify the co-morbidities, there did not appear to be a standard identifiable sheet for operation notes.*
>
> *The orthopaedic case notes contained little or no information about other relevant conditions and often little diagnostic information, this made it very difficult to identify the reason for the operative procedure.*

1.157 The report was presented to a meeting of the Hospital Management Board on 5 March 2007.[214] Various recommendations were made for increases in staff, and improvement of training, which were converted into an action plan.[215] Strangely, no detailed recommendations seemed to have been addressed at improving the standard of record keeping, apart from some standardisation of ante-natal records. At the meeting on 19 March 2007, Mr Newsham presented an action plan and reported that a lot of work was to be done in the next few months.[216] On 14 May 2007 it was reported that the Trust had not yet been successful in recruiting a new clinical coding manager.[217] At the same meeting concern was expressed about the Dr Foster mortality report which had just been published. At the meeting on 25 June 2007 it was reported that a new manager had been appointed. An audit of 161 sets

211 CURE0001000026; HCC0023001433
212 CURE0001000028
213 CURE0001000030, para 3.1
214 ESI00216608; Mid Staffordshire General Hospitals NHS Trust, Hospital Management Board dated 19 March 2007 MON00030012107 Recording of Clinical Activity presentation dated 5 March 2007
215 MON00160000239
216 CURE0037000507
217 CURE0037000519

of notes on patients who had died showed the coded diagnosis had had to be changed in 75 cases.[218]

1.158 By October 2007 managers were able to report some progress in recruitment, support and training of coding staff to the Hospital Management Group.[219] Not only was this project not completed by this time, the issue concerning note-keeping standards still seems to have been left unaddressed, even in the terms of reference for the clinical coding group set up at that time.[220]

1.159 The Trust responded to this report, as related to Monitor in October 2007, by recruiting more coding staff and merging data quality and coding functions.[221] This was yet more evidence of cause for concern about the Trust management's ability to get on top of persisting issues of crucial importance to the Trust as an organisation and as a provider of services to the public.

Staff and inpatient surveys 2007

1.160 The HCC commissioned annual surveys of staff and patient opinion conducted by the Picker Institute. The results of the survey taken for the previous year were published in about April the following year and several witnesses identified this as a delay which diminished the usefulness of the exercise,[222] but it is clear that the Trust was, at least on some occasions, aware of results before publication, and, one must assume, so was the HCC.

1.161 The 2007 inpatient survey compiled by the Picker Institute, on behalf of the HCC, was based upon information received from patients in 2006.[223] There were many areas in which the Trust did well or performed satisfactorily, but in several areas it was in the worst performing 20%. It was in respect of the following questions that the Trust performed in the worst 20% of trusts in the UK:

- Overall, how long did you wait to be admitted to hospital?
- As far as you know did doctors wash or clean their hands between touching patients?
- In your opinion were there enough nurses on duty to care for you in hospital?
- As far as you know did nurses wash or clean their hands between touching patients?
- Did your family or someone close to you have enough opportunity to talk to a doctor?
- Did a member of staff explain the risks and benefits of the operation or procedure?
- Did a member of staff answer your questions about the operation or procedure?
- Afterwards did a member of staff explain how the operation or procedure had gone?
- Did you receive copies of letters sent between hospital doctors and your family doctor?
- While in hospital were you ever asked your views on the quality of your care?

218 CURE0037000529
219 MON00160000254
220 MON00160000261
221 TRUST00030001310
222 Bell T53.127; Brisby T129.59–60; Bell WS0000007741, para 59
223 ESI00211188

1.162 The Board was made aware of the 2006 survey figures at the meeting on 3 May 2007 when it was reported that the Trust was in the worst 20%. Predictably, an action plan was said to have been developed.[224]

1.163 At the same meeting the results of a different staff survey, presumably one commissioned by the Trust, were reported. Concern was expressed at the percentage of staff who said they would not want to be treated at the hospital, nor wish a relative to be either. The HR department was to develop yet another action plan. The results of the staff survey were also reported to the JNCC on 12 April 2007 by a member of the HR department,[225] and Denise Breeze, a Royal College of Nursing (RCN) representative at the Trust, was reported to have contested them.[226]

1.164 These survey results were entirely consistent with the later findings of the HCC in its formal investigation, but the reaction to them appears to have been more administrative than one of concern at the implications for the standard of care being delivered.

Problems in A&E

1.165 On 11 April 2007 Karen Morrey, the Trust's Chief Operating Officer, emailed Yvonne Sawbridge and Geraint Griffiths of the PCT an urgent plea for help:

> *... we're sinking under patients in A&E. Any support would be gratefully received. We've tried to get hold of the Community matrons but only got a voicemail service. We have 12 ambulances queuing.*[227]

1.166 Ms Morrey explained that:

> *At various times during my period as Chief Operating Officer we faced difficult situations in A&E. On occasion I would raise these to the attention of the PCT. And seek help to ease the strain.*[228]

1.167 In itself such an incident probably happens in other A&E departments from time to time. Ms Morrey was unclear in her evidence whether she and the Trust were concerned about staffing matters at this stage.[229] Mr Griffiths said this sort of email would not have raised a concern and would be regarded as a request for help on a particular day.[230] Mr Kelly thought

224 MON000400010315
225 ESI00237395
226 Breeze T42.81–84
227 KM/30 WS0000011520
228 Morrey WS0000011218, para 78
229 Morrey T62.101
230 Griffiths T63.115

that this sort of event was common across the system at the time and would not have been thought out of the ordinary.[231]

1.168 However, at this time A&E enjoyed the services of only two consultants in emergency medicine and there was a general shortage of middle grade doctors. A year later in a report dated 23 April 2008 Ms Morrey was to set out at length detailed serious issues concerning A&E.[232] These included:

- A preponderance of trainee doctors requiring a high level of supervision;
- A difficulty in achieving this with only two emergency medicine consultants in the department and a small number of middle grade staff;
- The 24/7 middle grade rota was provided by two WTEs and locum cover which was "inconsistent in its sustainability";
- A comparative scoping exercise indicated that a comparable hospital was staffed by four consultants in emergency medicine and nine substantive middle grade staff.

1.169 The conclusion was that:

> *With only 2 emergency medicine consultants and 2 WTE middle grade staff with various locum doctors it is proving very difficult to treat the critically ill patients, supervise the junior doctors and provide an efficient high quality service to the local population.*[233]

1.170 The report explicitly stated that this situation had "implications", by which it must have meant risks in relation to matters including:

- Delivery of substandard care;
- Patient satisfaction;
- Litigation from patients;
- Patient and staff safety.

1.171 Turning to A&E consultants it was reported that the department currently had two consultants, one of whom was due to leave that week. The Royal College adviser had refused to give approval for the replacement post on the basis that there should have been a minimum of four consultants:

> *Clearly it is not acceptable not to have consultant cover in the Trust. We can look at interim locum arrangements, although have been unsuccessful at the first attempt.*[234]

231 Kelly T75.87–88
232 Morrey KM/45 WS0000011631
233 Morrey KM/45 WS0000011631
234 KM/45 WS0000011632

1.172 Finally a shortfall of 7.5 nurses had been identified in the skill mix review.

1.173 Although Ms Morrey was unable to help the Inquiry as to whether most of these deficiencies were present in April 2007 when the urgent plea for help was sent to SSPCT,[235] they probably were. Unfortunately, no deeper look was taken then into whether there were underlying reasons for concern lying behind the incident. In an area so crucial for the care of seriously ill and injured patients this suggests an unacceptably high threshold for acting on concerns and possible concerns. Ms Morrey did accept that although this report was probably the first time a detailed analysis of the issues had been written down, it was not the first time there had been a realisation they existed.[236]

Dr Foster report

1.174 In April 2007 Dr Foster published its report on mortality rates.[237] It seems first to have appeared in the *Daily Telegraph* on 24 April. The Trust was listed as the second worst outlier in the country in terms of its overall mortality rate as measured by the Hospital Standardised Mortality Ratio (HSMR) methodology. The history of this vexed issue is considered in *Chapter 5: Mortality statistics*. However, it has to be concluded that this was a clear alarm bell requiring urgent action to find out whether this result could be explained by a review of the care provided. It should have been prioritised over the arid debate about the accuracy and reliability of the figures, which in fact occurred.

1.175 If this was not enough, during the course of 2007 the Trust received a number of mortality alerts as set out in the table below.

Table 1.2: Mortality alerts 2007

Date	Mortality alert	Generated by
Jul 2007	Operations on jejunum	Dr Foster
Aug 2007	Aortic, peripheral and visceral artery aneurysms	Dr Foster
Aug 2007	Diabetes	HCC
Aug 2007	Peritonitis and intestinal abscess	Dr Foster
Sep 2007	Epilepsy and convulsions	HCC
Oct 2007	Repair of abdominal aortic aneurysm	HCC
Nov 2007	Other circulatory disease	Dr Foster

Source: *Investigation into Mid Staffordshire NHS Foundation Trust* (March 2009), Healthcare Commission, page 146

235 Morrey T61.161
236 Morrey T61.158
237 BJ/12 WS0000042958

The view at the Strategic Health Authority

1.176 Phil Taylor, Director of Performance at SaSSHA, left that post in March 2007. In November 2008 he was interviewed by the HCC in the course of their investigation and was recorded as having the impression that the Trust was not performing very satisfactorily:

> *Phil recalled that Mid Staffs was 'always around the edge'. Never suffering from the big problems of the two poorest performing Trusts but never doing well. At some stages the Trust was in deficit and at others it was in surplus.*[238]

1.177 In his written evidence Mr Taylor, not unreasonably, questioned whether the note was a reliable record as he had not been shown it at the time, it contained numerous demonstrable inaccuracies, and he could not now recollect precisely what was said.[239] Whether or not it is completely accurate, it seems to me to be a fair reflection of the attitude at SaSSHA at the time: this was not one of the best performing trusts but they did not think it merited any special attention, focusing, as they were, largely on financial issues rather than clinical ones.

The concerns of Helen Moss

1.178 Dr Moss started in post as Director of Nursing at the Trust in December 2006 and immediately contacted Peter Blythin, Director of Nursing at the WMSHA, asking for a meeting as part of her induction.[240] The meeting did not take place until March 2007. While no note was taken Mr Blythin recollects that Dr Moss:

> *... highlighted the challenges she was facing in not having the benefit of a corporate nursing infrastructure similar to the one at the teaching hospital she had just left. She noted that she had to focus much more at Mid Staffs on detailed implementation of her work, whereas in a larger hospital, the organisation would usually have an infrastructure in place to deal with such details for her ... I do not remember she expressed any concerns about her role at the Trust.*[241]

1.179 Mr Blythin was aware that Dr Moss was relatively inexperienced as a director, particularly in a small trust such as this, having previously been a deputy director at a much larger organisation.[242]

238 PT/27 WS0005000664
239 Taylor WS0005000444, paras 80–81; Taylor T72.19–20
240 PB/8 WS0000019824
241 Blythin WS0000019657, para 74; Blythin T69.121
242 Blythin WS0000019665, para 102

1.180 Mr Blythin had contact with her in connection with the Dr Foster report, in which Dr Moss was party to communicating the Trust view that the problem was one of coding and poor community provision of care for the elderly.[243] There were regular meetings at which she could have raised any concerns she may have had but did not.[244]

1.181 According to Mr Blythin, the first expression of concern about nursing he heard from Dr Moss was in July 2007, when she approached him with concerns about the infrastructure supporting her, and to tell him she was beginning to consider issues on the ward. In September 2007, almost 12 months after her appointment, according to Mr Blythin, they had a more specific conversation about identifying someone to carry out a nursing skill mix review.[245] Dr Moss recollected that she informed him of this problem before the review actually started at some point between June and August 2007.[246] In spite of the lack of clarity in the evidence it seems likely that Dr Moss made Mr Blythin aware at least in general terms, of her intention to conduct a skill mix review no later than July, given the fact that she had included this in the Trust's business plan in April. Whenever this occurred, she expressed the view that the Trust did not have enough registered nurses. Although she accepted she had no formal evidence to support this view, she was "convinced" there were not enough nurses.[247] Mr Blythin told the Inquiry he advised her that she should conduct a formal review of staffing levels.[248] He understood that a shortage of appropriately qualified nursing staff was a significant issue for patients and he discussed with Dr Moss what steps she was taking to ensure cover during the review and suggested to her a person capable of conducting such a review.[249]

1.182 The review was carried out between October and December 2007, but the report of the review was submitted to the Trust Board in March 2008. [250] It does not seem to have struck Mr Blythin as a matter of concern that it had taken a new Director of Nursing nearly half her first year in post to identify that there were concerns about nursing levels and that she had then needed to seek advice about setting up a review before doing so. Others have advised the Inquiry that the skill mix inherited from her predecessor was obviously inadequate. It may be that, as Dr Moss herself testified, she went to him to ask for someone to help carry out the establishment review,[251] but this would not alter the nature of the concern an SHA director of nursing might be expected to have. Mr Blythin would have been available at any time during that year to offer the advice he appears to have given at the earliest in May 2007, and yet no concerns had been expressed to him before then. This does not seem to have prompted concerns about Dr Moss's performance as a Director of Nursing or any real appreciation of the

243 Blythin WS0000019661, para 87; WS0000019667, para 108; PB/15 WS0000019878
244 Blythin WS0000019662, para 90
245 Blythin T69.126. Mr Blythin had initially stated that Dr Moss first spoke to him about this in December 2007 – Blythin WS0000019669, paras 118–119 – In oral evidence, he referred first to July and then finally to September 2007 – Blythin T69.126–127.
246 Moss WS35 WS0000009465; Moss T62.26–27. In a later communication she told the Inquiry she had spoken to Mr Blythin about this in May 2007.
247 Blythin T69.127
248 Blythin WS0000019670, para 120
249 Blythin T69.128
250 PB/22 WS0000019919
251 Moss T62.53

need for urgency about the conduct and implementation of the review. This point would be even more striking if, as he variously recollected, contact on this issue occurred in July, September and December. He may have received some assurance from Dr Moss because on his account he had advised her to use temporary and agency staff in the interim.[252] It did not seem to have concerned him either that Dr Moss might have needed this type of advice or that the overall time taken since the concerns about nursing had first been raised until completion of the report and the presentation of the issue to the Board was so long. In fairness, Mr Blythin did say that he had become "very anxious" about Stafford by Christmas 2007, but he made no connection between what he was hearing about staff shortages and skills imbalance with reported HSMR figures.[253]

The death of Mrs Gillian Astbury

1.183 Mrs Gillian Astbury died on 11 April 2007, in the same month as the release of the Dr Foster HSMR results. Mrs Astbury was an insulin-dependent and confused patient who was attended to in the community devotedly by Mr Ron Street, her partner. In March 2007 she developed a urinary tract infection for which she was admitted to Cannock Hospital. While there she experienced a fall which caused troubling symptoms, which persisted after her discharge. As a result she was referred to Stafford Hospital and was admitted there via A&E on 1 April. She was found to have a cracked right humerus and a pelvic fracture.[254] It was made very clear to hospital staff that she was an insulin-dependent diabetic. Mr Street told the Inquiry:

> *I made it perfectly clear to the doctor that Gill was a diabetic. I explained that she was what is categorised as a "brittle diabetic" and that she had early stage dementia and no longer appreciated the importance of her diet. I explained that she would therefore need regular monitoring.*[255]

1.184 There is absolutely no doubt that the fact of her diabetes and the need for insulin was something known to some members of staff and recorded in Mrs Astbury's records. They contain a note from Mr Street to that effect. The A&E records include a diabetes care plan including the need to give insulin, monitor blood sugar, and observe for hypoglycaemia.[256] The admitting doctor in the ward to which she was initially sent made a note of the diabetes and ordered that if her blood sugar rose beyond a specified level at any of the four blood tests to be conducted daily, she was to receive Actrapid. A daily dose of insulin was also to be given.[257] The doctor entered the prescription on a drug chart. A referral to a dietician was also required. Mrs Astbury developed suspected *C. difficile* and was transferred to Ward 8 on 8 April. While there the nursing shift coming on duty failed to undertake appropriate observations or administer insulin when required. There was a conflict of evidence available

252 Blythin WS0000019670, para 112; Blythin T69.43, 128
253 Blythin T69.135–136
254 Street WS0001000702, para 17
255 Street WS0001000703, para 19
256 SC00120000101–102, *Preliminary report to police of Irene Water* (July 2009), pages 11–12
257 SC00120000093, *Preliminary report to police of Irene Water* (July 2009), page 4

as to whether this was due to a failure of handover, or of staff failing to act on what they knew, or a combination. It is unnecessary for the purposes of this Inquiry to make a determination of that issue. Sadly, Mrs Astbury died on 11 April. Professor Tattersall, a forensic pathologist engaged by the police, expressed the opinion in a report in July 2007 that Mrs Astbury died of diabetic ketoacidosis.[258] The coroner's pathologist, Dr Whitwell, agreed in a report dated October 2007.[259]

1.185 An SUI report was filed on the national Strategic Executive Information System (STEIS) shortly after Mrs Astbury's death.[260] The report made it clear that the deceased was an insulin-dependent diabetic and that insulin had not been signed as having been given on the morning before her death. At the time of the report this could not be confirmed as a staff member was off duty and could not be contacted. Had the report been considered by an informed manager at the SHA it would have raised serious questions requiring urgent investigation.

1.186 A thorough investigation of the case was conducted by Stuart Knowles, Trust Solicitor, but it was not concluded until considerably later in the year. As the report[261] is undated it is not possible to be sure of the precise dates, and Mr Knowles could not remember,[262] but as it refers to statements taken from members of staff in May and June, and an action plan which is dated October 2007, that is likely to be the date the report was finalised. The report identified the following "problems":[263]

- Failure to control diabetes;
- Failure to administer prescribed drugs;
- Failure to undertake nursing handovers properly or at all;
- Failure to complete nursing records adequately or at all;
- Failure to conduct medical ward rounds properly;
- Failure to make adequate or proper notes of ward rounds and care plans;
- Failure to give the patient a diabetic menu;
- Failure to report this matter as an SUI in a timely fashion;
- Failure to report to the coroner.

258 SCC00130000069, *Supplementary Expert Medical Report in the case of Gillian Astbury, deceased* (30 July 2007), Professor Robert Tattersall
259 SCC00130000063, *Additional Statement of Dr Helen Whitwell* (16 October 2007), Dr Helen Whitwell, page 3
260 Although Mr Knowles's report alleges there was a failure to report the incident as required by the relevant policy (see below), there is a record of an SUI report no 2007/3518 which relates to this incident and is recorded as having been reported on 10 April (see list at CURE0046000546, Moss HM/76). The report itself – PB/54 WS0000024900 – contains an audit trail indicating that it was first logged in STEIS on 13 April. Therefore, it must have been filed in the STEIS system within a short time of Mrs Astbury's death.
261 SCC00110000019; HCC0024000128; WS0000001358
262 Knowles T131.123
263 In fact, there is compelling evidence that the matter was reported to the coroner before this report was completed as the coroner's post-mortem was conducted on 12 April 2007 – SCC00130000014

1.187 Other serious concerns raised by the report included:

- *Nursing staff appeared to be demotivated and on occasions ignored instructions (for example with regard to note-taking) given by line managers. There was a failure to comply with professional guidelines with regard to note taking and more generally. There was poor communication between nursing and medical staff ... There was a common complaint that the skill mix on the ward was wrong ...*
- [on root cause analysis] *the incident decision tree shows that a systems failure led to this patient safety incident and we need to concentrate on tackling the underlying problems involved;*
- *Handover between nursing staff is inconsistent and sometimes non existent;*
- *Whilst the consultant is clear about the ward rounds that should take place it is unclear whether these actually do take place properly;*
- *The nursing records for this particular patient are almost non-existent. There is no evidence of what care took place ... during interview nursing staff admitted that they did not check or read the notes regularly (if at all) and there was no linkage with notes from other wards;*
- *I was unable to discern specific procedure, policies and guidelines to ensure that nursing care, communication and staff morale were properly monitored and controlled.*
- *Staffing levels and skill mix on the ward were poor ... there were occasions when there was only one qualified nurse on the entire ward ... one common complaint was that nursing staff felt inadequately supported by a lack of healthcare support workers ...*
- *Unfortunately it cannot be said that these failures are an isolated incident and unlikely to re-occur. It is clear from talking to the staff (and examining other medical records) that similar issues are occurring regularly.*

1.188 It is not clear from the evidence what was done with this report. Mr Knowles thought he would have given it to Dr Moss, Director of Nursing.[264]

1.189 At the SHA the SUI should have been considered by someone capable of judging its gravity and followed up, but the SHA system did not ensure that this happened. In his initial evidence to the Inquiry Peter Blythin, the SHA's Director of Nursing, said that "sadly" the report had not come to him.[265] Having reconsidered the matter, he returned to give further evidence that in fact the incident had been "red flagged" and he had been informed of it by email on 13 April 2007.[266] The email contained a link to enable the recipient to read the form, but Mr Blythin stated that he had not done this. The email suggested that there was no expectation he should do so. On 24 May 2007 he was sent a further email listing all 110 "red flagged" SUIs,

264 Knowles T131.123
265 Blythin T70.53
266 Blythin T75.4–5; Blythin WS(2) WS0000024876, para 3; PB/53 WS0000024882

including the Astbury case, requesting an update.[267] Again, it is unlikely that he was expected to review them. An SHA manager was listed as the lead for this particular incident.

1.190 On 12 June 2007 the Trust provided an update to the effect that it was a coroner's case and that the post-mortem result was awaited.[268] The incident was included statistically in a summary report considered by the SHA Patient Safety and Quality Group on 8 August 2007,[269] but there is no evidence that it was specifically discussed, and it seems unlikely that it was, as was accepted by Mr Blythin.[270] For unknown reasons, a DH official logged into the case on 20 August 2008. On 27 August, the same day as it sent a copy of the investigation report to Mrs Astbury's family,[271] the Trust updated the report to record that its internal investigation had been completed and actions identified. It is not clear whether this was intended to refer to Mr Knowles's report, but the Inquiry is satisfied this had been completed in or before October the previous year. No further action on the part of the SHA is recorded as having taken place until 27 January 2010 when, in a routine exercise, the SHA emailed the Trust with a list of "open" SUIs, including the Astbury case, asking for an update.[272] The Trust replied on 4 February 2010 stating that in all cases root cause analysis had been completed and action plans implemented. Someone at the SHA logged in on 22 March 2010 to record that the case was closed.[273] The SHA did not receive a copy of Mr Knowles's report until 20 September 2010.[274]

1.191 This incident, as is clear from Mr Knowles's report, raised in the clearest possible terms issues of concern which were not limited to the facts of a tragic case, but demonstrated serious systemic failings on the part of the Trust in nursing supervision, conduct and support, medicines management and record keeping, to name but a few. The theory behind the SUI reporting system is that such matters are identified rapidly and appropriate steps are taken to put them right. Instead, the case was blighted by a delayed investigation and, as will be explored in *Chapter 13: Regulation: the Health and Safety Executive*, considerable delays in the conclusion of the inquest, and to this day an inability on the part of the Health and Safety Executive (HSE) to decide whether it should prosecute the Trust over the deficiencies shown up by the case.

Children's services risk score

1.192 In 2007, the Children's Services Steering Group developed a system of risk scoring of acute trusts based on the results of previous visits. In May 2007, more than a year after the 2006

267 Blythin T75.4; PB/55 WS0000024890 letter from SHA containing additional evidence and attaching documentation from Peter Blythin
268 SHA00000000349
269 PB/57 WS0000024927; Blythin (WS2) WS0000024878, para 11
270 Blythin T75.10–11
271 Blythin T75.24
272 Blythin WS(2) WS0000024878, para 13; PB/58 WS0000024933
273 Blythin WS(2) WS0000024879, paras 14–15
274 WS0000025006, e-mail containing original investigation report dated 20 September 2010

visit, the Trust was sent a letter showing the risk score arising from it.[275] According to Ms Eminson:

> *This analysis showed Mid Staffordshire General Hospitals NHS Trust as having the highest risks of any acute Trust in the West Midlands.*[276]

Strategic Health Authority risk assessment

1.193 In a report of 16 July 2007 the SHA management team reported on the risk assessments of NHS trusts in their patch by reference to quality and outcome indicators.[277] It reported the Trust as being a high risk by reference to the 18 week waiting time target, hospital acquired infections and quality and safety. The high mortality as reported by Dr Foster, high hospital acquired infection and an absence of a plan to control *C. difficile* were noted. Steve Allen from the WMSHA pointed out that the list did not include FTs, several of which were causing equivalent or great concern.[278] That is unlikely to be a factor reassuring to the public. Mr Allen agreed that this report meant that the Trust was one requiring particular attention with regard to hospital acquired infections and safety.[279] It is generally agreed that the quality measures in place at this time were neither sophisticated nor sensitive, but it appears that even on those that were available there was cause for concern. It is fair to say that action does appear to have been taken on hospital acquired infections, but that taken in relation to the HSMR was, as we shall see, wholly inadequate.

Helene Donnelly's complaint

1.194 On 28 October 2007 a nurse in A&E at the Trust lodged a whistleblowing complaint with her manager about the conduct of senior staff in her department.[280] She alleged that she had been asked to "lie" about a number of patients whose length of stay in the department was breaching the four-hour waiting time target. By this she meant that she had been asked to fabricate the times recorded in the notes, to make it look as though the patients had not been in breach of the target.

1.195 She told the Inquiry that this was a practice which had been going on for a long time:

275 CJE/25 WS0000023436
276 Eminson WS0000022931, para 57
277 STA/8 WS0005000274
278 Allen T71.57
279 Allen T71.58
280 Donnelly WS0000022301, para 19; HD/2 WS0000022336

I think generally if there'd been an excessive amount of breaches on a particular shift, or what the trust deemed as an excessive amount, it was always reported and explained in a meeting the following morning, which again is why there was the pressure to massage the figures because if you as the nurse in charge in that particular shift had had an excessive amount of breaches, you were then held responsible and had to explain it. And I understand that a lot of pressure was placed upon sisters in charge, particularly, and they felt responsible and sort of were made accountable, which was why they wanted to avoid that happening by obviously lying about the times.[281]

1.196 On 27 November 2007, she supplemented the first report with a second.[282] In this she complained that she had been threatened by colleagues of the nurses referred to in the first report and alleged that the senior sister behaved in an inappropriate and bullying manner towards her staff and junior doctors, for instance in making derogatory comments.

1.197 In her evidence to the Inquiry, Staff Nurse Donnelly described the bullying culture that appeared to prevail in A&E for some years:

The culture in the department gradually declined to the point where all of the staff were scared of the Sisters and afraid to speak out against the poor standard of care the patients were receiving in case they incurred the wrath of the Sisters. Nurses were expected to break the rules as a matter of course in order to meet target, a prime example of this being the maximum four-hour wait time target for patients in A&E. Rather than "breach" the target, the length of waiting time would regularly be falsified on notes and computer records. I was guilty of going along with this if the wait time was only being breached by 5 ... or 10 minutes and the patient had been treated ... [but] *when wait times were being breached by 20–30 minutes or more and the patient had still not been seen, I was not prepared to go along with what was expected.*[283]

I was concerned about the terrible effect that our actions were having on patient care. I did raise this with Sisters [X] *and* [Y]*, however their response was extremely aggressive, basically telling me that they were in charge and accusing me and anyone else who agreed with me of not being team players.*[284]

1.198 An investigation involving an external investigator was conducted into Staff Nurse Donnelly's complaints, and for a time the senior sisters who were the subject of the allegations were moved out of the department.[285] The Trust has been unable to trace any final report of the investigation but has produced to the Inquiry an email to the then Head of HR at the Trust summarising the stage reached in it by 7 February 2008. In addition to Ms Donnelly, it was

281 Donnelly T133.128–129
282 Donnelly WS0000022302, para 21; HD/3 WS000002238
283 Donnelly WS0000022298, para 8
284 Donnelly WS0000022300, para 13
285 Ovington WS(2) WS0000074514, para 4; Plant WS0000074507–508, paras 5–7

recorded that three other complainants had been interviewed. The "themes" that had emerged from the interviews were reported to have included:

- *Staff were fearful of previous managers and Sisters were harshly spoken to if breaches occurred on their shift;*
- *Staff within the A&E department developed ways of avoiding breaches, such as transferring patients to CDU or to record an incorrect time;*
- *Sisters still report considerable pressure to avoid breaches. This is noted to be very difficult at times, with bed pressures, patient flows, portering difficulties etc;*
- *Junior members of staff have felt pressured by some sisters to alter discharge times and have felt unable to challenge them ...*

1.199 It is fair to note, as did the email, that some of the information received in the investigation was disputed.[286]

1.200 After she had made her complaint, Ms Donnelly felt the atmosphere was so unpleasant she approached the RCN for assistance and was offered advice by Adrian Legan, the RCN's Regional Officer. Unknown to her, he was also advising and representing the nurses who were the subject of the complaint.[287] She described him as being "dismissive" of her complaints.[288] His advice was that she should "keep her head down". Effectively he told her there was little that could be done. When Ms Donnelly found out that he was representing the others, she was understandably upset:[289]

> *... at the time it felt almost like a conspiracy. I felt completely on my own.*
>
> *I suppose that's quite a strong word, but at the time, particularly with all the threats that were being made against me and the fact that nothing really seemed to be moving forward, nothing seemed to be really happening, albeit the two sisters had been removed, but nothing seemed to be happening, no resolution seemed to be forthcoming, I started to get concerned, which again is obviously why I accessed the RCN in the first place. And then to be dismissed in the way I was and to be actually told just to keep my head down and not raise any further issues, and then to find out that he was representing one of the other sisters, so obviously had further knowledge about the situation, which he hadn't declared, just did seem very unfair to say the least, really, that I hadn't at least been made aware of that, so I could have then sought advice from perhaps somebody else.*[290]

286 CP/1 WS000007451–512
287 Donnelly WS0000022304, para 28
288 Donnelly T133.143
289 Donnelly WS0000022303–4, paras 26–30
290 Donnelly T133.145–146

1.201 Mr Legan's recollection differed from Ms Donnelly's. He recalled only being contacted once by her after the complaint against the A&E sisters had been dealt with at a point where it was too soon to offer support or action as there had been no opportunity for the decision and the resultant changes to take effect. He did not accept that she had asked for representation or advice or raised concerns about patient care or safety. In hindsight he accepted that he should have referred her to RCN Direct (the RCN's helpline).

1.202 Although Ms Donnelly offered evidence to the first inquiry she did not at that time refer to the issue with Mr Legan. Indeed, some of her evidence could be read as being inconsistent with her statements to the Inquiry. While she gave oral evidence, Mr Legan was not asked about this issue in his oral evidence. However, this is unnecessary to resolve the central issue of interest in this Inquiry. The Inquiry is satisfied that Ms Donnelly did have contact with Mr Legan and that she did raise her concerns at the time: there is no other reason why she would have contacted him. It is accepted that he had also assisted the nurses complained against. As he accepts, he should have referred her elsewhere for assistance in what was obviously a very difficult situation for her. It cannot have been appropriate for him to have done less, particularly given his prior involvement with the very members of staff against whom Ms Donnelly's complaint had been directed. The absence of any action by Mr Legan in response to this approach from a nurse, who must have been anxious at the time, suggests that, whatever precisely was said in this conversation, Ms Donnelly reasonably received the impression she was being advised to "keep her head down" and was offered no further help.

1.203 No issue was raised in the course of the evidence to suggest that Ms Donnelly was incorrect in the other assertions she made, and they are accepted as being broadly reflective of the state of A&E at the time.

1.204 What she says is consistent with the observations of the HCC investigation which made its findings without knowledge of what Ms Donnelly could have told it. However, it would be wrong to make any findings suggesting that the specific allegations against the sisters she named in her statement, but whose names were not read into the public record, were proved. Those individuals were not invited to give evidence to the Inquiry and it would not have been proportionate to have conducted what would have amounted to a trial of their conduct in any event.

1.205 In due course the nursing sisters were returned to duty in A&E. The Trust accepts that there is no complete record of the disciplinary process and no formal determination appears to have been made as to whether Ms Donnelly's allegations were accepted or not. Chris Plant, current Head of HR at the Trust, told the Inquiry that a member of staff who attended the meetings recollected that the two nursing sisters complained against had been issued with "level 1 warnings", which was understood to have been the result of an agreement between

Mr Legan and Mr Yeates. It appears that the investigation was then stopped and the sisters were allowed to return to their posts in A&E.[291]

1.206 In the course of the HCC investigation Ms Donnelly approached a member of the team to speak to them and her name was taken down.[292] As far as she was concerned the atmosphere in the department continued to be poisonous and she felt it was impossible to continue to work there. In June 2008 she found a job elsewhere.

1.207 It is clear that Ms Donnelly's reports at the time made a serious and substantial allegation about the leadership of A&E. This was not resolved by the Trust management who reinstated the nurses without coming to any final resolution of the issues and gave no adequate support to Ms Donnelly. These issues were not made known by the Trust at the time to any external agency, including the HCC at the time of its investigation of A&E, but they were known to the RCN because of its involvement with the protagonists described above.

1.208 A department in which performance information is or is alleged to be fabricated, and in which staff feel bullied into doing this, is not one which can safely be assumed to be providing a safe service to patients.

Royal College of Surgeons invited review in 2007

1.209 From the time of her appointment as Medical Director, Dr Val Suarez had harboured concerns about the Surgical Department. She had particular concerns about two consultant surgeons. She had a number of audits and other reviews undertaken but these came up with no evidence of concern. She approached the National Clinical Assessment Service (NCAS) who agreed with her proposal to invite the Royal College of Surgeons (RCS) to conduct a review, which she then did in January 2007.[293]

1.210 The review team attended the Trust in June, but its report was not delivered until October. One of the surgeons criticised in the report complained that it was unfair and amendments were made, although these did not alter the thrust of the critical findings. These included, in summary:[294]

- It was a widely held perception within the Trust that the Surgical Department was dysfunctional and lacked effective leadership;
- The colorectal department had been perceived as dysfunctional since the appointment of a particular surgeon in 2003;

291 Plant WS0000074507, para 6
292 Donnelly WS0000022306, para 36
293 Suarez WS0000012499, paras 84–85
294 VS/19 WS0000012667

- There appeared to be no working relationship between that surgeon and the other surgeon working in the team:

  There is no cohesion within the department, which makes it very difficult for other members of the team to function in a satisfactory way ...

- Multidisciplinary team meetings were compromised by disagreement;
- The surgeons worked independently of one another; there was little communication between them;
- There were no departmental protocols on bowel preparation, antibiotic usage and post-operative management;
- Many colleagues perceived the decision-making of one of the surgeons in the colorectal department as sometimes being poor, and the complication rate from operations conducted by this surgeon as being high;
- The surgeon was prone to blame others; many perceived this individual as very difficult to work with:

  The situation in theatre appears to be fraught and the Panel learned of serious problems. It would appear that [the surgeon concerned] *finds it difficult to work under stress, when the atmosphere becomes very tense. A number of theatre staff will not work with* [X]. *The Panel understand that there have been a number of complaints made against* [X] *and at least three of these were allegations of assault, which the Trust has investigated and dealt with accordingly ... when* [X] *is not in a stressful situation* [X] *is very charming and courteous when talking to patients ...* [The surgeon] *has no idea as to why there are these perceived problems;*[295]

- A major concern for the panel was that the surgeon had little or no insight into the problems that had occurred over the previous four years (although colleagues had noted improvements recently). The surgeons put themselves into stressful situations:

  ... especially when [X] *does not communicate with* [X's] *senior colorectal colleague ...*

- Both surgeons were well-meaning but lacked a degree of insight into their own personalities and the effect of their actions on others;
- None of the audits provided by the Trust for review indicated abnormal complication rates or post-operative mortality;
- Four litigation cases relating to this surgeon were reviewed. Adequate information was available on three of them to form a view of the surgeon's conduct. The report stated:

  Although these cases expose very real concerns regarding [the surgeon's] *competence, they were all early in* [the surgeon's] *career in Stafford and one hopes that lessons have now been learned.*[296]

295 VS/19 WS0000012668
296 VS/19 WS0000012661

1.211 The report made a number of recommendations, including:

- That the department needed to be revitalised with strong leadership;
- Both surgeons needed help to communicate more harmoniously;
- An additional surgeon should be appointed;
- Funds should be made available for audits;
- Agreed protocols were required in a number of areas.[297]

1.212 Specific recommendations were made for the surgeon about whom there was the most concern expressed. They suggested the involvement of a psychologist, mentoring, and a very careful audit of the surgeon's work, possibly including a redirection to less stressful activity. The Trust was urged to formally review the situation regularly and take appropriate action if improvement was not sustained.

1.213 The Trust's reaction to the report and implementation of its recommendations were less than energetic. While an action plan was prepared:[298]

- It took until April 2008 to replace the clinical lead for general surgery in spite of the problems identified in the report;
- Arrangements for retraining of the surgeon giving cause for most concern were only agreed in June 2008;
- The recommendation to appoint a new colorectal surgeon was not accepted but instead it was agreed to "consider" replacing an existing surgeon. By October 2008 a post had been advertised, and discussions were continuing with a neighbouring trust about a shared post;
- Clinical audit plans were approved by the Board only in May 2008. It is unclear when, if at all, these started to be done by the clinicians. The October 2008 report on progress does not say they were;
- The two surgeons for whom psychological support was recommended underwent this fairly promptly, but both told the first inquiry that they had not found this helpful.[299] However, it was decided to give this support to all surgeons;
- The recommended protocols were still not in place in October 2008 but were "currently being developed".

1.214 The report reviewing progress on implementing the recommendations, from which the above summary of actions is taken, was made in October 2008. It claimed that:

297 VS/19 WS0000012675
298 HCC0083000360, *Report of Medical Director to Executive Governance Group at Mid Staffs* (20 October 2008)
299 *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005* (March 2009), chaired by Robert Francis QC, volume 1, p277

the majority of the action plan is complete ... the outstanding items relate to lack of progress by the previous Clinical Lead for General Surgery ... now being addressed by new Clinical Lead.[300]

1.215 This invited review was sought by the Trust because of long-standing difficulties that it perceived existed in surgery. The report itself only arrived three months after the review team's visit, at which the deficiencies described were identified, nearly a year after the Medical Director Dr Saurez had identified the concerns prompting the review. She herself accepted that this period was "unacceptable".[301] The risks to patients clearly implied by its findings were not only in the past but were continuing. More than enough time had elapsed before the report was finalised to warrant the most urgent and decisive action. The consequences of this prevarication were to be seen clearly in the findings of the next RCS review in 2009, as described in *Chapter 2: The Trust*. The 2007 report itself was known at the time only to the Trust, the relevant staff and the RCS. It showed a state of affairs which would have been expected to cause serious concern to the public and any regulator if known to them.

1.216 Dr Suarez told the Inquiry that she had difficulty with the report:

In my evidence to the first inquiry I said that I was disappointed with the report ... and that I felt a sense of "false reassurance". The RCS's first report did not say that the Trust had a problem with one or both of the surgeons. It gave recommendations for psychological support and implementing audits which all seemed very reasonable. However, there would seem to have still been problems with the relevant Department, which were not resolved by these recommendations given the need for a second review [ie the 2009 review].[302]

1.217 In retrospect Mr Durrans, a consultant at the Trust, described the report as being "soft".[303]

1.218 While it is possible to be sympathetic with their disappointment, to the extent that the report did not offer findings and recommendations which were as clear as they might have been, or offer robust solutions, the Inquiry does not agree that it offered "false reassurance". It raised serious concerns about lack of leadership, absence of essential protocols, and issues around the attitude and competence of at least one consultant. These were all matters which were likely to impact on the safety of patients and the standards of care offered to them, even if the report did not make such a link explicit. On an objective reading the report contained evidence that this was a trust with serious problems that the management appeared to be incapable of solving in a timely and effective manner.

300 HCC0083000360 *Report of Medical Director to Executive Governance Group at Mid Staffs* (20 October 2008)
301 Suarez T59.106
302 Suarez WS0000012504, para 103
303 Durrans T55.25

2008

Healthcare Commission concerns

1.219 On 14 January 2008 Dr Rashmi Shukla of the WMSHA was informed in a telephone call by Nicola Hepworth, Investigation Officer at the HCC, that they were considering an investigation into the Trust.[304]

1.220 On 28 January Dr Heather Wood of the HCC wrote to the Trust, formally requesting under its statutory powers further information to enable it to consider what was the appropriate course of action, including the possibility of a formal investigation.[305] The letter referred to the information obtained about significantly high mortality rates for various diagnoses derived from the Dr Foster Unit's data, which had been the subject of the alerts referred to above, the absence of a response to an HCC request for information about some of this, the HCC's own analysis of mortality showing significantly high rates in other diagnoses and an above average rate for all emergency admissions with an increasing trend from 2005 to early 2007. The letter was copied to Dr Rashmi Shukla. Dr Shukla was surprised that mortality alerts had been generated without the SHA knowing about it. She had been unaware that the HCC was undertaking its own analysis, which generated additional alerts.[306]

1.221 On 29 January 2008 Dr Shukla circulated the HCC letter to colleagues, including Ms Bower in an email which referred to the mortality work already being conducted at the SHA's behest. She gave this warning:

> *As for all our high mortality trusts the issue of coding has been a significant factor. However we cannot explain the high rates to be solely due to coding inaccuracies so we are auditing care for three specific conditions to examine as a proxy ... This area is a potential minefield as Steve* [Allen] *will attest. Depending on what subanalysis is done, there is bound to be at least one or more statistically significant abnormal results* [sic][307]

1.222 Having deferred the Trust's FT application on a previous occassion, once it became apparent that there was going to be a protracted investigation, Dr William Moyes, Chair of Monitor, thought that Monitor would then have decided to reject it:

304 Shukla WS0000018560, para 106; RS/37 WS0000019030,
305 CURE0061000031; SHA0011000048
306 Shukla T69.49–50
307 RS/39 WS0000019040; Shukla T69.51

if we had known at this stage, before we authorised, that the Healthcare Commission were planning an investigation on this scale – I shouldn't speak for my former colleagues, but I can't really envisage Monitor's board saying, "Well, it doesn't matter, we'll just carry on", or, "We'll just postpone it". I think this would have [been] *regarded as extremely serious, serious enough to say, "No, we'll reject this application".*[308]

1.223 In an undated letter of reply to the HCC's letter of 28 January, Dr Suarez offered some of the information requested but not all of it, citing a "loss of corporate memory".[309]

1.224 On 5 February 2008 Nicola Hepworth of the HCC informed Monitor of its interest in the Trust by email asking for any information Monitor might have about them.[310] FT status had been granted to the Trust with effect from 1 February, four days earlier. At the time it appears that the HCC investigation team was unaware that an application for FT status was pending, and Monitor was unaware of the HCC's concerns about the Trust. The HCC's regional team was aware of the application, but had not communicated that information to the HCC head office. Monitor had not been informed by the SHA of what it had learned from the HCC in January.

1.225 It is clear that if Monitor had learned of the HCC's concerns, even as late as the letter of 28 January, it could, and probably would, have halted the process of granting FT status until these developments had been reviewed. Dr Moyes told the Inquiry:

I think ... if I'd seen [the HCC letter of 28 January] *or* [others at Monitor] *had seen it, any of us would have said right in the way, "In the light of this, we should stop". And – and I don't mean reject, I just mean stop and say to the trust, "Until this is clarified, we will put your application on hold, and then once we know the outcome of this, we will reactivate the application and take a decision."*[311]

1.226 On 14 February a report was given to the HCC investigations committee about the serious concerns harboured about the Trust.[312] In the report the number of mortality alerts to which the Trust had been subject was described as "unprecedented". As it appeared likely that a decision to launch an investigation might follow a planned but unannounced visit to the Trust, the committee resolved to delegate any decision to launch an investigation to the Chairman of the committee to prevent any delay.[313]

1.227 On 26 and 27 February 2008 the HCC conducted an unannounced inspection of the Trust. The HCC had had its level of concern increased by further work on the mortality rates, an apparent lack of cooperation by the Trust with HCC enquiries, and a flood of complaints from the public.

308 Moyes T93.25
309 NE/29 WS0000028140
310 HW/5 WS0000025127
311 Moyes T93.24
312 NE/26 WS0000028110
313 NE/31 WS0000028150

The SHA became aware of the visit as it happened, because, coincidentally, Mr Blythin was visiting the Trust at the time.[314] Dr Wood informed Dr Shukla of what had happened, and the latter made an informative note of what she was told about the findings of the visit:

> *... the Healthcare Commission has received through its helpline and completely unsolicited a number of concerns raised by patients and relatives in the locality expressing dissatisfaction about the nursing care, particularly care of older patients and surgical patients, although there were a few that related to maternity. They received thirty to forty such representations. Given this information and the alerts the HCC decided to undertaken an unannounced visit ...*
>
> *From the unannounced visit, there were concerns about nursing that related to numbers of nurses available at night, nurses not answering the buzzers, patients not getting pain relief, elderly patients not being helped to go to the toilet. During the visit in the Emergency Assessment Unit, the* [HCC] *visitors had to rescue one patient from falling out of bed and there was a tendency in the visit for the* [HCC] *visitors to be escorted rather than being allowed the free reign of the Trust ...*
>
> *In addition, despite nursing levels being an issue that the Trust is aware of, and given that nursing care has been identified as one of the top five concerns on the Trust's Clinical Governance and Effectiveness Committee, there has been no mention in the public Board* [meetings] *about this.*[315]

1.228 The HCC's concerns were in relation to:

- Mortality relating to emergency surgical admissions;
- Levels of nursing and nursing care;
- The care and attention given to patients in terms of patient experience;
- The level of cooperation from the Trust with the HCC.

1.229 A meeting was arranged between the HCC and the Trust, with an SHA observer present, on 5 March, and there was communication between the HCC and Professor Lilford and Dr Mohammed Mohammed's team from Birmingham University, which was analysing the HSMR data for the SHA. Those steps did not allay the HCC's concerns and Dr Shukla was informed of this by telephone on 6 March.[316]

314 Shukla T69.57
315 RS/41 WS0000019051–052, paras 3–4
316 RS/43 WS0000019057

1.230 On 13 March 2008 Dr Wood emailed Dr Shukla to inform her confidentially and in advance of the public announcement that the HCC had decided to launch a formal investigation.[317] A formal letter and terms of reference followed on 19 March.[318]

1.231 A formal investigation of the type launched by the HCC into this Trust was an unusual event, only embarked upon where there was serious cause for concern. The reaction of other bodies responsible for oversight and regulation was to await the outcome of the investigation and to rely on the HCC to inform them of matters requiring urgent attention, rather than to consider for themselves what was wrong and what, if anything, needed to be done for the protection of patients.

Healthcare Commission concerns identified in May 2008

1.232 On 20 and 22 May the HCC's investigation team inspected the Trust's A&E. The team had a number of provisional findings which caused them serious concern.[319]

- The department was considered to be understaffed in relation to medical and nursing staff. There was a single-handed emergency consultant in A&E in spite of a College of Emergency Medicine recommendation that there should be at least four.
- The consultant did not appear to be offering leadership to the department.
- At times the most senior doctor in the department was someone without postgraduate qualifications in emergency medicine.
- There was inadequate cover from middle grade doctors.
- Junior doctors received insufficient support and advice.
- There was no nurse leader with clear accountability for nursing and leadership, no regular appraisal, induction or preceptorship. There was low morale evidenced by distressed staff, excessive hours, no meal breaks and staff turnover.
- Staff were so low in numbers that receptionists were undertaking triage.
- The policy for use of the Clinical Decisions Unit (CDU) was unclear to staff. The CDU had minimal staffing and patients were not adequately monitored.
- There were few protocols and pathways for use in the departments and those that did exist were not audited. Little clinical audit was apparent and where it had taken place it had not been acted on, even where the results were unsatisfactory. There were no mortality or morbidity meetings and junior doctors rarely received any feedback on performance.

1.233 So serious were the concerns raised by this visit, Dr Wood immediately informed Mr Yeates and Mr Poynor, PCT Chief Executive, late that night. She followed this up with a letter on 23 May.[320] The letter concluded:

317 RS/46 WS0000019088
318 NE/32 WS0000028155
319 HW/6 WS0000025129
320 Wood WS0000025057, para 126; HW/6 WS0000025133

In summary, there appears to be an almost complete lack of effective governance.

Although we noted some positive factors ... our judgement is that the staffing shortages, operational problems, and lack of leadership and governance mean that, despite the efforts of staff, the quality of care is compromised and that this constitutes a risk to the safety of patients.[321]

1.234 The letter was copied to the SHA and SSPCT. Nigel Ellis of the HCC emailed a copy to Monitor and the DH of the action being taken. Dr Wood told the Inquiry that her team had to consider whether to issue a notice to close the department but concluded that the adverse implications for patients needing its service outweighed the risks of permitting it to continue:

Because we unearthed such serious concerns about the safety of patients in A&E, the team had to consider whether to issue a notice to close the Department. However this would have been a major step to take with very serious implications – not least where patients could go ...[322]

1.235 However, they felt that:

This was an occasion where the risks to patient safety required immediate attention and we flagged those up for action straight away.[323]

1.236 The Trust and the PCT held a meeting to discuss the issues raised on the day of the inspection. A report dated 28 May 2008, prepared by Mr Griffiths of SSPCT, noted that the Trust requested an additional £775,000 funding for medical and nursing staffing and support.[324] It was also reported that the Trust had identified a £2.5 million shortfall in the necessary funding to correct nursing capacity and skill mix issues. The Trust had stated that it could not afford more than £1.15 million out of its own resources. The report stated that the PCT supported the view that nursing levels should be increased but was not sympathetic to the request to fund the gap.

1.237 Mr Yeates replied to the HCC on 3 June.[325] He accepted that:

A comprehensive approach is required in order to ensure that all issues are addressed in a systematic way ... A detailed project plan is now being developed to ensure that all matters outlined in your letter and any further issues raised in the diagnostic phase by the clinical team ... are captured and addressed.

321 HW/6 WS0000025133
322 Wood WS0000025057, para 126
323 Wood WS0000025057, para 126
324 Morrey WS0000011226, para 108; KM/50 WS0000011712
325 NE/44 WS0000028232

1.238 Mr Yeates set out his plan to obtain advice from a team from Heart of England NHS Foundation Trust. In relation to staffing issues he explained that advertisements for permanent consultants had been placed in May and interviews were due soon. Locums had been appointed in the meantime. One of two permanent consultants had left at the end of April and the process of replacement had been complicated by advice from the Royal College that a minimum of three consultants was required. It had also been indicated that the advice might change in the autumn to a requirement for four consultants. He said that middle grade cover had been reduced to fund the additional consultant cover but accepted that this was not tenable: the Trust was now recruiting for nine posts, of which it appears that only three were currently filled. He said that the Board had agreed to further nursing recruitment following the recently completed nursing skill mix review. He assured the HCC that the governance arrangements were being reviewed.

1.239 Later in June the Trust prepared an action plan entitled *Making It Happen in A&E in MSFT June 2008*.[326]

1.240 The HCC had clearly uncovered an appalling state of affairs in the Trust's A&E, giving rise to risks to patient safety. While Mr Yeates's letter sought to give the impression that the Trust was aware of, and had been in the process of addressing, many of the issues, it ought to have been clear to any informed observer at the time that the fact that such a state of affairs existed gave rise to serious questions over the capabilities of a leadership that had not succeeded in forestalling it.

Educational concerns

1.241 The SHA Workforce Deanery was managed by Mr Blythin. On 13 May 2008 deanery staff visited the Trust to review junior doctor training, clinical placements and supervision. Dr Turner, then a Specialist Registrar in emergency medicine, raised his concerns about A&E with them.[327] He had joined the Trust's A&E in October 2007, at which point he would have had over 15 years' training as a doctor and was in his fifth, the final, year in emergency medicine.[328] He is now a consultant and, as one of the few medical practitioners to raise concerns articulately and in spite of being in the difficult position of a trainee, albeit a very experienced one, his assessment of what he found is worth reciting in some detail:

326 Morrey WS0000011226, para 109; KM/51 WS0000011718
327 Blythin WS0000019679, para 153
328 Turner T50.2–3

On arrival at Stafford I found the Emergency Department to be an absolute disaster. Its culture was unlike any other I had worked in despite being in the NHS for 25 years. There was a culture of bullying and harassment towards staff, especially the nursing staff. There was no evidence of an aspiration towards high quality patient care … There was no significant medical leadership, and fundamentally no vision of what "good" looked like … The quality of care which we provided for people coming into the Emergency Department was way below the quality provided in Stoke where I had been a few weeks before …

The first key reason for the dire situation was that there was not enough nursing staff and the staff who were in the Emergency Department, both medical and nursing, were utterly demoralised. They were struggling to survive during the day, doing their best for patients but facing a chronic lack of manpower …

The second reason for the problems encountered was the lack of a senior nurse, a matron-like figure to unite the team …

At the outset [management] *was clearly antagonistic. There was a blame led culture, the culture being that problems had to be fixed or nursing jobs would be lost. The treatment by management of nurses in particular was beyond belief. The nurses were threatened on a near daily basis with losing their jobs if they did not get patients out within the 4 hours target … it was quite normal for nurses to come out at the end of …* [bed management] *meetings crying … To prevent patients "breaching" the nurses would move them when they got near to the 4 hours limit and place them in another part of the hospital … patients were moved without people knowing and without receiving the medication … prescribed. The overriding concern … was to get patients out as soon as possible. The consequence was that patients received poor care.*[329]

1.242 Although he had not seen it before the Inquiry, Dr Turner thought that the concerns described in the HCC letter of 23 May, referred to above, exactly reflected his own concerns about A&E.[330] He considered that the number of staff available in the CDU was unsafe and that the practice of pushing patients out of A&E to meet targets was potentially dangerous.[331] He was also concerned at the proposal to introduce consultants in acute medicine alongside emergency consultants, particularly if it were to mean that emergency physicians would be the only senior doctors in the department at times, given their lack of qualification to deal with some major types of cases.

1.243 Dr Turner told the Inquiry that he had tried to raise his concerns with his educational supervisor but "got nowhere".[332] He raised concerns at a meeting of the College of Emergency Medicine at some point during 2008.[333] He telephoned the HCC twice without getting a

329 Turner WS0000005881–884, paras 6–17; Turner T50.4–6
330 Turner T50.28
331 Turner T50.14–15
332 Turner WS0000005885, para 21
333 Turner WS0000005886, para 22

response. On the third attempt there was a reaction and in due course he was interviewed as part of their investigation.[334]

1.244 On 13 June 2008, Dr Elizabeth Hughes (Acting Postgraduate Dean for the West Midlands Region) received from Dr Andrew Malins (the Head of the Postgraduate School of Anaesthesia, Critical Care and Emergency Medicine) a copy of a job evaluation survey tool (JEST) which had been completed by Dr Turner, although he is not identified by name on the form.[335] The following answers are illuminating about the state of A&E at the time:

- *Patient Safety: This appears to be low in the trust's priorities. It is compromised by a drive to avoid breaches at all costs;*
- *... Appraisal and assessment: No educational supervisor currently. Last one has left;*
- *Feedback on your work: No formal feedback thus far. I've been in post 6 months;*
- *Protected teaching – bleep free: Cancelled by trust on >75% of occasions. There is absolutely no commitment to education;*
- *Service based teaching: There is so little senior cover that it is unusual to find the opportunity. I have been criticised on 2 occasions in the last week for teaching (once in my own time and the other time I was not even teaching ...);*
- *Senior doctor cover: No on call rota, so no senior* [out of hours] *cover ... it is sink or swim. Department frequently covered by acute medics rather than emergency medicine during the daytime hours. As a consequence they cannot advise on anything other than physician matters;*
- *Clinical workload: ... The department sees between 50,000 and 55,000 per year with only 4 FT equivalent middle grades and 6 F2/GPVTS Drs. This reaches unsafe levels;*
- *EBM and audit: In general there is a complete lack of the will or ability to critically appraise information. Audit is commencing soon ...;*
- *... Would you recommend this post to one of your friends? Categorically no.*[336]

1.245 Dr Hughes forwarded this form to Mr Blythin. In her email she referred to the recently published Postgraduate Medical Education and Training Board (PMETB) survey for 2007 as being "really not too bad" for Stafford in A&E.[337] However, she thought that the JEST form:

> *shows the educational climate to be dreadful ... things are now very bad there for training and has significantly worsened since one of the consultants left ... it is an inappropriate training placement currently and we need to remove the trainee ...*[338]

334 Turner WS0000005887, para 25
335 ESI00003149–150
336 EH/19 WS0000062547–8
337 PB/30 WS0000020070
338 PB/30 WS0000020070

1.246 She accepted that, at that point, the training placement was inappropriate and that it would be necessary to remove the trainee. She thought there would be a need: "to manage the potential political consequences of this".

1.247 On 24 June Dr Hughes discussed the matter with Dr Suarez, and followed this up with an email the following day, referring to her "grave concerns" regarding training of the Specialist Registrar (SpR) in A&E.[339] She pointed out that it was possible that PMETB would remove accreditation for the post, which would have a knock-on effect for the placement of more junior trainees. In the meantime, an action plan was required. Dr Suarez replied on 2 July outlining the Trust's proposals in similar terms to those in Mr Yeates's letter to the HCC of 3 June (see above). In fact, it appears that Dr Hughes did not inform PMETB of these concerns at the time because she understood that because of the HCC investigation the matter was confidential to them.[340] This was never the intention of the HCC, and in any event would have been an unjustifiable position for them to take. However, this misunderstanding resulted in PMETB not finding out about these concerns before the publication of the HCC report.

1.248 It is clear from Dr Turner's evidence that the state of the A&E department he described in his answer to the job evaluation survey tool in June 2008 had existed, in his eyes, since his arrival in October 2007. It suggests that it predated this arrival. While some of what worried him might have been due to difficulties in retaining or recruiting consultants, this cannot account for his observation of a bullying, target-driven management culture.

Children's service review`

1.249 On 13 June 2008 a further peer review, following up the 2005–2006 review, was carried out at the Trust, to look at the care of critically ill and critically injured children. This identified a number of concerns which will, by now, be only too familiar to the reader. They included the points set out below:[341]

- The system for alerting and organising the appropriate team, such as paediatric resuscitation, was not considered robust. They found potentially dangerous confusion about the order in which various professionals should be called.
- A&E staffing levels were described as "seriously deficient". There was no consultant available outside normal working hours. There was a shortage of middle grade doctors. Nurse staffing was insufficient. There was no lead nurse working clinically in the department.
- Children arriving in the department were not routinely triaged.
- Dangerous drugs were found in accessible locations in open ward areas.

339 PB/33 WS0000020081
340 Hughes T114.90–96; Hughes WS0000062188, para 130
341 CJE/34 WS0000023625

1.250 Not surprisingly, the findings were consistent with those being made almost simultaneously by the HCC.[342] What is less easy to understand is that the Peer Review Team was not aware of the HCC assessment of A&E even though the letter of 23 May had been copied to the SHA. Ms Eminson commented: "... we were doing our job and they were doing their job ..."[343]

1.251 On 30 June Ms Eminson of the Peer Review Team, writing on WMSHA headed paper, wrote to Mr Yeates to inform him of these findings, which were described as: "an immediate risk to clinical safety or clinical outcomes".[344]

1.252 The letter made clear that on delivery of the report responsibility for follow-up of immediate risks transferred to the Trust's host PCT and requested a copy of the Trust's action plan before 21 July 2008. The letter was copied to, among others Mr Poynor, Chief Executive of the PCT, and Mr O'Donnell, Lead Commissioning Manager for Children's Services, West Midlands Specialised Commissioning (WMSC).

1.253 The final version of the report was sent to the Trust on 24 October 2008, and was copied to the PCT and SHA. Ms Eminson stated that this length of time was due to the number of comments made by the Trust and their unwillingness to accept the report's conclusions. There must be some doubt whether this was the reason for the lapse of time as Ms Eminson's July letter to the Trust made it clear that the final report would not be sent until October. However, the impression she conveys of the Trust's reaction is consistent with the conclusion reached in the first inquiry report: that the Trust was generally defensive in its reaction to constructive criticism. Ms Eminson stated that the balance of critical and positive remarks in this report was very unusual and was an indication of the level of concern the Peer Review Team had of this Trust.[345]

1.254 This report itself should have been sufficient to make apparent to the organisations receiving it that there was potential concern about the systems in place at the Trust for ensuring patient safety and quality of care, and in particular the capacity of senior management to address such matters. A previous peer review report had raised such concerns and yet they had not been addressed within a sufficiently reasonable period.

Staff and inpatient surveys in 2008

1.255 A report on the 2007 inpatient survey was presented to the Board on 31 March 2008 by Dr Helen Moss, the Director of Nursing and Governance.[346] This was published in March 2008.[347] In some areas, the Trust performed well, but in a number of sections the Trust

342 Eminson T96.205
343 Eminson T96.206
344 PCT0007000121
345 Eminson WS0000022934, para 68
346 TRU000100180033; HCC00640000981
347 AG/26 WS0000024328

performed among the worst 20% of trusts in the country. Out of 72 questions, the hospital scored in the lowest 20% of UK trusts in relation to 37 of the responses. The patient surveys revealed significant areas of concern in the following categories, amongst others:

- Information provided about condition when receiving treatment in the emergency department;
- Privacy in A&E;
- Waiting time for operations;
- Waiting after arrival;
- Confidence and trust in doctors treating patients;
- Doctors washing hands;
- Enough nurses on duty;
- Nurses washing hands;
- Information and communication at all levels;
- Waiting for help once the call button had been pressed;
- Explanations before and after procedures and operations.

1.256 Themes identified in the report to the Board included:

- Not enough staff on duty;
- Not enough being done for pain control;
- Lack of assistance to go to the toilet.

1.257 The Board appears to have agreed that it would be better to commission its own survey.[348] A presentation of the results had already been delivered to the management board, and, of course, an action plan was to be produced.

Audit Commission report on coding

1.258 In July 2008, the Audit Commission produced a report of an audit of coding at the Trust.[349] The sample looked at related to Finished Consultant Episodes (FCE) completed between July and September 2007. This looked at the accuracy of coding in four specialties and found overall that 28% of primary diagnoses and 40% of secondary diagnoses were incorrect. In 7% of cases tested, the error would have changed the Healthcare Resource Group (HRG). In Trauma and Orthopaedics, 20% of primary diagnoses, 24% of secondary diagnoses, 28% of primary procedures and 33%of secondary procedures were found to be incorrect. These errors would have led to a change in HRG in 15% of cases.

1.259 This added to the previous concerning evidence that the Trust's coding was unreliable, calling into question the accuracy of information derived from it.

348 Bell T53.126; TRU0010016157
349 Audit Commission WS (Provisional) AC0000000000329

Outbreak of infection

1.260 Between 14 April and 14 July 2008, eight patients were found to be suffering from *C. difficile* on Ward 11. One had died and seven remained on the ward. On 15 July an extraordinary meeting of the Trust's Operational Infection Prevention and Control Committee was convened, attended by the Trust's Director of Nursing, infection control doctor, microbiologist, lead infection control nurse and senior staff from the ward. The first item discussed was whether this development constituted a "localised cluster" or an "outbreak".[350] The significance in the difference was that, had an "outbreak" been declared, this would have triggered a requirement for urgent collective action to be taken to minimise the risk of the infection spreading, including bringing together representatives of the PCT and the Health Protection Agency (HPA) with senior Trust personnel, so that practical advice could be offered by experts to those battling with the issue on the ground. Dr Musarrat Afza, the HPA's local consultant in Communicable Disease Control (CDC), considered that declaring an outbreak should not be viewed as a step attracting adverse comment but as a positive step, ensuring that everything was being done to locate the cause of the infection and to employ effective control measures. Justin McCracken, Chief Executive of the HPA, described the importance of the distinction thus:

> *I think the importance of the difference is an outbreak indicates that you have got transmission happening within the hospital, and declaring an outbreak should focus attention from all parts of the hospital trust to make sure that the resources necessary to deal with the cases are put in place. So that it isn't just simply a question of the infection control team working with the staff on the ward to address the cases, but actually an outbreak control team would be formed that would also, typically, involve the facilities managers, would involve senior management, so that one could arrange isolation facilities, one could make sure that thorough cleaning of beds and wards is undertaken, that the policy for antibiotic prescribing is reviewed. So that all the aspects that actually relate to the incident and transmission of the infection receive a high priority within the system.*[351]

1.261 In short, as Dr Afza said, it would get the right people round the table.[352] This is not to say that similar measures are not required for a "cluster" but it reflects the greater level of concern generated by an "outbreak".[353] The DH definition of an "outbreak" at that time required an incidence of "site specific *C. difficile* alert levels for two weeks or more than three cases of hospital acquired infection per week for 2 consecutive weeks in a ward". A "cluster" was defined as "two or more cases of hospital acquired *C. difficile* in a defined area ie ward per week."[354] Dr Afza seems to have adopted a different definition. She told the Inquiry that a "cluster" was a case of "two or more cases of infection which cannot be described as an

350 MA/2 WS0000041509
351 McCracken T101.34
352 Afza T101.131–133
353 McCracken T101.34–35
354 MA/2 WS0000041509

outbreak because there is no established link between them".[355] She considered the DH definition of an outbreak at the time "very narrow".[356]

1.262 At the meeting in July the committee decided that it was dealing with two clusters rather than an outbreak and was concerned that it was difficult to be so specific. On receiving the minutes of the meeting, Dr Afza was concerned that seven of the cases had been on one ward. On 17 July, Dr Afza emailed the Trust arguing that as seven of the cases appeared to be hospital acquired and three of them within approximately one week, the first part of the definition of an outbreak appeared to be satisfied.[357] She asked whether the Trust had considered involving the HPA in the meeting. Dr Adams, Lead Nurse for Infection Control, replied that if a further case were identified that would be the trigger for calling a wider meeting. She suggested that the Trust had a "robust action plan underway".[358] Dr Afza did not agree. On 18 July she noted:

> *That you have not detailed isolation and cohorting arrangements for these patients ... the audit undertaken in wards 11 and 12 in February highlighted minimal compliance with environment and equipment standard. I wonder if you have had the chance to re-audit since and what were the findings.*

1.263 She noted that a number of points were missing from the action plan, including requirements to clean shower chairs and commodes with bleach rather than with general purpose detergent, and the disinfection of mattresses after incontinence. Dr Moss replied that these matters had been attended to.[359]

1.264 Dr Afza told the Inquiry there were other steps the Trust would have been highly recommended to take, such as closure of the ward to new admissions and the isolation of infected patients, as not only were there patients on the ward with *C. difficile* but others could have been incubating it. She also felt the Trust should have been typing the infection to establish whether there were links between cases.[360] It emerged that the Trust could not provide an isolation ward as there was no space in the Trust for one.[361] Instead, side rooms were used.

1.265 On 18 July Dr Afza was informed that there had been another case on Ward 11 of a patient who had been admitted onto the ward weeks previously. At that point the Trust had decided to close the ward to admissions and to declare an outbreak.[362]

355 Afza WS0000041480, para 41
356 Afza WS0000041482, para 48
357 MA/3 WS0000041515
358 MA/3 WS0000041515
359 Afza WS0000041482, para 49; MA/3 WS0000041514
360 Afza WS0000041483, para 53
361 MA/9 WS0000041533
362 Afza WS0000041485, paras 59–60; MA/5 WS0000041521

1.266 Although it appeared that the outbreak was under control by the end of July, Dr Afza remained unhappy about the Trust's reaction to it. She did not feel that there had been a sufficient sense of urgency conveyed in relation to taking medical measures or sufficient regard to her advice. She feared that this raised a risk of a similar outbreak occurring in the future.[363]

1.267 A further incidence of *C. difficile* did indeed occur in September and October. Four cases occurred in Ward 7 in the course of 11 days. As ribotyping was not undertaken it was not possible to say whether the cases were linked and therefore constituted an outbreak. Dr Afza harboured the same level of concern about this incident as she had in July.[364]

1.268 Sadly, these bouts of infection took their toll. For example, of 74 patients who died in the hospital in June, four (over 5% of the total) had *C. difficile* included on their death certificates.[365] A later analysis reported in January 2009 showed the following figures:[366]

Table 1.3: Total number of deaths due to *C. difficile*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total number of deaths	102	91	74	84	71	48	70	92	90	632
C. difficile on death certificate	1	5	4	4	7	2	4	2	2	31
% *C. difficile* on cert./total deaths	1	5.6	5.4	4.8	9.9	4.2	5.7	2.2	2.2	4.9

1.269 This concerning series of events occurred in the course of the HCC investigation. In spite of the increased level of scrutiny to which the Trust was being subjected, it appears that its patients were suffering a high mortality rate from healthcare associated infections, although the rate reduced towards the end of the calendar year. Dr Afza's evidence suggests that the Trust systems of prevention were inadequate during at least part of this time. As we shall see, matters did not improve in this regard in 2009.

Healthcare Commission expression of concern about basic nursing care

1.270 The letter of 23 May 2008 (see above) written by Dr Wood to the Trust had focused on the serious difficulties exposed in the A&E department. However, by July 2008 the investigation had analysed the information obtained from about 100 members of the public, patients and relatives. Dr Wood wrote again to Mr Yeates on 7 July to communicate the concerns raised by this information and to ask the Trust to address any of the concerns raised which were not already part of its plans.[367] The letter was copied to the PCT, SHA and to Tim Young (the Deputy Director of Finance Performance and Operations) at the DH. The areas raised were:

363 Afza WS0000041487, para 69
364 Afza WS0000041487–488, paras 70–73
365 MA/10 WS0000041537–539
366 Derived from table at MA/15 WS0000041565
367 Wood WS0000025057, para 126; HW/7, WS0000025135

- Basic nursing care:

  ... such matters as the supply of and help with food and drink, a timely response to call bells and buzzers, attention to the hygiene needs of patients, and respecting the privacy and dignity of patients. A related area is that of cleanliness and hygiene and infection control. Concerns about these matters occurred in over half the feedback we received.

- Medication:

  A number of patients and relatives noted that patients were not given the correct medication or were given incorrect medication. This issue was referred to in a third of the feedback. In several instances patients were not helped to take their medication. In others patients were taken off or not given their routine medication when they came into hospital and this appeared to have adverse consequences for their health.

- Failure of clinical care:

  ... such as nurses completing charts, weighing patients, checking intravenous infusions, dressing wounds, avoiding pressure sores etc. These concerns also featured in about a third of feedback. About a third of patients were distressed by delays in admission from A&E or delays in diagnosis or treatment. Others were upset by transfers within the hospital often late at night.

1.271 Dr Wood noted that many of these areas of complaint correlated with the 2007 inpatient survey. The information on which this letter was based had largely been obtained from stakeholder days for patients and relatives which had taken place in April.[368] The letter had not been written until July because of a wish to see if what the patients and carers had alleged was confirmed by what was seen on visits to the hospital. In the course of May and June the team saw confirmation of the concerns that had been raised:

> *... it's balancing difficult things here. On the one hand, I think the team were very convinced of the reliability of those who came to see us to talk about their experiences in the trust, but I think sometimes you have to exercise caution in acting in the first instance on the basis of stories that patients have told you. But increasingly, as we both visited A&E in May and went on then to the emergency assessment unit and the medical wards and so on, I think we saw for ourselves the fact that many of these issues were very likely to be the case.*[369]

1.272 The conduct of the investigation is dealt with elsewhere, but by this time the evidence available suggesting that appalling care was being delivered at the Trust was becoming overwhelming. The matters raised in this letter carried the clear implication that patient safety was at risk, and that minimum standards were commonly not being complied with.

368 Wood WS0000025056, para 123; Wood T81.115
369 Wood T81.115–116

External review of A&E

1.273 An expert team from the Heart of England NHS Foundation Trust was commissioned to review the A&E. Following visits in June and July, a final report[370] was delivered to the Trust on 30 September 2008.[371] The review confirmed a number of deficiencies that had been identified by the HCC earlier in the year. These included:

- "A clear deficit" in trained emergency medicine consultants and the department was not covered 24/7 by an accredited emergency department consultant. This was described as "a significant risk". They stated that the department needed four full-time consultants in emergency medicine, one of whom should be accredited in paediatrics;
- There appeared to be a deficiency of middle grade doctors;
- In spite of recruitment following from the 2007 skill mix review, there was a "worrying deficit" of senior nurses, compounded by the recent release of staff to the CDU. The review found that each WTE nurse had an average of 1,600 attendances in contrast to the 1:1,200–1:400 of comparable departments in the region;
- A lack of Band 7 sisters was "a significant risk" which required urgent remedy "if further episodes of poor or variable care are to be avoided in the future";
- There was an "atmosphere of 'crisis management' that had developed ... out of necessity to cope with increasing patient numbers and the additional demands of the NHS Four Hour Target";
- Concerns were expressed about the communication style of the sole emergency consultant in post;
- The nursing management team was "struggling to cope";
- Governance arrangements were "sub-optimal" with staff found to be unaware of guidelines which were theoretically in place;
- The assessment and treatment area within the CDU was inadequately staffed and was being used to "stop the clock" on the target time contrary to DH guidance. They recommended that this area be closed immediately;
- There was no adequate audit of the standard of care delivered;
- Resuscitation equipment was inadequate: for example, the team found only one defibrillator for the four bays.

1.274 The report was greeted with a somewhat laconic response by Dr Moss, who, in circulating it to colleagues said:

> *Suggest we all have a read and if there are any burning problems identified please can you let me know.*[372]

370 TRU00010019130; HCC0066000281; EIS00031499
371 PCT00210065860
372 PCT00210065860

1.275 The report was copied to the PCT where Geraint Griffiths, a Locality Director, observed after a brief read that:

> *Some of the nurse establishment issues look worrying despite the recent investment.*[373]

1.276 Action on the recommendations in this review was incorporated by the Trust into its existing action plan for the A&E department.[374]

1.277 The fact that amendments were required to the action plan generated as a result of the HCC letter sent in May suggests that the Trust was reacting slowly and ineffectively to the serious criticisms being made about A&E. These were not matters of insignificant detail worthy of a low priority, but matters affecting the safety of patients attending A&E. The Trust's approach remained reactive to the observations of others, rather than proactively ensuring either that A&E was brought rapidly up to standard or that alternative arrangements were made for patients.

Primary Care Trust performance notice – October 2008

1.278 On 1 October 2008 the PCT sent the Trust a formal performance notice under the terms of the contract for the provision of services.[375] The requirement was that the Trust rectify its consistent breach of the A&E waiting time target which was suggested to often be caused by lack of bed availability. The Trust was required to resolve the monthly performance deficiency in this regard by 31 October.

1.279 Monitor, which received a copy of the notice, required the Trust to inform it of what steps were being taken to comply with the notice and the concerns separately raised by the HCC (see below), and the date by which this would be completed.[376] This was to enable it to decide what, if any, further action Monitor should take. On 22 October, Mr Yeates wrote to Dr Moyes of Monitor, assuring him that the Trust was determined to meet the targets and core standards and could show "positive progress" on these issues. However, A&E performance was, he accepted, a "significant concern".[377]

1.280 A report from the Trust Chief Executive to the Board of 30 October outlined continuing plans for the improvement of A&E which were being monitored by a steering group on which the PCT had representation. It was proposed to reply to Monitor in somewhat vague terms:

373 PCT00210065860
374 TRU00010019129
375 TRU00010019013
376 MON00030000368
377 MON00030000370

The Trust is currently implementing a detailed programme of improvement for the Emergency Department. The Trust is also implementing several operational changes within the Emergency Care Pathways and increasing the level of bed capacity in support of the current levels of demand.

The focus of attention on this key performance issue ... is being taken seriously by all levels of staff within the organisation.

The Board therefore anticipates continuous improvement in achievement of the performance target with 98% compliance being achieved regularly towards the end of Quarter 3 and consistently in Quarter 4.[378]

1.281 A reply in similar terms was sent to the PCT on 30 October,[379] only a day before the date for compliance required in the performance notice, and to Dr Moyes on 3 November.[380]

1.282 Mr Yeates's reply to the PCT was met with a degree of scepticism. Mr Griffiths, in an email to Stuart Poynor and Yvonne Sawbridge (PCT Director of Quality and Nursing) on the same day expressed doubts about whether the Trust would be compliant even by the fourth quarter as they had not been at any point during the same quarter the previous year.[381]

1.283 An analysis of the Trust's performance against the A&E target showed that, for the financial year to the end of October, it had been met only during 11 weeks out of 30.[382] In the previous year it had been met for 27 weeks out of 52.[383]

1.284 The position did not improve. On 4 November the Trust Board held an emergency meeting because of continuing breaches of the A&E waiting time target. It was reported to the meeting that the measures approved as recently as 30 October had not succeeded in dealing with the issue. The Board was assured that a number of steps were being taken which would improve the situation, although some of them would take time to have an impact. The Board was told it was not possible to open more beds to address the issue as there were insufficient staff to ensure safe care. For reasons which do not emerge clearly in the minutes, the Board accepted that it now felt more confident that the situation would be resolved.[384]

1.285 On the same date, the PCT issued a second performance notice.[385] They expressed concern at the projected time expected to elapse before compliance could be achieved.

378 TRU00010019035
379 TRU00010007266
380 TRU00010000250
381 PCT00280071713
382 TRU00010000360
383 TRU00010000361
384 TRU00010021541
385 PCT00280071814

Healthcare Commission expression of concerns in October 2008

1.286 By October 2008 the HCC investigation team had conducted a large number of interviews with Trust staff and others, visited the Trust and inspected various departments and analysed a great deal of other evidence. On 15 October Dr Wood wrote to the Trust again.[386] The letter was copied to Monitor, the PCT, SHA and Mr Young at the DH. This time she raised issues which she suggested were not as urgent as those raised earlier about A&E, where there had been: "a deteriorating and potentially unsafe position".

1.287 These were matters, however, which they felt needed "attention" and warranted informing the Trust about them "without delay". They required, she said, "immediate focus" before receipt of the draft report. The areas of concern raised were:

- The Emergency Admissions Unit:
  - This was felt to be "generally understaffed" with both doctors and nurses;
  - There were concerns about the adequacy of the training for nurses there, of which there was found to be "a longstanding deficit";
  - There was poor practice in relation to recording fluid balance, a use of pumps for intravenous infusions, cardiac monitors, observations, and assessments;
  - A lack of multidisciplinary meetings, or mortality and morbidity meetings;
  - Feedback for junior doctors;
- Trauma patients:
  - The seniority of doctors making out-of-hours assessments in A&E;
  - The skill mix of nurses receiving patients with traumatic injuries;
  - Insufficient theatre time for emergency cases;
  - Lack of beds in trauma wards;
- Surgical cover out of hours:
  - There was a lack of senior surgical cover after 9.00pm leading to stressful situations for junior doctors;
- Use of care pathways and capacity modelling for emergency admissions:
  - There were few protocols or pathways for unscheduled care;
  - Those in use were not audited.

1.288 On 31 October Mr Yeates replied seeking to assure Dr Wood that the Trust was addressing these issues.[387] The steps to be taken included:

- A modelling exercise to ensure the capacity of the EAU is calculated to ensure appropriate use;
- Further reviews of capacity and location had been commissioned to ensure that the needs of the emergency care pathway were addressed;

386 Wood WS0000025057, para 126; HW/8 WS0000025141
387 TRU00010019025

- A further review of nurse staffing levels was to be carried out by the Director of Nursing;
- As an interim measure, the bed capacity had been increased to meet A&E targets;
- Surgical emergency pathways were under review;
- It was believed that the medical staffing of the EAU was sufficient for the patient mix;
- A matron and a practice development nurse were being appointed to support A&E and the Emergency Assessment Unit;
- The services of Quality Nurses had been acquired to "drive up" standards of care;
- A training needs analysis was being undertaken;
- A department teaching programme had been set up for junior doctors;
- A review of out-of-hours senior medical cover was being undertaken;
- With regard to A&E governance, a monthly joint business and governance meeting had been held since July and a group was in the process of being set up to review mortality at which audits of mortality and "near misses" would be presented.

1.289 The concerns evident to both the HCC and the PCT in the latter half of 2008 – sufficient to prompt a formal letter to the Trust from the HCC and (for what was probably the first time in its experience)[388] performance notices on quality from the PCT – were met with explanations and reactions indicating a failed or failing leadership at the Trust. While, no doubt, the steps it proposed to take were reasonable ones, it is clear that the organisation was in an ever deepening state of crisis in which the minimum standards of the service it was obliged to provide were being missed in a number of areas. This state of affairs, identified by the HCC in May, and therefore likely in substance to have existed for some time before that, was persisting in October/November in spite of a plethora of plans, and assurances that matters were being attended to.

2009

Hospital acquired infections

1.290 A further *C. difficile* outbreak occurred in January 2009. It was to last until May. By this time a new definition of "outbreak" had been adopted. The term "cluster" was replaced by "a period of increased incidence" (PII) which was defined as:

> *two or more cases occurring (more than 48 hours post admission, not relapses) in a 28-day period on a ward.*

1.291 An "outbreak" was:

> *two or more cases caused by the same strain related in time and place over a defined period that is based on the date of onset of the first case.*

388 Poynor T65.26–7; Sawbridge T64.155; Griffiths T63.178

1.292 Therefore the number of cases required for an "outbreak" was reduced from three to two.[389] Between 5 and 24 January four cases of *C. difficile* were identified on Ward 8. This was classified by the Trust on 27 January as a PII. At a meeting of the Infection Control Steering Group on that day, a number of problems were identified on this ward, all of which could potentially contribute to the spread of *C. difficile*:[390]

- A commode audit was reported as showing a 0% compliance rate;
- 70% of prescription charts were found not to identify the length of time antibiotics should be administered as required by relevant standards. An increase in *C. difficile* is known to be associated with prolonged use of antibiotics;
- It was also reported that agency staff were being used because of staff shortages. They were less likely to be familiar with Trust routines, thereby increasing the risk of hospital acquired infections.

1.293 Dr Afza felt that at this time the Trust was not showing sufficient evidence of leadership in the area of infection control, as the team, which she described as hard working, was not receiving sufficient support from senior management in order to bring about the necessary changes of practice throughout the Trust.[391]

1.294 Dr Afza believed that this incident should have been classified as an outbreak. In fact the number of cases increased and the affected areas of the hospital increased so that it was recognised to be an outbreak from 11 February, nearly a month later. On 27 February the following figures were reported to the PCT:[392]

Table 1.4: Number of *C. difficile* cases, January–February 2009

	Jan	Feb
Number of cases	17	14
Number of deaths in affected patients	7	5

1.295 Ms Wright, on behalf of the PCT, observed that the mortality rate seemed high. The episode lasted from January to March 2009.

1.296 For April 2007 to March 2009, the number of *C. difficile* cases diagnosed more than 48 hours after admission (and therefore likely to have been acquired in hospital) can be seen in the table below.[393]

389 Afza WS0000041489, para 75
390 Afza WS0000041489, para 78; MA/13 WS0000041553
391 Afza WS0000041491, para 83
392 MA/26 WS0000041599
393 Derived from the tables in the HPA report pages 18–19, HPA0001000617–618, and Trust report Afza MA/15 WS0000041565

Table 1.5: Number of *C. difficile* cases diagnosed more than 48 hours after admission, April 2007 to March 2009

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2007/08	31	15	14	19	10	14	4	10	7	18	13	10	165
2008/09	14	13	10	19	7	9	4	7	8	16	15	6[394]	128
Total deaths in hospital 2008/09	102	91	74	84	71	48	70	82	90	10			
% of *C. difficile* patients with *C. difficile* on death certificate	1	5	4	7	9	2	4	2	2				

1.297 There was a clustering of cases on Wards 11, 10 and 8, but also a widespread distribution on other wards. In the January to March 2009 outbreak, the HPA calculated the fatality rate to be 27%, but in 10 out of 13 cases of affected patients who had died, *C. difficile* was included on the death certificate. However, it is and was difficult to pinpoint this infection as a cause of death: the vast majority of those who died were over 75 years of age and would be likely to have had multiple co-morbidities. It was also not clear whether they had been affected by a more virulent strain of the infection.

1.298 By 11 March 2009, the HPA remained concerned about the Trust's approach to infection control. An acting unit director of the HPA informed Dr Rashmi Shukla by email:

> *Our principal concerns and advice to date were regarding the reluctance of the Trust to recognise the situation as an outbreak requiring clear trust-wide leadership and coordination (in particular no overarching action plan/strategy, the lack of robust information from the trust to better understand the epidemiology and assess effectiveness of control measures, and the lack of certain actions to control the outbreak and its consequences (e.g. regarding the cohort ward and cleaning regimes)).*[395]

1.299 Professor Hawkey (Regional Microbiologist), Dr Afza, and two other HPA officers conducted a peer review of the outbreak and reported their findings on 18 March.[396]

- The review noted that the Trust had been identified in 2008 as having the highest antibiotic prescribing rate in the West Midlands (40% spot prevalence as opposed to 30% for other trusts) and recommended that this be urgently and systematically addressed.
- While the Trust was commended for opening a new "cohort" (ie isolation) ward, the review commented that it would have been helpful for this to have been opened earlier. Dr Afza had suggested it a year previously.
- Dirty commodes had been seen on occasions.

394 Provisional figure
395 Afza WS0000041496, para 107; MA/25 WS0000041596
396 HPA0001000600

- Sluice facilities shared between wards were also of concern.
- The Trust's reported high level of compliance with hand hygiene audits was at odds with the evidence of recent cross-infection.
- The management structure and governance arrangements for infection prevention and control were "unconventional".
- The Trust had a "relatively high prevalence" of *C. difficile* compared with other trusts in the West Midlands, many of which had reduced levels well below DH targets in recent years.[397]

1.300 The Trust had therefore failed to institute effective measures at the time of the 2008 outbreak to forestall a repetition in 2009. Deficiencies remained then, at least some of which had been identified by Dr Afza the previous year. The figures were available to the PCT and SHA. While it is not possible to determine that *C. difficile* in fact contributed to the deaths of those affected patients who subsequently died, all of them will have gone through serious suffering which might have been avoided had appropriate and thorough measures been put in place earlier. The terrible consequences of this infection are only too clearly described by many of the families who have given evidence at both this and the first inquiry. The Trust appears to have been over-preoccupied with the formal definition of an "outbreak" rather than focusing on ensuring that everything possible was done to prevent the spread of infection.

Conclusion

1.301 It will no doubt be said that episodes similar to those described in this chapter could be found during the period looked at in many trusts. A number of responses can be made to such a complacent attitude.

- Each of these episodes in themselves had implications for the ability of the Trust to deliver safe care to a minimum standard and for its ability to assure itself of its performance.
- Many of the more serious concerns were demonstrably not addressed effectively, in spite of management assurances that they were being attended to, as evidenced by repeated findings.
- The pattern was such as to indicate a management incapable of successfully leading and running the Trust, even after the change which brought in Mr Yeates in place of Mr O'Neill.
- The episodes in this chapter have to be seen in the context of the appalling experiences of patients and the many serious complaints being made by patients and their families as dealt with in the first inquiry report, and further described in *Chapter 6: Patient and public local involvement and scrutiny*.

397 Dr Afza: "most trusts in the same category as the Trust were showing comparable rates ... at the time," Afza WS0000041492, para 90

1.302 If any trust were to display a similar incidence of serious concerns, it should be examined rigorously to ensure that patient safety and care standards have not been compromised. The Stafford experience shows that signs of this nature just cannot be ignored and that it is dangerous to assume that management is successfully addressing the issues.

Chapter 2
The Trust

Key themes

- Dissatisfaction with the leadership of the Trust was being expressed from as early as 2001. This did not result in a change of Chief Executive until 2005 when Martin Yeates was appointed. He was widely, but not universally, regarded as a significant improvement on his predecessor. Both the Chair and Chief Executive were made aware at or around the time of their appointment of serious issues facing the Trust including endemic financial challenges, lack of governance, managerial structures and cultural issues.
- The Trust Board leadership between 2006 and 2009 was characterised by lack of experience, great self-confidence, a focus on financial issues, obtaining foundation trust (FT) status and meeting targets, and a lack of insight into the impact of their decisions on patient care. The non-executive leadership remained aloof from serious operational concerns even when they had obvious strategic significance and the potential for causing risk to patients.
- The clinical executive leadership lacked or did not raise a strong professional voice at the Board. The medical professional staff remained largely disengaged from management throughout the period and did not pursue their concerns effectively or persistently.
- There was a culture of tolerance of poor practice, denial of the significance of concerning mortality figures or of patient complaints, isolation, and lack of openness.
- The focus on finance led to staffing cuts made without any adequate assessment of the effect on patients. Once it was appreciated that there was a shortage of nursing staff, ineffective and prolonged steps were taken to address it. Serious concerns about A&E were not addressed. Issues of poor clinical governance were not remedied.
- A nurse who came forward with serious and justified concerns about A&E was not given effective support or protection.

Introduction

2.1 The first inquiry was focused exclusively on the conduct of the Trust and those who worked there. The report set out in detail the appalling care given to so many patients and gave them a voice which, it is my impression, has resounded round the National Health Service (NHS) since. I addressed a great number of the deficiencies in culture, leadership and performance that were uncovered by the Healthcare Commission (HCC). It would over burden what is in any event a long report to repeat much of what was said in the report of the first inquiry. However, for good reason, this Inquiry has heard evidence from patients and Trust witnesses covering a range of matters, many of which overlap with the subject matter of the first inquiry. I received evidence from some witnesses who did not give evidence at the first inquiry, in particular Martin Yeates, the then Chief Executive. I have heard from a wider range of Trust officers and employees about their interaction with the broader NHS system. There were also a very large number of documents seen this time which, due to the more limited terms of reference or the requirements of proportionality, were not before the first inquiry. There remain many lessons to be learnt from the events at the Trust and in this chapter I will identify those that seem to be the most important. Therefore some review of what went wrong is necessary. I will seek to deal with these issues in themes, many of which I shall gratefully take from the analysis of Counsel to the Inquiry in his closing submission, rather than strictly chronologically.

The Trust described

2.2 In order to understand the problems that developed at the Trust it is helpful to bear in mind the scale and nature of its operation and the environment in which it worked in 2009 and before. For this purpose I can do no better, as did Counsel to the Inquiry in his closing submissions, than quote from the HCC report, which summarised the position as it was in 2009:

> *Mid Staffordshire NHS Foundation Trust (the Trust) provides services for patients on two sites: Stafford Hospital and Cannock Chase Hospital. These hospitals are about 10 miles apart. Stafford Hospital opened in 1983 and in 2008 had approximately 354 inpatient beds. Cannock Chase Hospital opened in 1991 and had approximately 115 inpatient beds. There are around 3,000 employees working in the two hospitals.*
>
> *Stafford Hospital is an acute hospital offering a range of non-specialist medical and surgical services, including some specialty wards and a 24-hour accident and emergency department. Cannock Hospital has orthopedic services for planned surgery, a nurse-led minor injuries unit, elderly care services and rehabilitation facilities. There have been various structural refurbishments across both sites in the past few years including, in 2007, the A&E department.*

The Trust serves a population of around 320,000 people from Stafford, Cannock, Rugeley and the surrounding rural areas ...

Since October 2006, the Trust has provided services commissioned by South Staffordshire Primary Care Trust (PCT). South Staffordshire PCT was created at that time by a merger of four PCTs: Burntwood, Lichfield & Tamworth, Cannock Chase, East Staffordshire and South Western Staffordshire. The PCT is responsible for organising primary care and community health services for the local population, and commissioning hospital care. The Trust also provides services to other PCTs.

From July 2006, the Trust has been in the area covered by the West Midlands Strategic Health Authority (SHA) following a merger involving Shropshire & Staffordshire, Birmingham & the Black Country, and West Midlands South SHAs. The role of Strategic Health Authorities includes establishing and managing annual performance agreements with PCTs and NHS trusts.

The Trust was awarded Foundation Trust status on 1 February 2008. NHS Foundation Trusts are independent public benefit corporations. Although remaining part of the NHS, they are free from central Government control and are not subject to performance management by Strategic Health Authorities. They are free to retain any surpluses they generate and to borrow in order to support investment.

... Monitor was established in January 2004 and acts as a regulator for Foundation Trusts. It is responsible for approving new applications for Foundation Trust status, which it grants once approval criteria have been met by the applicant trust. Once a Foundation Trust is established, Monitor reviews the trust's activities to ensure that they comply with the requirements of their terms of authorisation.

In 2002, the Healthcare Commission's predecessor, the Commission for Health Improvement carried out a clinical governance review of the Trust. Its report was published in December 2002. The key areas for action included resolving problems associated with high numbers of emergency admissions, and ensuring patients were put on appropriate wards with fewer transfers of patients between wards. The report noted that the number of nurses was a cause for concern, and that the Trust needed to improve the privacy and dignity of its patients. The Trust was advised to develop an open and learning culture. The report also noted that the quality of clinical data was poor.

In 2004/05, the Trust was awarded one star by the Healthcare Commission in its annual performance (star) ratings. In the 2005/06 Annual Health Check, the Trust was rated by the Healthcare Commission as having "fair" quality of services and "fair" use of resources. In the following year (2006/07), the Trust received fair for its quality of services and "good" for its use of resources. In the same review, the core standards score was "fully met" after having a risk-based assessment undertaken by the Commission. The Trust was rated as good against the existing standards but "weak" against the new national targets score.

The most recent assessment by the Healthcare Commission, for 2007/08 and published in October 2008, noted that the Trust was being investigated at the time and was therefore based largely on the Trust's assessment. The Trust was rated as good for quality of services and good for use of resources. In publishing this assessment, the Commission's website noted that this investigation was underway and that the assessment would be reviewed in the light of the report.[1]

2.3 Today the Trust sees about 250,000 patients per year, with approximately 63,000 patients admitted and 354 inpatient beds across two sites (301 in Stafford and 53 in Cannock Chase).[2] There have been significant changes in senior leadership. Antony Sumara and Sir Stephen Moss joined the Trust as Chief Executive and Chair respectively in the wake of publication of the HCC's report. Both have since moved on, with Lyn Hill-Tout joining the Trust as Chief Executive in June 2011, and Professor John Caldwell as Chair in February 2012.

2.4 At the time of writing Monitor's most recent assessment of financial and governance risk ratings places the Trust in 'significant' breach of its terms of authorisation with a governance risk rating of 'red' and a finance risk rating of 1 (where 1 is the highest risk and 5 the lowest).[3] As described in *Chapter 10: Regulation: Monitor*, there is continuing intervention by that organisation with the Trust. On 17 January 2013 Monitor's Contingency Planning Team reported that the Trust was not financially or clinically sustainable, in spite of cash support from the Department of Health (DH) in 2011/12 of £21 million.[4] It should be noted that the Trust is not alone as being viewed as in significant breach. In the first quarter of 2012/13 there were a total of 17 other NHS FTs being closely watched by Monitor.[5]

2.5 The NHS in Staffordshire faces significant change following the Health and Social Care Act 2012. The Stafford and the Surrounds Clinical Commissioning Group (CCG) will, subject to authorisation by the NHS Commissioning Board, bring together 14 GP practices, including all those in Stafford, covering a patient population of approx 135,000.[6] The collaborative partnership of Stafford and Surrounds CCG and Cannock Chase CCG is likely to commission around 90% of all work conducted at the Trust.

1 HCC0015002814 *Investigation into Mid Staffordshire NHS Foundation Trust*, (March 2009) Healthcare Commission, p16–17,
2 Information taken from the Trust's website at: www.midstaffs.nhs.uk/About-Us/Our-Hospitals.aspx
3 Information taken from Monitor's website at: www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-directory/mid-staffordshire-nhs-foundation-trust
4 *Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability*, Ernst & Young, McKinsey & Co, January 2013 Monitor. www.monitor-nhsft.gov.uk/node/1953
5 Information taken from Monitor's website at: www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/regulatory-action/nhs-foundation-trusts-significant-breach-their-authori
6 Taken from website for Stafford and Surrounds CCT at: www.staffordpbc.nhs.uk/

Trust leadership

2.6 A detailed account of the make up of the directors and other leaders of the Trust can be gleaned from the first inquiry report but it is germane to look at a few of the characteristics relevant to learning lessons for the future.

2.7 Annex H sets out a table of Trust senior post holders and non-executive directors.

Chief Executives

2.8 During the period with which the Inquiry has been concerned, and since, the Trust has been led by four different individuals in substantive posts and one Interim Chief Executive.

David O'Neill

2.9 Mr O'Neill held the post from 1998 to September 2005.[7] Ms Llewellyn, who started in her post as a Complaints Manager at the Trust in 1998, described Mr O'Neill as "very hands on" in relation to complaints.[8] However, she later had the perception that he was "struggling with issues in his personal life".[9] Dr Peter Daggett told the Inquiry that consultants had always got on well with him, as they had with his predecessor, and there had been no history of disagreement with him.[10]

2.10 Mr William Price, Chief Officer of the Stafford Primary Care Group from 1999 to 2002 and Chief Executive of the South West Staffordshire PCT (SWSPCT) from 2002 to 2006, had a very adverse view of Mr O'Neill. He told the Inquiry that there had been concerns locally about Mr O'Neill's leadership for a considerable time. A report was sent by the then South Staffordshire Health Authority to the NHS Executive, West Midlands in August 2001 outlining serious concerns about the Trust.[11] The summary alleged that the "underlying issues" at the time were:

> *Lack of engagement and leadership of clinicians in the Trust*
>
> *Lack of engagement with the whole health economy*
>
> *Failure to implement agreements.*

2.11 Resolution of these issues was said to require, among other points:

> *Change of leadership at CEO and Strategic Director level*

7 Newsham T60.4; WS0000011918, para 3; Llewellyn T29.5,
8 Llewellyn WS0002000459, para 12
9 Llewellyn T29.75
10 Daggett T46.56
11 Price WS0000016117, para 57; WP/1 WS00000161136–147; T94.5–16

Supported development for the whole leadership team at the Trust.[12]

2.12 The problems identified included:

- Failure to achieve waiting list targets;
- Loss of consultant staff, citing lack of management support, equipment deficiencies, poor theatre management, over reliance on agency nurses and waiting list initiatives at short notice leading to "intolerable" strains and a "general deterioration in standards";
- A failure to remedy issues about referral letters in spite of the matters having been raised over two years;
- Lack of management commitment to undertake agreed tasks;
- Lack of management coordination between Trust management and clinicians;
- Lack of management action to ensure key objectives were delivered.

2.13 Although this report was submitted to the NHS Executive in the West Midlands it did not result in the recommended change happening at that time, and, according to Mr Price, it failed to bring about any change in Mr O'Neill's performance.[13] In fact:

... one of the things that we found with David was his lack of engagement, he didn't regularly turn up for – he certainly never came into any of our commissioning meetings. He didn't regularly turn up and certainly turn up on time to health authority chief exec meetings.[14]

2.14 Mr Price was critical that action was not taken then, but only much later; something he thought was characteristic of the NHS.[15]

2.15 Michael Brereton, Chair of Shropshire and Staffordshire Strategic Health Authority (SaSSHA), pointed out that the relationship between primary care trusts (PCTs), or their predecessors and trusts, was often "brisk" by the very nature of their different perspectives. However he had been aware (towards the end of Mr O'Neill's tenure) that the leadership of the Trust needed "refreshing".[16] He did not necessarily mean this as a fundamental criticism. He pointed out that there had been difficult issues to attend to both in terms of finance and performance and that:

12 Price WP/1 WS0000016137
13 Price T94.18–19
14 Price T94.19
15 Price T94.91
16 Brereton T97.59

the leadership that did it, in some cases didn't embrace ... or were unable to embrace the new world in the way most – most of us hoped they would. I think we felt this might have been such a case and that the individuals involved probably needed support to refresh themselves and address a new challenge probably in a different environment.[17]

2.16 He told the Inquiry of the support given to Mr O'Neill to ease his departure from this post:

My understanding is that there were chief executive-to-chief executive conversations, which were fair, supportive but blunt and where the proposition that a career development to a different environment would be desirable, would be refreshing and would restart the career of someone who had perhaps got a little stale in the post they were in. And arrangements were then made, as I understand it, by the chief executive for a post of a suitable sort for that sort of recovery programme to be made available to Mr O'Neill.[18]

2.17 Kath Fox, a UNISON representative, thought Mr O'Neill was aggressive in Joint Negotiating Consultant Committee (JNCC) meetings, describing him as a "bully". She said that as a result the unions could not work with him at all. She compared him unfavourably with Mr Yeates in that respect.[19]

2.18 David Kidney, then MP for Stafford, recalled a meeting with him in 2004 when the Trust was downgraded to "zero stars" and found him displaying "genuine anger" at what he regarded as an unfair assessment of his Trust in the face of what he perceived to be improving performance.[20] He perceived that there seemed to be frequent arguments between Mr O'Neill and the PCT, mostly over funding, leading to an atmosphere which was "fraught", and that the relationship seemed to become more constructive under Mr Yeates.[21] Mr Kidney perceived that after the loss of the star rating Mr O'Neill seemed to be quietly "dropped". It was announced for unexplained reasons that he had been seconded to another part of the country and "he simply never came back".[22] He described the departure as "quite mysterious" and it is clear that Mr Kidney was never informed of the reason for this departure.[23] Once Mr O'Neill had gone Mr Kidney heard from some at the Trust that the atmosphere had not been good under his leadership.[24]

17 Brereton T97.62
18 Brereton T97.71–72
19 Fox T43.67–68
20 Kidney T39.17
21 Kidney WS0000002775, para 20; T39.38
22 Kidney WS0000002776, para 27;
23 Kidney T39.54
24 Kidney WS0000002776, para 27

2.19 Dr Tony Wright, then MP for Cannock Chase, also formed an unfavourable impression of the Trust leadership before the arrival of Mr Yeates, because of various difficulties that had occurred and of which he was aware. At one stage an issue made him wonder who was actually running the Trust.[25] However his concerns were of a general nature without his being aware of evidence substantiating them.[26]

2.20 It must be emphasised that Mr O'Neill was not invited to give a statement of evidence to the Inquiry: his tenure of office at the Trust formed part of the background to the period under review and it would have been disproportionate to investigate it in detail. Therefore, while it is clear that there were many who had criticisms to make of his performance, I do not make any findings as to whether they were justified, and intend no concluded criticism of Mr O'Neill by the account given of the evidence. However, that evidence does satisfy me that the Trust experienced difficulties during his time as Chief Executive which spilled over into the later period; many of those issues contributed to the very many problems his successors had to address.

2.21 Little seems to have been done in response to the very explicit complaint made by the Primary Care Group (PCG) in 2001. It is also clear that Mr O'Neill's departure was eventually engineered because of dissatisfaction with his performance. This was achieved by assisting him, or, to use a favourite term in the NHS, "supporting" him to find another post. This has been a common method used in the NHS for "moving on" a problem rather than confronting it. Mr Brereton's justification for this pragmatic approach will find a later echo in that taken over Mr Yeates' departure:

> *I mean, are we putting dysfunctional people elsewhere in the NHS? The answer is no, actually ... most chief executives in the NHS get there because they're good at something. Things do go wrong from time to time. These people are very expensive, they're expensive to train, their experience is of enormous value. When things go wrong for them, it is good management to try and recover them and get them back into a post where they can be useful to the NHS. The cost of severance is very high, and you lose all that investment in training and experience. And most of us believe that's not a good way to proceed.*[27]
>
> *I mentioned earlier what we regarded as, you know, ... the hidden moral imperative to the SHA, make the system work. We undertook the best action we could, both to recover a resource, which wasn't being used adequately, in terms of human resource, and to provide the Trust with the leadership which would allow it to up its game.*[28]

25 Wright T38.89; WS0000003641, para 5
26 Wright WS14 WS00000003643
27 Brereton T97.72
28 Brereton T97.73

Martin Yeates

Previous experience and appointment

2.22 Mr Yeates came to the post of Chief Executive with no previous experience in the role other than his period at the Trust as Interim Chief Executive. He had previously had three years experience as a Director at Wolverhampton PCT, and prior to that for 10 years as a Director at New Cross Hospital, Wolverhampton.[29] Sir David Nicholson, who was on the panel which decided to offer him the permanent post, explained that there was and is no formal training for this post as such, over and above the general training available to any manager in the NHS. Selection for posts of this nature was more by way of exhibiting the relevant experience than by reference to any formal qualification.[30] In retrospect he accepted that this was the wrong appointment to make: while Mr Yeates had plenty of operational experience, in knowing how to make things work, he did not have sufficient capacity to undertake the necessary strategic thinking. In Sir David's experience, the usual problem when appointing someone to their first executive director post is the opposite one of a lack of operational experience.[31]

2.23 As Mr Yeates was unable to give oral evidence, it was not possible to find out more about his background. However, in a very full statement taken with the assistance of the Solicitor to the Inquiry and Mr Yeates' own legal adviser, it is noteworthy that he gave no details of any specific training and called for a structured mentoring process to support those that are new to the role of becoming the Chief Executive.[32] Therefore, I have to assume that he received no more than the basic sort of training described by Sir David. I have no description of the nature of the work Mr Yeates had previously done as a director, but it is unlikely to have embraced as wide a range of operations as required to be led by the chief executive of even a relatively small district general hospital. It is therefore open to question whether he was appropriately qualified to take on this role at a trust which was known to be suffering from sufficiently serious issues to require a change of leadership.

Assessments by others

2.24 The Inquiry heard a mixture of impressions about Mr Martin Yeates. Ms Kath Fox offered a relatively positive view of Mr Yeates. She said that he was very open and honest with the union representatives, but she and her colleagues were not willing to go to meetings with him on their own, as he was "quite intimidating".[33] Adrian Legan, Regional Officer of the Royal College of Nursing (RCN), on the other hand described him as "approachable" – to the extent that he would not have wanted to spoil their relationship with threats of industrial action.[34] Christine Woodward, latterly a Governor, admired Mr Yeates. She thought he was very "hands

29 Yeates WS0000074921–922, para 5
30 Nicholson T127.127–128
31 Nicholson T127.139–140
32 Yeates WS0000074969, para 151
33 Fox T43.68
34 Legan T42.179

on" and was to be seen everywhere in the Trust.[35] Dr Glennon, a local GP, was impressed by Mr Yeates, finding him to be:

> *... a pleasant guy who seemed keen to know what we needed.*[36]

2.25 Dr Wright found him to be more responsive than Mr O'Neill had been, and he formed a favourable impression of his ability to handle community meetings.

2.26 Dr Philip Coates, a clinical lead at the Trust for clinical governance, thought Mr Yeates did want to take a firm line with consultants when necessary.[37]

2.27 Dr Turner found that Mr Yeates was initially unreceptive to his concerns, but then became approachable and constructive. He attributed this to his having been previously unaware of the extent of the problems Dr Turner was raising about A&E:

> *I could tell that it came as a surprise to him just how dire the perception, both internally and externally, of the department was. And he was he was clearly keen to find solutions to this, but in order to do that, wanted to understand what the problems were. And I had a fair amount of dialogue with him from thereon in. I always found him receptive to – to my point of view. He didn't necessarily agree with me but he certainly would – would listen and have the discussion with me. And from that point onwards, from a personal perspective, he became approachable.*[38]

2.28 Others were less positive. Dr Daggett described him as having a forceful personality which may have inhibited clinicians speaking up at meetings.[39] Dr Singh suggested that after Mr Yeates' arrival there was an atmosphere in which raising concerns was unwelcome.[40] Another consultant had told a local GP that if a letter of complaint was handed to him he would hand it straight back.[41] A trade union officer, Mark Young of UNITE, described a JNCC meeting with Mr Yeates at which, in what he described as an "aggressively delivered" message, Mr Yeates demanded an abridgement of the normal consultation period of a proposed redundancy scheme, contrary to the relevant legal rules.[42]

35 Woodward T45.116
36 Glennon T33.131–132
37 Coates WS0000004859, para 32
38 Turner T50.29
39 Daggett T46.56
40 Singh T46.145
41 Eames T32.147
42 Young T41.155

2.29 Mr Sumara, somewhat reluctantly, told the Inquiry that from his contact with Mr Yeates he thought he was somewhat self-confident, to the point of having a rather better opinion of his abilities than others had of him.[43]

2.30 The overall impression gained from this evidence, but also from the array of documentation emanating from him, is of a manager assigned a difficult and challenging role, who could give the appearance of being open and willing to listen, and very ready to give assurances that concerns would be addressed. He was clearly a persuasive individual who convinced experienced and senior health service officials of his ability. For example he persuaded the DH that he and his team had a "can do" attitude, an attribute which if possessed is doubtless valuable so long as it is focused on achieving the best for patients; this led them to overlook the apparent deficiencies in the Trust's FT application.[44] However to some staff he could be intimidating and unapproachable. He was intent on leading the Trust to FT status and whether intentionally or not emphasised positive points at the expense of any concession in relation to the many issues challenging his organisation. He was much better at giving an appearance of intent to address issues raised with him than he was at ensuring that the appropriate action was actually taken. In short he was that most dangerous of leaders; one who was persuasive but ineffective.

2.31 In the end perhaps it is the result of his leadership on which he has to be assessed, as did Mr Sumara, who swiftly formed a view of why the executive team was, to him, so obviously not addressing the relevant issues:

> *At that time the Executive Team ... were doing their best but had no one to give them clear direction or guidance. On many occasions one or more of them told me that no one had said to them the specific requirements of their roles and what they were expected to deliver. Each Executive was holding office for the first time, and delineation of responsibilities was a key – and reasonable – requirement. This was added to by the fact that the person leading them had been in his first Chief Executive role ... this was almost entirely an inexperienced team. Responsibility for the fact that many of them were too inexperienced must lie with Martin Yeates as he had recruited most of them.*[45]

Insight

2.32 Mr Yeates asserted in his statement to the Inquiry that, following his interview with the HCC's investigating team in October 2008, he had appreciated how serious the outcome of the HCC investigation was going to be. However, it is not clear that he in fact realised how bad things were until later than that. In any event he did not evidence any real appreciation of the implications of the mortality figures, or of the fact that the HCC had decided on a formal

43 Sumara T58.39
44 See the chapter on the FT authorisation process for details.
45 Sumara WS0000005917–918 para 33

investigation, or of the many complaints considered by both this and the first inquiry where he signed off letters of apology and undertakings to learn lessons.

2.33 There is evidence that Mr Yeates lacked an appreciation of quite how serious the position was in the Trust, even shortly before the publication of the HCC report. In his own meeting with Mr Yeates, Mr Stone, the incoming Interim Chair formed the impression that, although he recognised there were serious deficiencies in various departments, they were retrievable and not of such long standing and persistence that he needed to resign.[46] Dr William Moyes, Executive Chairman of Monitor, after speaking to Mr Yeates at the beginning of March 2009, recorded that Mr Yeates was undecided whether to remain in post or go but:

> *Martin is in no doubt that he wants to be part of the turnaround of the hospital.*[47]

2.34 Peter Shanahan, of the West Midlands Strategic Health Authority (WMSHA), recollected that Mr Yeates was in "denial" in late 2008, although he was beginning to think of escaping the pressure.[48]

2.35 Even at the point of FT authorisation, Mr Yeates was made aware by Monitor that the Trust was not reaching its A&E targets or meeting its MRSA trajectory, and in the first two quarters of 2007/08 had failed to deliver its thrombolysis target.[49] Less than two months later, on 18 March 2008, the HCC's investigation was formally launched into the Trust.[50] A briefing meeting took place on 8 May 2008 between the Trust's Board and Monitor during which the likely outcome of the HCC investigation was discussed. The feedback relayed to the Trust was that the final report would be negative. Although the HCC acknowledged that the investigation had been triggered by mortality rates, concerns surrounding the standard of care received by patients were highlighted and the remit of the investigation widened.[51] The HCC's concerns surrounding the Trust's A&E statistics, governance and staffing were reiterated to the Trust later that month in a letter from the HCC to Mr Yeates sent on 23 May 2008. The letter was strongly worded, going as far as stating that the Trust lacked "effective governance."[52] Dr Moyes viewed these provisional findings with concern and regarded the problems at the Trust as being so serious that Monitor would have to consider using its statutory powers of intervention. He questioned whether Mr Yeates and Mrs Toni Brisby, the then Chair of the Trust, should stay at the Trust in the long term although he admitted that this was not formally conveyed to either party by Monitor.[53]

46 Stone T54.35–8
47 DS/2 MON000400010341
48 Shanahan T76.49–50
49 PWS/13 WS0000020787, *Minutes of Board Meeting (Jan 2008),* Monitor, para (ii)
50 WM/16 WS0000040005
51 WM/16 WS0000040007
52 WM/18 WS0000040018–21
53 Moyes WS0000039656, para 80

2.36 The investigation was met with negativity by Mr Yeates and Mrs Brisby, especially as the focus broadened into quality of care.[54] However, even by late 2008, Mr Yeates still appeared to Mr Shanahan to be in denial and under the impression that the investigation was focused on Hospital Standardised Mortality Ratio (HSMR) statistics.[55]

Process leading to departure

2.37 Mr Yeates said that he spoke to both Dr Moyes and David Nicholson, Chief Executive of the NHS, in October 2008 to warn them that the report was going to be damaging and to offer to resign. He claimed that they both told him they wanted him to stay, that the Trust was moving forward and that he was part of the solution.[56] This was denied by Sir David who could not remember ever talking to Mr Yeates together with Dr Moyes, and questioned why Mr Yeates would be speaking to him about that in any event. As the Trust was an FT, Sir David would have had no "leverage" as to whether he remained or resigned.[57] The question of resignation did come up in conversation with Dr Moyes, but at a much later stage. Insofar as it is relevant, I prefer the evidence of Sir David on this point. There is evidence that the prospect of alternative employment was put before Mr Yeates at some point, but it appears to have been at the instance of the WMSHA, under the leadership of Peter Shanahan,[58] rather than of the DH and Sir David.

2.38 At a point when publication of the HCC report was imminent, Dr Moyes talked to Mr Yeates on the telephone. Mr Yeates is recorded as having said that he had heard there was a lot of ministerial interest in this and the view was that if he resigned in advance of the report they could offer him another post somewhere, but that if he did not and was forced to go after the report was published they would not be able to "save him". Dr Moyes reminded him that the DH had no remit over an FT post. Dr Moyes noted that Monitor were "not currently thinking of replacing" him and indicated he would speak to David Flory at the DH.[59] At about this time, Dr Moyes said Peter Shanahan had told him that the WMSHA, he presumed on behalf of the DH, had been putting to Martin Yeates the sort of proposition mentioned above.[60] In fact David Flory, then Director General of Finance and Performance at the DH, had endorsed the proposition that Mr Yeates might be offered another job. In a submission on 13 February 2009 he said:

> *The SHA's view is that the Chief Executive will also leave his post. The SHA is in discussion with him about this. A likely scenario is that he will move to another post in the system. This seems reasonable to me in the particular circumstances of this case.*[61]

54 Moyes WS0000039655, para 77
55 Shanahan T76.49–50
56 Yeates WS0000074964, para 134
57 Nicholson T128.155
58 Yeates WS0000074965, para 139
59 Moyes WS0000040157, para 53, MON00030000979
60 Moyes T93.129
61 DF/22, T121.153–154, DH00120000312

2.39 However, in evidence which I accept, he told the Inquiry that he changed his view very soon after that, on developing a clearer picture on how serious the position was. He accepted that he had made the wrong judgement at the time of this note.[62]

2.40 Dr Moyes explained that in saying that Monitor were not currently thinking of replacing Mr Yeates, this was not evidence that he retained Monitor's confidence. The thinking was that if the Chief Executive were to leave just as the Chair had also departed, the new Medical Director might be deterred from taking up his post and that it was better to leave the arranging of Mr Yeates' removal to the new Interim Chair.[63] He did not anticipate that Monitor would have to intervene to bring this about.

2.41 Mr Peter Shanahan (then Chief Executive of the WMSHA), accepted there had been conversations with Mr Yeates in late 2008 or early 2009 about the possibility of his stepping down and moving to another post, at a time when only limited extracts of the HCC report were available to the WMSHA. However once the tenor of the report had become clear it was felt his position was untenable and offering him another job ceased to be an option.[64]

2.42 There has been a considerable degree of dissatisfaction expressed about the manner of Mr Yeates' departure from his post. Mr Stone, the Interim Chair, explained that it was clear as soon as he arrived in post, even before publication of the HCC report, that a line had to be drawn with Mr Yeates' departure to enable corrective action to be taken. He had therefore asked him to resign.[65] When Mr Yeates said he was not prepared to do this, but only to stand down, Mr Stone considered dismissing him, but was aware that this may take time to resolve and that it was not clear legally whether dismissal would be justified. He therefore commissioned an investigation by Peter Garland to look at the position and produce recommendations.[66] Mr Garland's report suggested there was a *prima facie* case for disciplinary proceedings against Mr Yeates, but that there may have been mitigating circumstances.[67] However evidence to the Inquiry showed that the decision that Mr Yeates had to go had in effect already been taken by Monitor,[68] and also that this decision was made before Mr Garland's report was commissioned.[69]

2.43 On receiving Mr Garland's report, Mr Stone and others involved considered that seeking to dismiss Mr Yeates by a disciplinary process might be protracted and costly, and that this was not in the Trust's interests. Therefore it was decided that a compromise agreement would be

62 Flory T121.157
63 Moyes T93.130–131
64 Shanahan T76.46–47
65 Stone T54.39; WS0000007978, para 7
66 Stone WS0000007978, para 7
67 ESI00018977 *report of the investigation into the conduct and performance of Martin Yeates as Chief Executive Officer of Mid Staffordshire NHS Foundation Trust*, Peter Garland & Annette Facer (2009)
68 Stone T54.41
69 Stone T54.43

sought. The decision having been taken that Mr Yeates should go, Mr Stone felt that the issue of how he went became:

> *... slightly less significant ... it was not an easy decision to take, clearly. But weighing all the circumstances and the need, again, as I said, to move the agenda forward, it seemed to be not an ideal solution but the most – the least unsatisfactory way of moving forward ... There were, clearly, responsibilities that needed to be answered, but overwhelmingly we needed to move the agenda forward, so the action we took was taken ... I do accept ... we could have* [summarily] *dismissed ..., and taken the consequences which followed, but we decided not to.*[70]

2.44 I am in no doubt that the process leading up to Mr Yeates' departure was profoundly unsatisfactory both for the public and for him. He was given grounds for believing that if he left the post voluntarily another job would be found for him. There is evidence of such indications being passed around the DH as late as February 2009.[71]

2.45 While Dr Moyes may have been adopting a somewhat pragmatic approach of trying to keep Mr Yeates in post for tactical and short-term reasons, others, in particular Mr Shanahan at the SHA and Mr Flory at the DH, seem to have been genuinely supportive. Such support either indicates a general and concerning failure around the system to appreciate how fundamental the failings were at this Trust, even following the indications that had emerged during the HCC investigation, or an attitude which discounted the need for accountability. In Mr Flory's case he gave evidence, which I accept, that in the early days when this issue arose, he did not appreciate how fundamental the failings were – a position he quickly reconsidered. The same applies to Mr Shanahan whose explanation is recounted above; I accept that he also reconsidered his position once he finally appreciated the scale of the issues.

2.46 Although there was a necessity to be mindful of the strictures of both contract and employment law, the sort of gross failure of which there was clear evidence here ought to have been marked by immediate action.

2.47 In the result, Mr Yeates was quite unfairly given the impression that he would be able to find employment, until at the very last moment, just before he had to deal with the public onslaught following publication of the report, he would have learned he was to be rejected from the system entirely. I have no doubt that the shock of this is likely to have been great.

2.48 I have already made clear in the first inquiry that the management of the termination of his contract completely failed to take sufficient account of the need in the public interest to

70 Stone T54.45–48
71 DH00120000312 *Email exchanges and submissions between officials and Ministers' offices regarding publication of the HCC's investigation* (Feb 2009)

ensure that failure in duty on the scale revealed by the HCC report is reflected in holding properly to account those responsible. By embarking on a consensual settlement, the Trust Board deprived the public of that, and also deprived Mr Yeates of a fair opportunity to answer the criticisms made of him. While the present system for holding senior executives to account may be inadequate, this case was so serious that the Board should have been prepared to accept the financial risks of embarking on a proper and fairly conducted disciplinary process.

Finance Director

John Newsham

2.49 Mr Newsham was Director of Finance from 1987 to June 2008, and Acting Chief Executive on two occasions, shortly before Mr O'Neill was appointed and again for a short time before the arrival of Mr Yeates.[72] He was also the Deputy Chief Executive. He was extremely experienced in financial management, having first started working in the NHS in 1975.

2.50 Mr Kidney, formerly MP for Stafford, spoke highly of Mr Newsham. He said he was popular and that:

> *He was a thoroughly decent man, heart and soul NHS, had always done his very, very best managing these difficult financial situations.*[73]

2.51 Mr Kidney asked him if he had thought of applying for the Chief Executive post himself but he had said that he was too near retirement.

2.52 He was thought to be sufficiently trusted by staff to be the designated officer to be approached under the whistleblowing policy.[74] Denise Breeze, an RCN representative at the Trust, described him as being "trustworthy, honest and the soul of discretion."[75]

2.53 Whatever merits Mr Newsham had as Director of Finance, and there is no doubt he was an expert in that respect, he may have had a limited understanding or acceptance of his wider responsibilities as a director, and a senior one at that. An example of this was his handling of the whistleblowing report prepared by Dr Robina Barry.[76] He had commissioned this report, received it, and read it. He agreed it raised serious concerns and discussed the matter with Mr Yeates.[77] Even if he believed that Mr Yeates was going to follow up this report and the action that needed to be taken, he had a duty as a senior executive director to satisfy himself that this happened, or at least to confirm that some action was in fact being taken. However on his own admission, apart from writing to thank Dr Barry for her report, he had no further

72 Newsham T60.4
73 Kidney T39.55
74 Newsham T60.6
75 Breeze T42.33
76 CURE0001000001 *Internal Inquiry into the Standards of Care on Ward 3* (1 August 2005). For an account of this see *Chapter 1: Warning signs*
77 Newsham T60.12–25

involvement and does not appear to have followed up what, if any, action was being taken. Given his role in the whistleblowing procedures and his status as Deputy Chief Executive, he clearly should have interested himself more than he did. To be in the position of having to speculate that he might have raised issues from the report in later general discussions is not an adequate demonstration of the exercise of his responsibilities. While all executive directors have their own particular areas of responsibility where they take the lead and are the experts, all have a shared responsibility for matters such as this which are likely to affect the Trust as a whole. The concept of leadership by a board of directors breaks down unless all directors understand that joint responsibility means ensuring that colleagues have dealt with issues as important as this. Astonishingly, he admitted that this report had never been discussed by the Board.[78] Therefore, he had no means of knowing whether it had been shared at all with non-executive directors, even though it evidenced serious systemic failings of governance. His answers to my questions on this subject were profoundly unsatisfactory and showed no sign of acceptance that more should have been done.[79]

2.54 It is also clear that Mr Newsham's focus on financial matters did not allow him to take into account the possible impact of cost and staff cutting on the quality of care, unless it was specifically drawn to his attention. For example he admitted he had not drawn a link between the findings of the Barry report that there was a shortage of nursing staff with his plans for 2006/07 which involved substantial staff cuts.[80]

Chair

Toni Brisby

Experience

2.55 Mrs Brisby was appointed Chair of the Trust in October 2004 and resigned from that post on 3 March 2009. She had initially taken a degree in law, but in the 1990s moved into consulting and training, coming to work with planners of healthcare services. Between 1999 and 2004 she worked as a family mediator, and a Non-Executive Director and Complaints Convenor at South Staffordshire Healthcare NHS Trust. Therefore, this was her first post as a chair.[81]

2.56 She was appointed by a panel chaired by Mr Brereton, as Chair of SaSSHA. He told the Inquiry that she stood out among the candidates. She had been a non-executive director at a "very high performing" neighbouring mental health trust, was a lawyer and had a very clear grasp of how the NHS worked. He thought she had an impressive intellect.[82]

78 Newsham T60.28–29
79 Newsham T60.30–31
80 Newsham T60.126–127
81 Brisby T129.4
82 Brereton T97.65

Personality

2.57 Mrs Brisby was an impressively straightforward witness who stuck to her position with integrity and not a little courage in the face of what she knew would be public disapprobation. She clearly possesses a strong and forceful character. Unfortunately, this led her on occasion to maintaining positions which were untenable on the evidence. Her most remarkable assertion was that she and her Board had succeeded in "turning the Trust around".[83]

View of distinction between executive and non-executive roles

2.58 Her view of her own role was a hands off one:

> *I think the role is to challenge the chief executive in terms of the results that the trust is coming up with, not to tell him how to do his job.*[84]

2.59 She referred the Inquiry to the Higgs Report, a review commissioned by the then Department of Trade and Industry into the role of non-executive directors in commercial companies.[85] The responsibilities that review identified for the chair of a company were adopted by the DH in its guidance for NHS non-executive directors in the same year.[86] Higgs suggested, and the NHS guidance accepted with the one modification indicated in brackets, that the role of the chair was to be responsible for:

- *leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda;*
- *ensuring the provision of accurate, timely and clear information to directors;*
- *ensuring effective communication with shareholders* [staff, patients and the public]*;*
- *arranging the regular evaluation of the performance of the board, its committees and individual directors; and*
- *facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.*[87]

2.60 The NHS guidance warned that too often there was too large a gap between the board and the "operational heart of the organisation":

83 Brisby WS0008000005 paras 13–14
84 Brisby T129.14
85 *Review of the Role and Effectiveness of Non-executive Directors* (2003), Derek Higgs, DTI www.berr.gov.uk/files/file23012.pdf
86 CURE0029000083 *Governing the NHS: A guide for NHS Boards* (June 2003), Department of Health, page 16 at CURE0029000091
87 *Review of the role and effectiveness of Non-executive Directors* (January 2003), Derek Higgs, Department of Trade and Industry, page 23, www.berr.gov.uk/files/file23012.pdf; and
CURE0029000083 *Governing the NHS: A guide for NHS Boards* (June 2003), Department of Health, page 16 CURE0029000091

Boards should not get into the detail, but they need to know that their decisions have been translated successfully into actions by those who are close to patients. In this sense, Boards are there to lead, direct and monitor but also to serve and support those who are in daily contact with patients. Otherwise Board's efforts have no real value.[88]

2.61 Mrs Brisby took a particularly narrow view of her duties as set out in this guidance which resulted in her and her non-executive Board being inappropriately distanced from the way the Trust was being run and the effects for patients, staff and the Trust itself. The effect of this approach could be seen in a number of examples considered in evidence.

2.62 She had been aware of the Barry report (the report by Dr Robina Barry into whistleblowing at the Trust in 2005) and had discussed it with Mr Newsham. However, her view of the division of responsibility between executive and non-executive directors meant that she considered her role to be to:

... make sure that the governance arrangements are right so that this sort of thing actually gets picked up properly by the board processes ... John Newsham ... and I discussed it. It ... seemed very clear to me that the job of the chair was to make sure that the governance processes were robust enough to make sure that issues like this would actually come to the board in an appropriate form, not in the operational detail but in a form that meant the board could actually address it properly.[89]

2.63 This approach seems to have resulted in the Barry report not being considered at all by the Board and lost in what she called "high level information" about what was going on in the wards. Even though she accepted that the report showed that the executive team had not been doing their job properly, she did not think it appropriate for the Board to see this report, characterising it as being too detailed:

I'm not sure that it's ever appropriate for non-executives, who are part-time and don't come from the NHS, to involve [themselves] *in the detail of operational matters. I think it's always their job to make sure that the high level stuff is properly representative of what's happening.*[90]

2.64 However the Barry report was not preoccupied only with the performance of a single ward, concerning though its conclusions were about that, but with directorate and trust level governance:

88 CURE0029000083 *Governing the NHS: A guide for NHS Boards* (June 2003), Department of Health, page 7 CURE0029000087
89 Brisby T129.30
90 Brisby T129.32

Nobody at directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care needs are met ... There appears to be a lack of commitment at the highest level in the Trust to tackle these problems.[91]

2.65 This is an example of a conclusion of the first inquiry that the Board drew a false distinction between "strategic" and "operational" issues. This resulted in their failing to understand just how serious the issues facing the Trust were. It was an approach which left them reliant on assurances which they had no means of checking or challenging. Mrs Brisby maintained, however, that her approach was the only workable one.

2.66 She told the Inquiry she was aware that middle management at the Trust was thought to be weak, a point made by the Commission for Healthcare Inspection (CHI) in 2002. However, in her view this was a matter for the Chair to rely on the Chief Executive to deal with, having appointed the "right" one, along with the "right" executive team, and to ensure there were adequate resources. She felt she would have had no way of judging whether middle management were being effective.[92]

2.67 She described the process of putting the Trust's finances in order as being one whereby the Board set the savings to be made and placed the responsibility on the divisions to implement them effectively and, no doubt it was hoped, safely.[93] The need for such savings was common to all trusts in the region. Staff cuts were inevitable as a result of the financial demands, but she said it was "crucial" to her to ensure that cuts in staff did not compromise patient care. Her means of doing this was to ensure that the divisions would give effect to the cuts and undertake the necessary risk assessments.[94] There is no evidence that any such risk assessments were considered by the Board, or, indeed, that any effective assessment was actually carried out. Again, all that reached the Board was a series of assurances, such as that given in answer to Mr Bastin's question in April 2006 (this being a question from a member of the public).[95]

2.68 Her attitude to any perceived shortage of nursing staff is difficult to understand. In response to the evidence of the Barry report and the 2002 CHI review that there were nursing shortages, Mrs Brisby explained that this issue was tackled by the Board appointing Helen Moss as Director of Nursing.[96] She was aware that, at least at an "intuitive level", Dr Moss was clear there were not enough nurses. A lack of nursing staff is bound to have an impact on the Trust's ability to deliver safe and effective care and yet the emphasis throughout the financial year 2006/07 was on cuts in staff. Even an "intuitive" view that more nurses were needed

91 CURE0001000014, Internal Inquiry into the standards of care on Ward 3 (August 2005)
92 Brisby T129.14
93 Brisby WS0008000005, para 12; T129.17
94 Brisby T129.26
95 JN/13 WS0000012126–12135; Newsham T60.136–137, See paragraph 2.245 below
96 Brisby T129.35

should have led to the necessary review being conducted as a matter of urgency, and in the meantime rigorous information on the standard of care being delivered should have been required.

2.69 There is unhappily no evidence that this was the approach of the Board under Mrs Brisby's leadership. Instead, considerable delays in commencing and progressing Dr Moss' skill mix review were tolerated. When it finally arrived in March 2008 its consequences undermined the financial picture so carefully presented during the previous months in support of the application for FT status. In retrospect, it was clear that the Trust ought to have been spending more on nursing staff, not less.

2.70 I could detect no recognition or acceptance during Mrs Brisby's evidence that she had any understanding of this point, though it was put clearly to her during her oral evidence.[97] I conclude that once again her anxiety to avoid trespassing on what she considered to be "operational" matters disabled her from seeing the risks arising for patients.

2.71 Mrs Brisby appeared content that the Board received only the scantest information about patient complaints. She never looked at complaints herself.[98] Appreciating there is more than one approach to this sort of matter, hers was in stark contrast to that of a Chair at one hospital I visited after the close of the public hearings who read all complaints letters personally. Indeed Mrs Brisby seemed to divorce herself entirely from the complaints process and the mine of valuable insight complaints offered:

> *Individual complaints always risk giving a biased and partial view of what's happening in the trust. A complaint that's investigated properly and resolved is then put to bed and doesn't need to come to the attention of the hierarchy in the organisation, actually. The complaints that aren't resolved and end up with the chief executive have a further route to go, which is to the Healthcare Commission and the ombudsman. We got headline figures of those and there were actually very few and, if I remember, almost none upheld by the Healthcare Commission, which actually suggests that the complaints process was doing what it should do, to deal with complaints.*
>
> *Q. But it wasn't informing the board, was it?*
>
> *A. It was – it was certainly informing the board about the number and the sort of main headings of complaints. I have said before in my statement ... I think a bit more granularity would have been more informative.*[99]

97 Brisby T129.35–38
98 Brisby T129.41
99 Brisby T129.42

2.72 Her reaction to the unfavourable mortality analyses and alerts which emerged from Dr Foster was similarly detached. She did not accept that the HSMR figures required a look at the care being delivered, even while any coding issues were also being explored:

> *I think until you get sensible data on the coding it's impossible to draw any conclusions, and our view was that the data that was coming out, once we'd addressed the coding problems, was sensible and could be relied on.*[100]

2.73 In relation to mortality alerts, she thought these were a matter for the Medical Director, not the Board.[101] She did not consider the Board's role to include getting involved in what she considered to be operational detail:

> *I think what I was saying was that as a board we need to get the best possible information to the board so that it can respond at an appropriate level, that the operational details need to be dealt with at the right level.*[102]

2.74 It is far from clear, after considering her evidence as a whole, what she would have considered the "appropriate level" of response to have been. However she agreed that if it had become clear to them that the mortality figures were not due wholly to coding issues, that the Board "could" have taken "some action", although specifically what was difficult to say.[103]

Attitude to poor care

2.75 It was difficult to avoid the impression that Mrs Brisby, however caring an individual she may have been personally, had no grasp of the enormity of what has been uncovered at Stafford under her watch. She was asked about her reaction to the patient stories summarised in the first report and gave a revealing answer:

> *Q. Well, you've read* [the patient stories]*, Mrs Brisby. You were chair of the hospital for four and a half years, are you not able to say whether you think those people were speaking of genuine experiences?*

100 Brisby T129.75
101 Brisby T129.76
102 Brisby T129.78
103 Brisby T129.80

A. ... I really can't answer that. What I can say is ... I'm sure some were and I don't know which were. I think there's probably something else I'd like to say to this, which is that there seem to be two sets of reactions to the part 2 of Mr Francis' report. One is the one that you're I think voicing now, which is that it is really profoundly shocking, and I can absolutely see that. The other is a reaction that I've had from quite a lot of people within the NHS, which is actually that's the sort of thing that goes on in virtually all hospitals, and there but for the grace of God go we. Now, I'm not saying that to defend poor care, because I think poor care is indefensible, but I am saying that Stafford is not a peculiar hospital in spite of the shocking nature of part 2 of the report.

Q. If that is right and those experiences were happening but they happen elsewhere as well, are you surprised that you didn't pick up on it?

A. No, I'm not, actually.

Q. Why?

A. Well, ... because some of this, if it had been investigated at the level of complaints, would have been dealt with at the level of complaints. If it hadn't been dealt with satisfactorily ... the thinking of the complaints system is that it should be dealt with as close to the ward as possible. If it had gone to the chief executive, I would have expected him to deal with it at that level, and from there to the ombudsman ...[104]

2.76 Assuming she was correct in her assessment that similar poor care could be found in many other trusts, this, it might be thought, should have heightened concern as to whether she and her Board were really on top of the problems her Trust faced. The almost complete separation in her mind between her role as she perceived it, and the actual experiences of the patients her organisation was meant to be serving, must have effectively disabled her from any proper appreciation of what was really happening.

2.77 In part, however, her answer may be explained by her continued inability to accept that things were really as bad as the evidence to the first inquiry plainly showed. She rather contradicted the first part of her answer in her answer to subsequent questions:

Q. It [the large number of people complaining about the same things] *might be a reflection that the same sort of poor care was happening to a number of different people. Do you accept that?*

A. I think it's much, much more likely that the reason a huge number of people didn't find anything uniquely dreadful is that there was nothing uniquely dreadful to find out.

Q. And that is still your belief?

A. Yes.[105]

104 Brisby T129.45–46
105 Brisby T129.47–48

2.78 Even on the assumption that the substantial majority of the complaints were correct she refused to accept that the non-executive directors had a responsibility to get involved:

> *It would certainly tell me that my information systems weren't working well. There would be no question about that. It might say that the wrong people were in post. It still ... wouldn't tell me that the non-executives and the chair should get involved in operational issues.*[106]

2.79 This dissociation may explain her apparent lack of interest in the 2007 Royal College of Surgeons (RCS) report labelling the surgical division as dysfunctional. Neither the report nor its findings were disclosed to Monitor in the course of its assessment of the Trust's FT application, and neither were mentioned at the board-to-board meeting in December 2007. Mrs Brisby accepted that there should have been disclosure about it, if it was known about. She "dimly" remembered knowing something about the occurrence of the review because Dr Suarez, the Trust's Medical Director, was concerned at the compromise to the service caused by the disagreements between two surgeons. However she was unable to say if she had read the report itself before the Monitor meeting. She implied that she would have assumed Monitor had access to this sort of information, because their officials were in the Trust for three months before authorisation was granted and had access to any documentation they wished to see. It is difficult to think of an issue much more important to the ability of a Trust to provide safe and effective services than dysfunction of a surgical division. Yet either Mrs Brisby was aware of this and failed to see the inconsistency of this state of affairs with the bold assertion to Monitor that "quality drives our business", or she was not aware of it, which must have been due to a failure to concern herself with what she regarded as operational detail, by ensuring that reports of this nature were drawn to her attention. However, she did not feel disturbed that she had not been able to read the report before the meeting with Monitor because:

> *The focus of the Monitor meeting actually wasn't largely on clinical issues. It was largely on finance ... But not exclusively, no, I accept that.*[107]

Insight

2.80 Mrs Brisby was aware before and at the time of her appointment that there were serious issues to be addressed at the Trust, which included concerns about the efficacy of the then Chief Executive (see later under *Chronic deficiencies*). She was very keen to appoint Mr Yeates to the post of Chief Executive and thought, and still thinks, he was very good at the job.[108]

106 Brisby T129.49
107 Brisby T129.97
108 Brisby T129.9

2.81 While she says she was aware there were issues of quality which she drew to Mr Yeates' attention, she was unaware throughout her tenure of office of the 2002 CHI report, in spite of this being in the public domain.[109] She had looked at only more recent reports such as the CHI downgrading of the Trust from three to zero stars. As a result she may have missed the fact that there were concerns even then over staff shortages at the Trust.[110]

2.82 Mrs Brisby was certainly aware of problems with A&E that had persisted since at least 2002, and understood that they impacted on patient safety.[111] She accepted that they were still present in May 2008 when the HCC wrote to the Trust about them. It did not occur to her to consider whether A&E ought to be closed on safety grounds because no clinician or the HCC itself had suggested that. She expressed to the Inquiry little or no concern at the time that had elapsed with no progress in remedying these deficiencies to avoid the HCC's justifiable expression of concern. Indeed she described the progress the Trust was making as "good". She appears to have been consoled by the thought that many other trusts were likely to be suffering similar problems. In addition to the remarks quoted above, she commented on the prevalence of problems in other A&E departments:

> *THE CHAIRMAN: ... how long can you carry on tolerating a situation which impacts on patient safety, even if some progress is being made, if the Healthcare Commission is still able to say what it said in 2008?*
>
> *A. I don't know. I think probably what – again, what I think is worth saying is that this was a really bad situation. I would not – I'm not attempting to defend it. It's not unusual. There are many – probably the majority of A&Es in the country, particularly A&Es in small to medium district general hospitals, which had very similar experiences. I have on occasions asked to go and look round other A&Es to see if I could find a good model, and mostly people said they'd prefer not to be looked at.*[112]

2.83 If her assessment of other A&E departments is correct, that would clearly be alarming, but it does not take away her own responsibility as Chair of a trust to address the obvious problems in her own service. A "really bad situation" potentially compromising patient safety is one which she should not have tolerated, and yet she showed little sign in her evidence of appreciating that.

2.84 In spite of all that has been brought to light, Mrs Brisby remains persuaded that the HCC report was an unfair representation of the state of her Trust. She had detailed criticisms to make on the robustness of the evidence relied on, some of which she thought was mere hearsay. As is clear from her answer cited below she believes strongly that the uproar that followed was unjustified:

109 Brisby T129.11–12
110 Brisby T129.13
111 Brisby T129.106–109
112 Brisby T129.107

Q. Is the reality that you think that the furore that followed the Healthcare Commission's report was actually unjustified?

A. Oh, yes, I do. Yes, I think that.[113]

2.85 She also made it clear that she would have wanted to remain in post to continue as Chair if she had not been required to leave by Monitor. In spite of the gravity of the criticisms of the Trust made by the HCC, she did not think her resignation was warranted. Had she stayed in post, she would not have required the departure of Mr Yeates.[114]

2.86 It is only right to take account also of Mrs Brisby's closing remarks to me:

I feel [that] *I'm taking an uncomfortable position here in that I don't know that anyone else has said quite what I've said. I made the point that I'm clearly never going to work in the NHS again. So in a sense ... I have nothing to lose from telling the truth, and this seems to me to be as accurate a picture of the hospital as I can possibly portray. I just reiterate that I apologise absolutely unreservedly to anyone who's received bad practice. It's not acceptable, but I equally think it's not acceptable to vilify a hospital the way Stafford Hospital has been vilified on the basis of relatively shaky evidence from the Healthcare Commission.*[115]

2.87 In assessing Mrs Brisby's role as Chair of the Trust it must be borne in mind that unlike the Chief Executive and other executive directors, she was working only part time. In spite of criticisms that have been levied at her remuneration, I do not find that its level was in any way unacceptable for the serious responsibility of leadership of a complex organisation. Indeed it might be argued that it was a very low reward for what is expected in the job. However, it is clear that she lacked to a serious degree an insight into the significance of deficiencies in the Trust of which she was aware, and of the need to inject real urgency into correcting them if patients were to be protected. She exhibited a ready willingness to point to a lack of cogency in evidence supporting some criticism, but seemed not to realise the needs of governance for reliable and positive evidence that an appropriate level of performance was being maintained. She distanced herself from information, such as complaints that should have alerted her to quite how bad things were. To this day she cannot understand or accept the picture that has been presented by the HCC and the first inquiry. Such a person, doubtless capable of being distressed at poor care being given to patients, honest, well intentioned, and in many ways persuasive, but lacking in insight to the degree described, is a very dangerous person to be at the head of a service to patients.

113 Brisby T129.114
114 Brisby T129.129
115 Brisby T129.145

Medical Director

Val Suarez

Background

2.88 Dr Valerie Suarez was Medical Director at the Trust from late 2006 (although she was not fully operational in the role until January 2007) to March 2009 and therefore was the medical professional voice on the Board throughout virtually the whole period which this Inquiry has been tasked to review. She had been a consultant histopathologist at the Trust since 1989. Prior to taking up the post of Medical Director, she had occupied a number of managerial roles, including leading the Pathology Directorate and, for a period of about six years, she was Clinical Director for Clinical Support Services.[116]

Attitude to role

2.89 She was first approached and asked to consider taking on the Medical Director role in the spring of 2006, when Dr Gibson stood down. She was reluctant to do so for a number of reasons: it meant she would have to reduce her clinical commitments; she had seen colleagues elsewhere struggle to combine the burdens of the Medical Director's role with their clinical responsibilities; and she doubted she had sufficient training, although she had been on various management courses. Therefore, initially, she turned down the suggestion in the expectation that Mr Durrans, then Deputy Medical Director, would take up the post. He did not do so and she had to reconsider her position. After taking advice from external colleagues, she agreed, still reluctantly, to apply for the job, to which she was in due course appointed. She found the selection progress rigorous, more so than that adopted for appointments to consultant posts.[117]

2.90 Nonetheless she continued to feel under trained for the role:

> *I had a lot of experience in terms of management within the trust, but ... I have no management qualification. I'd attended a number of courses, management courses, but I had no formal qualification. Whereas, as a doctor, of course, I've got quite a few. So the comparison between being a doctor and a medical manager at that point seemed to me, yes, I'm well qualified on paper to be a doctor, I don't appear to have the same qualification on paper to be a medical manager. But that's not uncommon in medical managers at the moment in the UK.*[118]

2.91 Dr Suarez continued to undertake clinical work, theoretically devoting 20% of her time to clinical work and 80% to the managerial role. She reduced her range of practice, but felt she

116 Suarez WS0000012476–479, paras 1–10
117 Suarez WS0000012478–479, paras 7–9
118 Suarez T59.16

needed to spend more than that in order to retain proficiency. This can only have added to the pressure of the Medical Director's many responsibilities, which she described as "onerous".[119]

2.92 Another feature of Dr Suarez's appointment, which perhaps came through more strongly in the first inquiry than this one, was that the pathology department was not on the main hospital site. This meant not only that Dr Suarez was perhaps a less familiar figure than some to colleagues, but added a degree of separation from the organisation whose medical staff she had to represent on the Board. Dr Peter Daggett, for example, appears to have raised issues primarily through correspondence rather than in person.[120] Dr Suarez accepted that because her clinical work was off site she did not come across colleagues and visit wards as often as might have been ideal.[121]

2.93 However Dr Philip Coates, a diabetes consultant, told the Inquiry that Dr Suarez was:

> *An excellent medical director. She was hugely respected and most consultants thought she was the only person who didn't think she was right for the job. In the end, however, I think she struggled with the more unpleasant aspects of the job and events overtook her ... she had probably been here too long and so did not have the detachment to bring about real change.*[122]

2.94 The advantages of mixing clinical and managerial roles include enhancing the opportunities for engagement with clinical staff, and first hand awareness of issues at the front line. However it is open to doubt whether this important role can realistically be undertaken effectively, even in a district general hospital, by anyone other than an individual with appropriate training and on a full-time basis.

Role as advocate for the medical view

2.95 Dr Suarez told the Inquiry that it was difficult to promote a "medical" agenda because of the dominance of finance. She accepted that in hindsight she ought to have pushed against that. At the time she thought that:

> *... the drive for Foundation Trust status was, from Helen* [Moss] *and my point of view an opportunity to put systems in place, and we would, I think argue that that was the intention at that point. I think now that we know where we are now, it's clear we did not push that agenda hard enough.*[123]

119 Suarez WS0000012479–80, paras 12–13
120 Daggett T46.38, T46.41
121 Suarez T59.79
122 Coates WS0000004858–4859, para 31
123 Suarez T59.19

2.96 She agreed that the structure in which the Director of Nursing had sole responsibility for clinical governance was unsatisfactory, and that it would be better for there to be a joint responsibility for the medical and nursing directors together with the non-executive directors.

2.97 One opportunity that presented itself for a strong advocate of a medical voice to raise concerns in an open way was the Trust's application for FT status. Dr Suarez's appreciation of the dire state of clinical governance in the Trust was considered in the Inquiry's hearings. There is no evidence that she raised those concerns with Monitor during the assessment process. She may have been "surprised" that the deficiencies were not detected, but regrettably she does not appear to have done anything to assist Monitor to detect them.[124] While she may not have been alone in that, and the lead in clinical governance was taken by Dr Helen Moss, it might be thought that a Medical Director has a particular responsibility to ensure that regulators have all information relevant to their work where patient safety may be at risk. She must have felt able to remain silent at the board-to-board meeting in December 2007 when they were asked what the Board did with information on quality, and Dr Moss answered that the Trust had "robust governance arrangements" and, again, when she answered a question about how the Trust ensured quality was not compromised by financial cuts by saying that it did so:

> *... with the systems we have in place and by constant monitoring. Quality is what drives our business ...*[125]

2.98 She has accepted that with hindsight she did not appreciate the extent of the governance problems, believing that the process had been improved by that time.

Support for role

2.99 Dr Suarez was surprised at the extent to which she had to create systems for herself rather than there being a template to start from. She found that she had to talk to colleagues elsewhere and "pinch" ideas from them.[126]

2.100 She also found that as there was no Medical Director in post in the PCT, she did not have the same level of interaction with the SHA and PCT as other executives.[127]

Lack of urgency

2.101 As Medical Director, Dr Suarez had a responsibility for ensuring that the Board received expert medical advice on issues facing the Trust. One of these, it might be thought, was the impact on the safety of patients of deficiencies coming to light. She, admittedly among others, seems

124 Suarez T59.176
125 MON00030012478, Minutes of Mid Staffordshire General Hospitals Board to Board Meeting re Application for FT Status (5 December 2007)
126 Suarez T59.21
127 Suarez T59.122

to have failed to appreciate the degree of urgency required to correct some of the failings of which she was aware.

2.102 Thus she was aware of the absence of effective clinical governance in 2006, and yet was obliged to accept that although there had been some improvement, as a result of the implementation of an action plan, it was still ineffective in 2009.

2.103 Similarly she was aware of the issues affecting the A&E department. She pointed to difficulties, for instance in the recruitment of an adequate number of consultants, attributed by her to "personality difficulties in the department" "putting off" people applying, and accepted that because of them the department was not safe on anything other than a temporary basis.[128] Her evidence gave a sense of undue acceptance of those difficulties as being a reason for inaction with regard to protecting patients. In spite of her concerns, she did not approach any external body, such as the PCT, because it did not have a Medical Director at the time, or the SHA because she did not see them as "natural" people to go to.[129] No serious consideration seems to have been given as to whether A&E was viable, although the issue of whether it should continue to be open 24 hours a day was looked at on occasions.

2.104 Yet another example was the lack of robust action in connection with the issues in the surgical division of which she knew (see *Chapter 1: Warning signs*). It was Dr Suarez who was sufficiently concerned about interpersonal relationships in the division to invite the RCS review in 2007. She accepted that those issues were such that while they persisted the Board could not be assured that the division was safe.[130] Inevitably she therefore had to accept that the timescale over which the review was conducted, the fact its ineffective recommendations accepted were and the lack of further effective action were unacceptable. She pointed to the action plan which was created, the time that elapsed between the RCS being invited to review and its report be prepared, the time taken by the National Clinical Assessment Service (NCAS) to respond to a request for advice, the difficulties in recruiting another surgeon, the time taken to collect audit data, the impossibility of getting the surgeons to agree protocols and the dangers of acting inappropriately. While there is force in her identification of all these points as contributory factors to an unacceptable situation, as Medical Director she was perhaps in a unique position to ensure that others appreciated how serious the problem was. She may have acted no differently from many other medical directors faced with a similar problem, but it is a stark illustration of the need for medical professionals to refuse to tolerate situations which are unsafe for patients and of which they are aware.

128 Suarez T59.48
129 Suarez T59.43–53
130 Suarez T59.120

Director of Nursing

Helen Moss

Background

2.105 Dr Helen Moss was Director of Nursing at the Trust from December 2006 to November 2009. She also served as Director of Infection Prevention and Control from September 2007. She initially trained as a registered general nurse and worked predominantly in intensive care, before gaining her doctorate, specialising in clinical microbiology and infection control. She served as Associate Director of Nursing at University Hospitals Birmingham from 2002 to 2004, then as Deputy Chief Nurse at that organisation before taking up her role at the Trust.

Awareness of problems

2.106 It is clear that from the outset Dr Moss was aware that the Trust faced a number of serious problems within her area of responsibility.

2.107 She was aware in general terms that nursing at the Trust needed attention, although she had not realised the extent of what was required.[131] She knew that recruiting fresh staff presented a challenge because of the size of the Trust, its lack of specialist services and career development opportunities.[132]

2.108 She was aware of the closed culture among the nursing staff:

> *... it was a very unusual culture and closed – a closed workforce they didn't readily discuss any issues and it took a significant amount of time to gain the trust of the workforce.*[133]

2.109 Almost as soon as she arrived she realised that she would have to review the nursing skill mix and staff numbers.[134]

2.110 It was apparent to her that basic good nursing practice was absent. She was unaware of the Barry report, which revealed alarming poor practice.[135] However, she found that the Essence of Care programme was not running well at Stafford (even though it was being used in parts of the hospital). By reading complaints and attending the Executive Governance Group she was aware that:

- Failures of basic nursing care were the principal subject-matter for complaints;[136]

131 Moss T62.4
132 Moss WS0000009457, para 16
133 Moss T62.41
134 Moss WS27 WS0000009462
135 CURE0001000001, *Internal Inquiry into the Standards of Care on Ward 3* (1 August 2005)
136 Moss T62.19–20, 182

- Auditing of nursing performance under the Essence of Care programme, which covered key elements of basic care, was not running at all well;[137]
- Clinical dashboards, which covered matters such as patient falls and drug errors, were inadequate;[138]
- The Trust was under-staffed with nurses;[139]
- That it was difficult to obtain reliable figures of the staff establishment.[140]

2.111 She did set about seeking to address these issues, but the principal criticism arising out of the first inquiry is the length of time taken to achieve any action. This is considered below.

Insight

2.112 Mr Sumara, under whom Dr Moss worked for a time after he arrived at the Trust, considered that she did not appear to be prepared to take responsibility for what had happened.[141]

> *Q. You also say this, in your statement, and it may be important to highlight it: "When I arrived there was a definite reluctance on the part of any members of staff to accept responsibility for their actions. The only person that I remember as having any integrity and offering to resign immediately was Sharon Llewellyn. All of the others were in denial, thinking that they were not the ones to blame. This culture of denial permeated to all levels of the hospital." Does that include the board?*
>
> *A. Well, most of the ... non-execs on the board were brand new. I mean, certainly Manjit and Mike were relatively new. Helen Moss had been in the trust for three years, as an executive director, and my sense was that she wasn't taking responsibility for what had happened. In fact, was saying that she wanted to be part of the solution. So whether that's denial or not, I don't know, but there certainly wasn't a sense of remorse. There was more a sense of anger that we'd attracted that sort of attention, if you like.*[142]

Chronic deficiencies

2.113 The problems identified by the HCC in its investigation and subsequently were longstanding and apparently intractable. Some of that history has been outlined in *Chapter 1: Warning signs*. Issues such as deficient governance went back at least as far as 2002. It was clear to the Chair and Chief Executive on their arrival in 2004 and 2005 respectively that this was the position. Mrs Brisby said that on her appointment she understood the Trust was perceived to be in serious difficulties. She says, and I accept, that she was told by Mr Mike Brereton, then Chair of SaSSHA, that the Trust was suffering from poor governance and financial difficulties.[143]

137 Moss WS0000009460, para 24
138 Moss WS0000009460–1, para 25, T62.6–12
139 Moss T62.16
140 Moss T62.14–18
141 Sumara T58.64–65
142 Sumara T58.64–65
143 Brisby WS0008000003–004, paras 5–9; T129.5

While she may not have been specifically told by Mr Brereton this was a "failing trust" (he denied this)[144] it is likely this was her understanding of what she was told. Further, as recorded in the first inquiry report, she told me others had told her it was a "disaster area".

2.114 Mr Yeates told the Inquiry that when he applied for the post of Chief Executive he was aware of immediate challenges that he would face: a large financial deficit, "some quality issues", and two "fundamental issues":

> *Lack of governance – governance simply did not exist in a corporate or clinical sense.*
>
> *Lack of managerial structures – no one actually ran either site; the managerial structures in place at the Trust were bizarre.*[145]

2.115 He was told by Mr Bernard Crump, Chief Executive of SaSSHA, that there was a perception that the Trust was introverted and that there was a great deal to do, as his predecessor had been off sick for a long time. Mr Yeates accepted that:

> *... there were huge organisational and cultural issues to deal with which would take some time to resolve, particularly alongside a deficit, but I was confident that they could be resolved over a period of time.*[146]

Culture within the Trust

2.116 It is clear that in spite of the warning signs (listed in *Chapter 1: Warning signs*) the wider system did not react to the constant flow of information signalling cause for concern. Those with the close and clearest responsibility for ensuring that a safe and good standard of care was provided to patients in Stafford, namely the Board and other leaders within the Trust, failed to appreciate the enormity of what was happening. They reacted too slowly, if at all, to some matters of concern of which they were aware, and downplayed the significance of others. The first inquiry report attributed this in large part to an engrained culture of tolerance of poor standards, focus on finance and targets, denial of concerns, and an isolation from practice elsewhere. Nothing heard in this Inquiry suggests that this analysis was wrong. Indeed the evidence has only reinforced it.

Focus on finance and targets

2.117 Mr Yeates was clear in his statement that he had to concentrate on a number of serious problems from the moment he took up his post as Chief Executive:

144 Brereton T97.67
145 Yeates WS0000074923, para 9
146 Yeates WS0000074924, para 11

It took me some time to get to grips with the true scale and nature of some of the problems at Mid Staffs. As I have stated, I was faced with a number of priorities, such as reducing deficits, dealing with staffing problems and dealing with a range of issues on the Cannock site. There were not enough hours in the day.[147]

2.118 In fact, these issues were all related to the Trust's finances. It is clear from the evidence at both inquiries that the Trust was operating in an environment in which its leadership was expected to focus on financial issues, and there is little doubt that this is what they did. Sadly, they took their success at balancing the books as being the benchmark to which to aspire and paid insufficient attention to the risks in relation to the quality of service delivery this entailed.

2.119 Dr Philip Coates identified the priority given by the PCT to finance rather than quality. For example, there were occasions when he felt that National Institute for Clinical Excellence (NICE) guidance relevant to the Trust had not been implemented for financial reasons:[148]

My view from attending meetings with the PCT was that the PCT and the Trust were essentially commissioning care/providing care from a spreadsheet. They were interested in activity levels, throughput and monitoring contracts to make sure that we were not overspending but they were not focusing on detailed commissioning of healthcare for local people and ensuring the provision of good quality care.[149]

2.120 It might be thought that such an approach by the PCT encouraged the Trust and its leaders to divert their attention away from quality issues. The same can be said of Monitor's approach to assessment for FT status at the time which also focused on financial issues, with an underlying assumption that quality issues were being successfully addressed elsewhere in the system.

Isolation

2.121 Mr Yeates found on his appointment that the management was "a very inwards facing organisation, with a poor or defensive engagement with external bodies, including the HCC".[150] He thought the nursing workforce was stagnating with a lot of them "just wanting to do their day job" without attention being paid to professional development and career development.[151]

2.122 Dr Moss found on her arrival that there was little to attract new staff from outside the organisation.[152] She described the workforce as "closed":

147 Yeates WS0000074932, para 43
148 Coates T50.98–99
149 Coates WS51 WS0000004865, para 51; T50.150
150 Yeates WS0000074926, para 20
151 Yeates WS0000074928, para 27
152 Moss WS0000009457, para 16

it was a very unusual culture and closed – a closed workforce and didn't – they didn't readily discuss any issues and it took a significant amount of time to gain the trust of the workforce.[153]

2.123 Returning to Dr Coates' evidence on non-implementation of NICE guidance, he described the isolationist approach of some consultants:

... there's an abnormal culture which was both within the consultant staff and in other staff, whereby it ... frequently seemed to me that we had to produce a Stafford version of the NICE guidance as opposed to taking it as written by NICE ... I think that in retrospect there – there was an unwillingness to accept nationally agreed guidance at face value ... The DVT [deep-vein thrombosis] *issue isn't the only issue that has gone to prolonged and protracted – gone through a prolonged and protracted implementation stage.*[154]

2.124 This evidence was supported by Dr Turner who gave the example of the Trust not adopting the NICE guidance on head injury[155] which he had been accustomed to follow at his previous hospital:

I came to Stafford and was told that they were too difficult to implement and that we just didn't follow them. And actually, the exact quote was "We don't believe in them".[156]

2.125 In relation to the reluctance to adopt and implement proper clinical governance, Dr Coates admitted that consultants at Stafford were not at the forefront of promoting change:

It may be the case that Stafford was particularly recalcitrant in terms of picking up the newer ideas and going with clinical governance agenda. But, you know, I think other people had suggested that in some ways some consultants here have been relatively old-fashioned in their approach ...

Q. One wonders whether in terms of the culture amongst those working at the Trust, as well, there was a degree to which it was insular and cut off from a realisation within other parts of the country about the importance of clinical governance

A. I suspect that's – that's a significant factor. Yes.[157]

153 Moss T62.41
154 Coates T50.99–100
155 Turner T50.53
156 Turner T50.53
157 Coates T50.125–126

2.126 Dr Suarez thought that there were pockets of more inward looking staff, and attributed this in part to what she termed "the stability" among the consultants, as there was not a great deal of turnover.[158]

2.127 Looking back at the Board of Mrs Brisby and Mr Yeates, Sir Stephen Moss characterised it as "immature" with an inexperienced Chief Executive: they did not ask for help, perhaps because they did not even know help was needed, he suggested.[159] Sir Stephen saw this, as well as the fact that the Board was not being effective, as a warning sign that regulators should have detected.[160]

Professional disengagement from management

2.128 The Inquiry heard evidence which added justification to the view formed at the first inquiry that clinicians did not vigorously pursue with management concerns they may have had. The reason for this was in part a perception that the raising of concerns was not welcome by senior management, and in part the very human reluctance to risk job security and potential opprobrium.

2.129 Dr David Durrans told the Inquiry that from his position as Deputy Medical Director sitting on the Hospital Management Board, he felt that clinicians' views were not heard, which seems to have led to a resigned state of mind on his part:

> *There was an aggressive style and a certain degree of immovability, I think, in that sometimes when consultants were attempting to put their point across, there would effectively be a door closed ...*
>
> *Q. Some might ask, if you, as a senior consultant, who'd been at the hospital for quite some time, clinical lead, at one stage deputy director, if you can't speak up on behalf of the consultant body, who on earth can?*
>
> *A. I would agree with you. I mean, perhaps it says something about me. But, no, I think that's very true. If somebody of my standing can't be heard, what hope is there for others?*[161]

2.130 The resulting attitude is illustrated by the passive approach taken over concerns about a surgical colleague which had been a principal cause for inviting the RCS review in 2007. Mr Durrans, among others, was disappointed that the review's recommendations were "soft" and did not give "clarity" as to how to deal with the problem.[162] He remained aware of concerns from colleagues about this surgeon's character, and asked for their concerns to be

158 Suarez T59.26
159 Stephen Moss WS0000008836, para 38
160 Stephen Moss WS000000008837, para 45
161 Durrans T51.186
162 Durrans T55.25–26

produced in writing, but this was never done. In spite of his senior position in surgery, and as Deputy Medical Director, other than discussions with the Medical Director and the surgeon, which led nowhere, nothing further was done to go beyond the review's recommendations until the RCS was invited back in 2009. Sadly, this followed a serious untoward incident (SUI), which might have been attributable in part to the very defects about which concern had been expressed two years earlier.[163] A degree of passivity about difficult personnel issues is all too common in the NHS as, perhaps, elsewhere. In the case of Stafford, this attitude was undoubtedly exacerbated by the disengagement between clinicians and management, blame for which cannot be laid at the door of an individual. However, a system that is safe for patients requires a much more rigorous approach.

2.131 Dr Daggett was employed as a consultant physician at the Trust from 1982 to July 2010, when he retired. He told the Inquiry how he had raised concerns over staffing levels over an extended period. He produced a quantity of letters he had written to management from 2001 to 2008.[164] He raised matters with his clinical director, the Medical Director, the Director of Nursing and the Chief Executive. The issues covered included the standard of care for emergency admissions, insufficient numbers of doctors, nursing shortages, an inappropriate transfer of a patient to avoid breach of the A&E four-hour waiting time target, staffing of the Emergency Assessment Unit (EAU), overwork, lack of support staff, and lack of diabetic nurses. He said he received courteous responses from all except the Director of Nursing at the time (Ms Jan Harry) but the reaction had always been defensive of the Trust leadership's position. He considered that none of his three clinical directors between 2000 and 2009 appeared to react to consultants' concerns. As a result, he said, the consultants "lost heart":

> *Those consultants who were involved in management would have nothing to do with the dissent. Those who didn't have a management role would complain regularly but were told to "get back in their box".*[165]

2.132 Dr Daggett's view was endorsed by the House of Commons Select Committee to whom he gave evidence.[166]

2.133 He also felt that consultants tended to be excluded from certain committees. Thus for a time he was able to attend clinical directorate meetings, but in 2007 Dr Mulherin, then Medical Director, decided that only one doctor from each speciality should attend. Dr Daggett thought this was to stop discussion taking place.[167] I find this doubtful, and clearly there could be good reasons for limiting attendees to a directorate meeting, so long as the representative of each specialty took care to represent the views of colleagues. Dr Daggett's problem may have been more that his specialty was represented by Dr Coates, who, he said, did not go to the

163 RCS00000000180 *Invited Review Mechanism,* (October 2009), Royal College of Surgeons
164 PD/1 WS0000003791
165 Daggett WS0000003775, para 3
166 Daggett T46.80–81
167 Daggett WS25 WS0000003780, para 25

meetings. Nonetheless Dr Daggett's genuinely held perception, if shared widely, could well have been a factor in the general passivity of the consultant body.

2.134 Dr Daggett also considered that colleagues in management positions were not challenged, and suggested a potential conflict between the two roles:

> *It is very difficult to have a robust discussion on some management matter with a colleague at a committee, and then a few hours later require that colleague's assistance looking after a sick patient in the intensive care unit. I think on account of that, the managers were given a fairly calm ride, if you like, and that's one other thing which I think you – should be perhaps – considered at some point that substantial directorates with large numbers of staff and money should have a professional manager, rather than a clinician.*[168]

2.135 It is possible this is a reason why Dr Manjit Obhrai, a full time Medical Director, previously at another trust, was so conspicuously more successful and well regarded in the role of Medical Director than his predecessors.

2.136 Similar deference seems to have been accorded to the Chief Executive. According to Dr Daggett, he came to Consultant Staff Committee (CSC) meetings, but no one ever raised issues with him there:

> *It was only once he left the meeting that everybody moaned.*[169]

2.137 Dr Pradip Singh, a Consultant Gastro-Enterologist, also told the Inquiry he had continuously raised concerns. The detail is dealt with later in this chapter in the whistleblowing section. His experience in this regard left him very concerned for his future. His story, widely known, would have discouraged colleagues from getting involved. He said that in 2005–2006 the only forum in which consultants could raise concerns was the CSC meetings but this was not easy, as it was only an advisory committee with many issues to address.[170] The consultants, he said, were completely disenfranchised.

2.138 Mr Verghese Cheeran David, a Consultant Surgeon, described his concerns about the surgical floor reconfiguration, which accorded entirely with the criticisms widely made of the project ever since. He recalled no consultation with the consultant body on this change.[171] He and others raised their concerns in the only way available to them, via the directorate structure, but the response came back that management said things would improve once FT status had

168 Daggett T46.69–70
169 Daggett WS0000003781, para 29
170 Singh T46.126
171 David WS0000042262–264, paras 2–8

been obtained. He did not raise his concerns externally; had he done so it would have been via the PCT, local GPs or even the press.[172]

2.139 He received the same response when he raised concerns about patient care with Mr Yeates. Mr David had been prompted to do this after witnessing poor care given in A&E to a retired consultant colleague of 25 years' standing. As Mr David put it:

> *If he was not getting the good care that he needed then one can only guess at what it must have been like for the rest of the patients. To me we were not working as a hospital any more.*

2.140 He clearly regretted not doing more about his concerns and expressed his reasons for not having done so with commendable candour:

> *Perhaps I should have been more forceful in my statements, but I was getting to the stage where I was less involved and I was heading to retirement ... I did not have a managerial role and therefore I did not see myself as someone who needed to get involved. Perhaps my conscience may have made me raise concerns if I had been in a management role, but I took the path of least resistance. In addition ... most of my patients were day cases and there was less impact on those patients. There were also veiled threats at the time, that I should not rock the boat at my stage in life because, for example, I needed discretionary points or to be put forward for clinical excellence awards.*[173]

2.141 His evidence highlights how easy it is for conscientious professionals to find reasons not to "rock the boat" and the need for very robust support to enable and empower even senior consultants to raise important issues and to persist in doing so.

2.142 Mr David was another witness who pointed to defects in the CSC meetings as a means of raising concerns. He said that it suffered from poor attendance and thereby lost authority. The vicious circle was completed by even fewer going as a result. He criticised Mr Yeates as being someone who did not enter into genuine discussions with the consultant body. He described his management style as "dictatorial" and as a result consultants tended not to challenge him.[174]

172 David WS0000042264, paras 9–10
173 David WS0000042265–66, paras 14–15
174 David WS0000045569–70, paras 27–28 and para 30

2.143 Mr David was not surprised at what he read in the HCC report:

> *My reaction was that we all saw it coming but we did not do enough about it. In retrospect, we should have been more explicit in making people aware of our concerns.*[175]

2.144 From outside the Trust, Dr Greaves, a GP and Director of Gnosall Health Centre, gave confirmation that there appeared to be a problem for staff to get their concerns through to central management.[176] Dr Eames, a local GP, gleaned a similar impression from her contacts with consultants:

> *I know that if clinicians took problems to the hospital management the criticism would fall straight back to them. I remember ringing one consultant and he told me that if I copied in the chief executive to my letters, the chief executive would simply hand the letter straight back to him and nothing would change.*[177]

2.145 There is evidence that directors were unaware of how disengaged staff felt. Mr Newsham, the Director of Finance, when taxed with the evidence that consultants felt disenfranchised, said he found that "surprising".[178]

Tolerance of poor standards

2.146 The first inquiry report described the culture of tolerance of poor practice.[179] Dr Turner was able to add to this evidence from his own observation, coming afresh into A&E from the outside. He pointed to the gradual corrosive effect of working in such a difficult environment and did not think staff there were aware just how much of a disaster it was:

> *I think they were aware that it was extremely difficult to work in the environment. I think they were aware that their jobs were near impossible to do to the standard that they wanted to do them to. But ... I think it had been an incremental thing where things had become harder and harder and harder and they didn't actually realise just how far off acceptable standards things had slipped to, and I don't think that any of them would have let that happen if it had happened overnight. I think they would have been up in arms, but I think it was just so gradual that they didn't recognise it.*[180]

175 David WS0000042271, para 33
176 Greaves T32.64
177 Eames WS0000002887, para 12; T32.147
178 Newsham T60.134
179 *Independent Inquiry Into Care Provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009, chaired by Robert Francis QC* (24 February 2010), vol 1 pages 174–175
180 Turner T50.81

2.147 It is also only fair to put on record that Dr Turner, like others, was at pains to emphasise that most staff were determined to do what they could for patients and were prevented only by staff shortage:

> *Where care was less than it should have been, this was never through a desire to provide that level of care, rather ... the sheer lack of numbers to provide it. And I unreservedly apologise where care was less than we would have wished. But hands-on care requires that, enough hands. We didn't have enough hands. In my time at Mid Staffs I saw numerous examples of selfless devotion on the part of staff. Staff coming in their own time, unpaid. Staff paying out of their own pockets for the educational needs of other staff. And just uncountable hours of unpaid overtime, all done with a view to providing the best quality of care that they were able to do under what I've said were exceptional circumstances, and I remain very proud to have worked with them.*[181]

Denial

2.148 Dr Coates, when asked about the Trust's approach to the mortality figures, accepted that in hindsight more should have been done:

> *Q ... One might ask in that context why the trust took the line "This is coding", rather than saying "Well, it may well be real problems with the quality of care"?*
>
> *A. Yeah, and I would agree ... First of all, sad to say I think nobody likes to feel that they're not doing a good job. So that was one thing. The second thing is that we had our data analysed by CHKS, which is one of the other data manipulators in the field, who suggested to us that we did not have mortality problem. And I think that gave us inappropriate and false reassurance ... So I fully accept that we should have been looking at quality of care, but I think we were misled by the alternative analysis by CHKS and, I think, the unwillingness to think that we were doing a bad job.*[182]

2.149 As can be seen in *Chapter 5: Mortality statistics*, it became clear from evidence to the Inquiry that there had never been a CHKS report to the effect understood by Dr Coates. Therefore, it appears that the unwillingness to accept a bad job was being done was accompanied by an over-willingness to believe that a positive external report existed without anyone actually having seen it.

2.150 Another example of denial can be found in the Trust's approach to the HCC's self-declaration process. Here the emphasis was on finding, rather than challenging, evidence to justify a declaration of compliance. In turn, where there was evidence of non-compliance, emphasis was placed on looking for evidence to the contrary. Trudi Williams (from February 2004

181 Turner T50.89–92
182 Coates T50.164

Deputy Director of Clinical Standards and from April 2007 Head of Governance) accepted[183] that there had been an excessive reliance on external assessments, such as those of the NHS Litigation Authority (NHSLA). She herself admitted to having been "shocked" and "sceptical" about the NHSLA's assessment categorisation of the Trust at level 3; the NHSLA's rarely granted, highest level of accreditation.[184] She described the overall approach, and the pressure that generated it, in this way:

> *If you have a hypothesis, you go out to prove it. So, you know, if we thought we were compliant, we would be looking for the evidence that said we were compliant.*
>
> *... It would start with a starting point of what evidence do we have to support whether we are compliant. As an organisation, I suppose the view is that – these standards – we should all be compliant at every single one of them. And every trust should be compliant and, therefore, there is a certain amount of pressure nationally, locally, you know, wherever it is, to not be seen as an outlier within your self-declaration. If you're declaring that you're non-compliant within all of those, then as a healthcare trust you would come under particular scrutiny, and certainly there would be questions asked as to, "Well, what the heck are you doing there?" And I suppose, you know, that is the basis that fundamentally people think that, you know, is there sufficient assurance to say we're compliant or not?*[185]

2.151 A somewhat striking illustration of how the culture of denial permeated and persisted in the Trust's leadership is to be found in the current views of Mrs Brisby and Mr Yeates as expressed to the Inquiry.

2.152 Mr Yeates stated without qualification in his statement that, at the time of the 2007 board-to-board meeting with Monitor, he believed the Trust was ready. This is in contrast to his belief at the FT diagnostic board meeting in 2005 with David Nicholson and Antony Sumara.[186] Given what is now known, and Dr Moyes' position that had Monitor known the full facts it would not have authorised the Trust, this is a startling belief to maintain.[187]

2.153 Mr Yeates also believes that the HCC investigation and report was unfair in its portrayal of the Trust. He told the Inquiry that he genuinely believed that, at the time the investigation started, the Trust had "turned the corner"[188] and that:

183 Williams T133.88–89
184 Williams T133.50–51
185 Williams T133/82–84, 90–91, 94–96
186 Yeates WS0000074927, para 24; WS0000074950–952, paras 96–103
187 Moyes T93.25 and T92.170
188 Yeates WS0000074921, para 3

We had got to a point where our finances were under control, we had a good grip on staffing matters and our management and governance structures were becoming embedded in daily life at the hospital. I'm not saying things were perfect as this was not the case. I would have been the first to admit that there was still a lot to do, but I also would have been the first to congratulate the many hard working and dedicated staff at the hospital for the effort that had been put into making Mid Staffs a hospital with a bright future.[189]

We had most definitely turned the corner, just as we were stopped in our tracks.[190]

2.154 Mrs Brisby also did not accept that the HCC report represented a fair picture of the Trust. She said she was shocked at the patient stories that appeared in the first inquiry report, but contended that neither they nor the HCC findings had been subjected to critical analysis and that insufficient account had been taken of the Trust's own report from Price Waterhouse Coopers (PWC).[191] She thought that the HCC report had been accepted in its entirety by Monitor because one regulator could not be seen to contradict another. She felt her own role had been distorted.[192] She considers it unfair to criticise her and her fellow non-executive directors for failing to spot deficiencies and said a myriad of professionals had not detected these either.[193] She contended that Cure the NHS (CURE) had "won" the battle and that "all history is written by the victors."[194] In short, she thought that the furore that followed the HCC report was unjustified.[195]

2.155 It is impossible not to have a degree of sympathy for Mrs Brisby, however understandable are also the feelings of bitterness towards her of those who have suffered from poor care at Stafford. A sense of some respect for her principled and clear expression of her honestly held views is even possible. She, like Mr Yeates, clearly took on the leadership of the Trust for the best possible motives and genuinely desired to improve its performance.

2.156 Mrs Brisby and Mr Yeates took over a Trust which was already experiencing considerable problems. While there were improvements made during their time in charge, the evidence shows that, by the time they left, there were many serious problems which had not been effectively addressed. The overall position was at considerable variance from the picture they portrayed to others, perhaps because they took undue comfort from their perception of the progress that had been made since their arrival.

189 Yeates WS0000074965, para 138
190 Yeates WS0000074971, para 156
191 TRUST00030006738, *Mid Staffordshire Foundation Trust, Final Report* (13 July 2009), Price Waterhouse Coopers
192 Brisby WS0008000139, paras 531–2
193 Brisby WS0008000142–143, paras 543–4
194 Brisby WS0008000145, para 550
195 Brisby T129.114

2.157 They have been inevitably distressed by the volume of criticism directed personally at them, when they perceive others shared the responsibility. They have had to bear a huge weight of public disapproval. However, I am unable to accept Mrs Brisby's castigation of the findings of the HCC or of the evidence summarised in the first inquiry report. I cannot here address each and every one of the points of detail she raises, but I consider that the combined weight of the evidence tendered to both of the inquiries clearly confirmed the thrust of the HCC's conclusions and the complaints made by so many patients.

2.158 It is a travesty to suggest that, in general, the patients and their relatives who have made complaints are not justified in what they say. Not only have I heard many of them, and been impressed by the care so many of them have taken not to exaggerate or be inaccurate in what they had to say, but the Independent Case Note Review (ICNR) confirmed that, in the significant majority of the cases they reviewed, sub-standard care was found by an inspection of the medical records alone. The story of Stafford is littered with verified case studies of appalling care, often showing serious systems failure. The sheer number of complaints of poor care summarised in volume 2 of the first inquiry report defies any suggestion that an acceptable and consistent standard of care was being delivered to the Trust's patients during the period under review. The deficiencies discovered by various peer reviews throughout that period could not have happened and persisted without deficient leadership and management. I have no doubt that some of these were recognised and attempts made to address them, but in many cases the steps taken were lacking in urgency, were ineffective and not followed through.

2.159 That others shared a responsibility for this state of affairs is undeniable. That Mrs Brisby and Mr Yeates, as the senior non-executive and executive directors, have a primary responsibility cannot, however, be denied. Their inability to accept that – even now – shows a lack of insight which is incompatible with what should be expected of anyone aspiring to such office.

2.160 Mr Sumara found on his arrival that staff thought either that the situation was not as bad as it had been portrayed, or that it was, but that the situation was the same as that at other hospitals. He found few at any level who were prepared to accept responsibility, suggesting others were to blame:[196]

> *... one of the familiar comments that was made time and time and time again when I first arrived, was "This happens everywhere and we were just the unlucky ones that were caught". And ... that was said by some fairly senior people, including consultants. And I think in my statement I also refer to a consultants' meeting I went to where, you know, one idiot tried to say actually, you know, "We're just like any other trust". And I said, "Well, name one other trust* [that's] *anything like us", and he said "Tunbridge Wells", where I think something like 500 people had died from C. difficile recently. So that was*

196 Sumara WS000005918, paras 34–5

the level of their analysis. And actually I tried to explain to them that, you know, the serial and repetitive nature of what had happened at Mid Staffs isn't usual in the NHS … So that was the level of denial, really. That's not the case now.[197]

2.161 Sir Stephen Moss suggested that this mindset could have been encouraged by the grant of FT status:

One of the problems when an organisation is approved as a Foundation Trust, in my experience, is that once it has passed this test, it is seen as being a successful organisation. This is dangerous for the mindset of the board who will often react by, at best, resting on its laurels and, at worst, becoming arrogant and complacent. What many new Foundation Trusts do is to build a fortress around themselves, reluctant to pass information on to commissioners and regulators, thinking that they are no longer answerable to anyone.[198]

2.162 Mr Sumara arrived to find a concerning lack of attention being paid to the issues at the heart of the crisis which had resulted in his appointment as "turnaround" Chief Executive. He told the Inquiry of an executive team meeting the day after he arrived which did not have on its agenda a single point dealing with the issues of poor performance, focusing instead on the state of the football pitch:

I interrupted and told the team they did not have a clue what they were doing. I could not believe that this was the worst performing hospital in the country, and yet they did not have a single agenda point which dealt with any of the major issues.[199]

2.163 While Mr Sumara attributed this attitude to poor leadership, and that must have been a factor, what he found is consistent with the very human instinct to ignore problems that are thought to be too difficult to solve.

Lack of openness

The case of John Moore-Robinson

Introduction

2.164 The Inquiry looked in considerable detail at the case of the late John Moore-Robinson, which had already received attention at the first inquiry. It is worthy of reconsideration because more detailed evidence became available, and concerns were raised by Ms Kate Levy and Mr Stuart Knowles, who were involved as in-house solicitors for the Trust, that the first inquiry had dealt unfairly with the matter to their detriment. Having looked again at the case in the light of all

197 Sumara T58.65
198 Stephen Moss WS0000008836, para 40
199 Sumara WS000005917, para 32

the evidence now available, it is concluded that the way in which the Trust handled the matter can be viewed as an object lesson in how the tragedy of an avoidable death can be exacerbated by inappropriate handling of the case. It demonstrates the sad fact that, for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism. Both Ms Levy and Mr Knowles regarded themselves as doing no more than their professional duty to act in the Trust's best interests. This claim has been examined below.

Factual background

2.165 The facts need to be set out in some detail:

2.166 John Moore-Robinson, a previously fit young man, was examined in A&E at the Trust on 1 April 2006 following an accident on his mountain bike. He was examined by a junior doctor and, in spite of the protests of friends who were with him, discharged – in a wheelchair as he could not walk – with advice to take an analgesic. He was still being sick as he left A&E.[200] He died the following day at another hospital.[201] It was later found he was suffering from a ruptured spleen, a lethal injury unless diagnosed and treated promptly. He was showing signs and symptoms which were indicative of this as a possible diagnosis and he should not have been discharged. It seems likely that his life could have been saved had he been kept in hospital for a thorough investigation and treatment.

2.167 The Trust received a request from the Coroner, Mr Andrew Haigh, for information in relation to the death. On 20 April 2006, Ms Rebecca Southall (Ms Levy's predecessor as Head of Legal Services), noting that the junior doctor had left the employment of the Trust, asked Mr Ivan Phair (the Senior A&E Consultant) for a "report addressed to the Coroner for use in the inquest."[202]

2.168 Mr Phair produced a report dated 26 April 2006 addressed to the Coroner.[203] The report gave a factual analysis of the admission to A&E and the opinion that the attending doctor should have interpreted that Mr Moore-Robinson could have been suffering from some form of bleeding.[204] On the last page, Mr Phair went on to say:

> *I would also conclude that as a result of my examination of the Doctor's medical notes I cannot find enough evidence which would lead me to conclude that a thorough abdominal examination was carried out on Mr Moore-Robinson on his attendance to the A&E department of Mid Staffordshire General Hospitals NHS Trust.*

200 These facts are taken from the statement of Janet Robinson summarising what she was told by her son's friends: I have no reason to doubt the accuracy of their accounts. Robinson WS000000042–44, paras 12–16
201 See "First report of Ivan Phair", within SK/6 at WS0000074824
202 TRU00000001054, Letter from Rebecca Southall to Ivan Phair (20 April 2006)
203 Within SK/6 at WS0000074824, "First report of Ivan Phair" (25 April 2006)
204 Within SK/6 at WS0000074824, "First report of Ivan Phair" (25 April 2006), WS0000074825

I remain gravely concerned that Mr Moore-Robinson died from the effects of his accident on 1 April 2006. I would therefore raise the possibility that his unfortunate, untimely death may have been avoided, had he been more properly assessed on his initial attendance to the A&E department at the Mid Staffordshire General Hospitals NHS Trust.[205]

2.169 The report also contained an opinion that the junior doctor's abdominal examination had been "brief and incomplete". It stated that the records of the patient's respiratory rate recorded by the ambulance crew should have been interpreted as showing that he may have been suffering from internal bleeding. Further, it concluded that death may have been due to an injury to the liver, spleen or some other intra-abdominal viscus.

2.170 As Mr Phair recognised in his report, at the time of writing he had been supplied with no information as to the cause of death, as the autopsy findings were not available.[206]

2.171 In May, Ms Levy came into post and took over conduct of the matter. On 25 May 2006, she wrote to Mr Phair of his report:

Rebecca has not forwarded it to the Coroner and on reviewing it I have some concerns as to its content. Whilst it would be entirely appropriate as a report in respect of a clinical negligence claim it goes beyond the issues which concern the Coroner. The Coroner is undertaking a fact finding exercise and does not concern himself with matters of blame or potential negligence. I would therefore like to suggest that the section of your report headed "Conclusion" with the exception of the final para be removed.[207]

2.172 On the same day, Ms Levy wrote to the junior doctor (now having been located) asking for a report. She asked in particular that the report:

... cover the abdominal examination you performed and whether the increased respiratory rate should have been interpreted as indicating some form of bleeding.[208]

2.173 It can be deduced that Ms Levy's request for these points to be dealt with were informed by Mr Phair's report.

2.174 Mr Phair initially refused to amend the report. He wrote to Ms Levy on 30 May 2006, stating that he had included such opinions in previous reports to the Coroner, that he could deliver a verdict of "death due to unnatural situations" and could "also make a judgement on suspicions of inadequacy of medical care."[209]

205 Within SK/6 at WS0000074824, "First report of Ivan Phair" (25 April 2006), WS0000074826
206 Within SK/6 at WS0000074824, "First report of Ivan Phair" (25 April 2006), WS0000074826
207 KL/3 WS0000076191
208 SK/6 WS0000074838
209 KL/5 WS0000076196

2.175 Ms Levy met Mr Phair on 21 June 2006 to discuss the matter. On 22 June she wrote to him:

> *With regards to the content of reports for the Coroner I entirely agree that issues in respect of care can be relevant to the decision as to how a patient came about his/her death. However, as reports are generally read out in full at the Inquest and the press and family will be present, with a view to avoiding further distress to the family and adverse publicity I would wish to avoid stressing possible failures on the part of the Trust.*

2.176 She suggested removing the two paragraphs of the conclusion quoted in full above. As to the removal of the suggestion that death could have been avoided:

> *In my opinion it is self evident from your report that that is probably the case but I feel such a concluding statement may add to the family's distress and is not one which I would wish to see quoted in the press.*[210]

2.177 Mr Phair amended his report in accordance with this request, producing a report dated 29 June 2006, leaving only the first sentence ("I remain gravely concerned ...").[211] The report also retained the opinion about the nature of the abdominal examination, the significance of the respiratory rate, and the possible cause of death.

2.178 Meanwhile, a statement was obtained from the treating junior doctor. Ms Levy disclosed this to the Coroner. Ms Levy did not disclose either version of Mr Phair's report to the Coroner.

2.179 In August 2006, Mr Knowles took over conduct of the file. He, too, made no disclosure of the reports from Mr Phair. In September 2006 the Coroner, Mr Haigh, asked the Trust if it could obtain a statement from a middle-grade doctor with whom the junior doctor had suggested they had discussed the case.[212] Mr Knowles replied that this doctor had left the Trust but offered to attempt to trace him or her if the Coroner wished.[213] On 15 November 2006, the Coroner wrote to Mr Knowles stating that if Mr Knowles was content that the treating doctor could adequately cover the assessment and discharge from A&E, then there was no need for the Trust to contact a middle-grade doctor to assist in this. His reason in seeking evidence from the latter had been to give some support to the junior doctor.[214]

210 KL/5 WS000076197
211 SK/6 WS0000074827
212 TRU00000001055, Letter from Andrew Haigh to Kate Levy (1 September 2006)
213 TRU00000001054, Internal letter from Rebecca Southall to Ivan Phair (20 April 2006)
214 TRU00000001058, Letter from Andrew Haigh to Stuart Knowles (15 November 2006)

2.180 On 11 December 2006 Mr Knowles emailed Mr Phair:

> *I can see you prepared a fairly detailed statement in this matter but I am not entirely sure whether or not the statement has been sent to the Coroner. I can't see that it was sent from this Office and perhaps you could confirm whether or not you sent it directly. I just need to know what information the Coroner has.*[215]

2.181 The inquest took place in April 2007. The family of Mr Moore-Robinson were not aware of the reports from Mr Phair until the time of the first inquiry, despite the inquest process and the fact that civil litigation was pursued and settled by the Trust.

2.182 On 17 April 2007 the Coroner wrote to Mr Knowles what has been described as a Rule 43 letter, although the letter itself does not explicitly state it is written under that rule. It asked whether there was an A&E protocol dealing with the risk of ruptures of the spleen, and seeking the Trust's views on whether or not such a protocol was practical, with a view to avoiding such fatalities in future.[216]

2.183 When eventually shown Mr Phair's report by Mr Andrew Vernon, the Trust's current solicitor, the Coroner, Mr Haigh, stated that:

> *It may have been helpful to have had Mr Phair's report prior to the Inquest ... It is difficult to think back and wonder if this would have changed matters. I suspect I would have asked Mr Phair to give evidence at the Inquest but I would not have engaged an independent expert. I doubt very much however if this would have changed my conclusions.*[217]

2.184 However, Mr Haigh told the Inquiry that this information would have enabled him to draft a more focused Rule 43 letter.[218] On 24 May 2007, Mr Knowles wrote to Mr Phair, among others, passing on the Coroner's request and asking for his view.[219] To assist him, Mr Knowles sent copies of various documents, included the junior doctor's statement to the Coroner, a note of the inquest, his own report, and the medical records. He did not inform Mr Phair that his report had not been sent to the Coroner, although it would have been apparent from the note that it had not been put in evidence at the inquest. Mr Phair replied, confirming that there was a protocol, but taking issue with various matters contained in the junior doctor's statement. For good measure he added his opinion that it was highly probable that the care given to Mr Moore-Robinson was negligent, and that the Trust would be at high risk in a negligence action.[220] Mr Knowles then wrote to the Coroner saying there was a protocol but

215 TRU00000001059, Email from Stuart Knowles to Mr Phair (11 December 2006)
216 SK/6 WS0000074851
217 AH/26 WS0000005847
218 Haigh WS0000005705, para 71
219 SK/6 WS0000074853; TRUST00000000254
220 SK/6 WS0000074858

that it was difficult to make it specific to this sort of case. He pointed to a number of difficulties which he claimed might have hindered a diagnosis. In doing so, he appears to have preferred explanations given by the junior doctor to the forthright critical opinion of Mr Phair, whose new report he did not disclose. However, he had mentioned in the letter that he had consulted both Mr Phair and another consultant before writing the letter, thereby implicitly associating Mr Phair with this position. Given what he knew to be Mr Phair's view of the case, this was unwise.

2.185 By August 2007, a claim for damages had been made against the Trust by Mr Moore-Robinson's parents. Mr Knowles advised the NHSLA that it would not be unreasonable to view the matter as indefensible. He suggested they might wish to obtain independent expert advice as issues were raised at the inquest that might be worth exploring.[221] He pointed to Mr Phair's adverse opinion but said Mr Phair was always pessimistic. He enclosed a further report from Mr Phair, this time commenting on the allegations in the claim, all of which he agreed with. In October 2007 it was agreed to settle the claim for £15,000,[222] a step Mr Knowles said was "eminently sensible" but "slightly overpriced".[223] Mrs Robinson said they only settled the case on the understanding that the Trust accepted liability for negligence.[224]

2.186 In due course, a letter of apology was sent to the Moore-Robinson family on behalf of the Trust by Mr Martin Yeates, in January 2008. The letter expressed his "apologies and regret" for their son's death, and pleasure that a settlement had been agreed. A copy of the Trust's reply to the Rule 43 letter was enclosed. In a sentence which has caused the Moore-Robinsons considerable resentment, Mr Yeates said:

> *While I understand that nothing can compensate for the loss of a loved one I hope that the fact that matters have been resolved speedily will go some way to enable you to put this matter behind you and move on.*[225]

2.187 Mrs Robinson said:

> *We could not believe what we were reading.*
>
> *... "to enable you to put this matter behind you and move on", I don't know how on earth he thinks that we can possibly do that. I can never, ever, put John's death behind me. It will always be with me.*[226]

221 SK/6 WS0000074864
222 Janet Robinson said the sum offered after negotiation was £13,000 [WS0000000046, para 34]
223 SK/6 WS0000074869
224 Robinson WS0000000048, para 35; T10.149–150
225 Robinson WS0000048, para 36; JR/2 WS0000000067; SK/6 WS0000074875
226 Robinson WS0000048, para 36; T10.151

2.188 Following a press report about the distress felt by the Moore-Robinsons, the Trust issued a press statement in March 2007 expressing concern that the family had been upset by what they had regarded as an unsympathetic remark. The statement went on to give an explanation for the settlement which seems to be at odds with the internal discussions described earlier:

> *Liability was not admitted and could have been investigated in detail. However the NHS was concerned not to prolong the matter as far as the family were concerned and so a prompt agreement was entered into.*[227]

2.189 In subsequent explanations to the NHSLA about the apology and the press statement, Mr Knowles seems not to have accepted that there was anything wrong with either:

> *The apology was the standard NHSLA affair and it was approved by someone ... This family have been going on about this and they appeared on telly recently ... You will remember that the apology was given at the express request of the family and* [solicitor]. *You will also remember that we settled very quickly even though there might have been issues that could merit further investigation. I take the view that we treated the family very well ... Who is causing a problem and what are they trying to achieve? ... Anyway hopefully we can sort this out soon but I suspect the family are having issues (quite understandably) with grief etc.*[228]
>
> *... it is indeed unfortunate that what appears to have been a rapid and well-handled* [settlement] *by the NHS does not appear to have been appreciated by the family and that they have taken this unfortunate line.*[229]

Was there a positive decision not to disclose Mr Phair's report?

2.190 Both Ms Levy and Mr Knowles said in their witness statements that they could not in fact remember making a conscious decision to withhold disclosure of Mr Phair's reports.[230] Ms Levy stated that, when she received Mr Phair's report, she had been busy with other work and had simply placed the report on file. She said it was likely she did so in order to think about what to do with it later.[231] In oral evidence, Mr Knowles accepted that he must have given consideration to the matter, but stopped short of accepting that he made a decision not to disclose the Phair reports.[232]

2.191 I accept that Ms Levy came to no concluded position on disclosure of the Phair report before she handed over the file to Mr Knowles. She had, however, clearly made a decision not to do

227 SK/6 WS0000074874
228 SK/6 WS0000074870
229 SK/6 WS0000074871
230 Knowles WS0000074656, para 67; Levy WS0000076132, para 69
231 Levy WS0000076132, para 69
232 Knowles T131.53–60

so for the time being when she chose to send the statement of the junior doctor to the Coroner. Further, as will be considered below, she had many reasons in her own mind justifying not making a disclosure and her default position would have been not to disclose a report damaging what she perceived to be the Trust's interests unless compelled to do so.

2.192 Regrettably, I have come to the conclusion that Mr Knowles' evidence on this simple point – of whether or not he made a decision about disclosure of the Phair report – was evasive. It is easy to accept that he has no direct recall of making a decision on this report, but he is an experienced solicitor, well used to dealing with cases of this kind. It is quite clear from his email to Mr Phair shortly before the inquest – asking whether Mr Phair had disclosed the report – that he had looked at it and was considering what evidence was before the Coroner. He told the Inquiry he did not receive a reply to that email; as far as he can remember none has been found in the file.[233] If that is correct, he did not know whether the Coroner had the report. By not taking further steps to find out if the Coroner had the report, or to offer to disclose it, Mr Knowles was effectively deciding not to disclose the report himself. At the time he had conduct of the file and it would have been open to him to decide to disclose this report, in one of its versions, to the Coroner. He did not do so, and assumed responsibility for that decision without taking any specific instructions from the Trust. His evidence had the unattractive characteristics of special pleading, of seeking to avoid criticism by advancing an alternative factual case, should it be concluded that the report ought to have been disclosed.

Should Mr Phair's report have been disclosed to the coroner?

2.193 Both Ms Levy and Mr Knowles were at pains to point out that the Trust had no legal duty to disclose either of these reports to the Coroner. In support of this position they relied on a legal opinion obtained by Michael Taylor (who investigated the matter for the Trust) from Capsticks LLP, highly experienced solicitors in this field, and from Bridget Dolan, Counsel and Editor of the Inquest Law Reports.

2.194 Ms Dolan's opinion, with which neither Counsel to the Inquiry, nor Counsel for any Core Participant to the Inquiry, expressed disagreement, was that, whatever duties there may be to report a death, there is no duty in law on those in possession of factual information concerning the death to volunteer such information to the coroner, either under statute or at common law.[234]

2.195 However, there may be a distinction to be drawn between the strict legal position with regard to the obligation of a trust and what is the proper approach for a trust to take. Capsticks LLP pointed out that there was no established local custom, practice or practice direction of which non-disclosure was a breach. They said this:

233 Knowles T131.61
234 SK/8 WS0000074909–910

There is no explicit duty of disclosure to the Coroner, particularly when, as here, there was no request for the consultant's report. Whilst in the spirit of NHS Guidance and good practice the Trust should have sent Mr Phair's report in order to assist the Coroner in carrying out a full inquiry, it is not mandatory to do so either in 2006 nor is that the situation now.[235]

2.196 Ms Dolan suggested there was no general practice of voluntarily disclosing opinion evidence in the possession of interested persons whether families of the deceased, treating doctors or organisations. For example, it is common for interested persons to have obtained their own expert reports before an inquest to assist them in preparing for it, and to consider whether there has been a breach of duty or evidence relevant to that issue emerging in the proceedings.[236] She also stated, presumably from her own professional experience, that many NHS trusts do not routinely provide voluntary disclosure to coroners of SUI investigation reports.[237]

2.197 She drew attention to the judgment of Phillips LJ in *R v HM Coroner for Wiltshire ex parte Clegg*[238] suggesting that the NHS Executive should give guidance about disclosure to its staff. Such guidance was given by the Chief Medical Officer (CMO) in 1998:[239]

Whilst there is no specific duty on clinicians to do this, all those who have information which could help Coroners' inquiries should disclose it voluntarily and not only when requested.

2.198 In fact the CMO reinforced this advice after the events related here, in 2008:

NHS organisations should aim to assist coroners by providing prompt access to information that may be relevant to an inquest. Where an organisation takes the decision to withhold information from an inquiry, this should be clearly documented with an explanation of the considerations that are believed to outweigh the public interest that would be served by disclosure.[240]

2.199 However, this advice was not located by Ms Dolan and there is no reason to suppose Ms Levy or Mr Knowles were aware of it, or could have been expected to be aware of it, as the CMO update in which this appeared, whilst published on the DH website, is not specifically directed to lawyers.

235 SK/6 WS0000074800
236 SK/8 WS0000074911, para 21
237 SK/8 WS0000074911, para 22
238 Clegg (1996) 161 JP 521
239 CMO update 20/98 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4013567.pdf
240 CMO Update 40, (October 2008) www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/CMOupdate/DH_091346

2.200 A number of justifications were put forward by Ms Levy and Mr Knowles for not disclosing either version of Mr Phair's report:

- *He had not actually treated the deceased, and was not able to give an independent expert opinion.*

  This cannot be considered a good reason for not disclosing Mr Phair's report to the Coroner. Mr Phair was asked to prepare a report addressed to, and for use by, the Coroner following the latter's request for assistance. It was known then that he had not treated the patient and that he was not independent. Mr Phair was the Senior A&E Consultant and had overall responsibility for what went on there. A coroner might well consider he would be assisted by evidence on what was the expected practice. In any event Mr Haigh said retrospectively that had he known of the report he would have called Mr Phair to give evidence. The coroner is the judge of what evidence should be called, and he cannot do that job properly unless a trust volunteers the information in its possession. Lack of independence from an employer may affect the weight to be given to an opinion, but that is usually relevant where it is supportive of the employer.

- *His opinion was relevant to the issue of negligence and not any issue which was for the Coroner to investigate.*

  Again, this is not a good ground for non-disclosure. Even if not admissible, and that is for the Coroner to judge, such a report could well assist him by informing him of appropriate lines of inquiry to take, or indeed to avoid. Objections to admissibility of evidence should be put to the Coroner and decided by him, rather than predetermined by a party interested in protecting itself against a civil claim. Ms Levy accepted in her oral evidence that if Mr Phair had asserted that the junior doctor had acted in accordance with accepted practice – in other words, if the report had been favourable to the Trust on this issue – she would not have asked for that opinion to be removed from the report, and, if the junior doctor's evidence had not been available, would have sent it to the Coroner.[241]

- *Mr Phair's opinion amounted to an admission of liability which the Trust was enjoined not to make by the terms on which the NHSLA granted indemnity against civil liability.*

  The simple riposte is that the opinion of one doctor, however senior, is not an admission of liability on behalf of the Trust. The Trust would not have been relying on the report or putting it forward on its behalf, and could have made that clear when sending it to the Coroner. Any opinion of this nature is open to be contradicted by a more persuasive one.

241 Levy T131.157–158

- *Mr Knowles in particular did not consider Mr Phair to be a reliable witness.*[242]

  This cannot be considered a substantial ground for non-disclosure. Ms Southall can have had no such reservations about Mr Phair when asking for a report. Ms Levy's hypothetical willingness to use a report from him if other evidence had not been available suggests she did not view his reliability as a reason for not sharing the report with others. Finally, Mr Knowles himself sought Mr Phair's assistance in relation to the coroner's Rule 43 request.

2.201 None of the reasons set out above, individually or cumulatively, were, in my view, sufficient to justify non-disclosure of Mr Phair's report to the Coroner. It is more difficult to assess the justification put forward that it was not in the best interests of the Trust to disclose his opinion.

2.202 Both solicitors emphasised their professional duty as solicitors to act in their client's interests. As a general proposition that is undoubtedly correct. Ms Levy agreed that, in assessing the Trust's best interests, she would have had to take into account the general requirements in the NHS of openness and transparency, as exemplified by the Code of Conduct for NHS Managers.[243] She accepted that the reference in her letter to adverse publicity was "badly phrased".[244] She had meant to signify that it was one opinion which was "not so much adverse" but "based on very little". She relied in part on the fact that the report had been written before the cause of death had been established.

2.203 The "interest" of the Trust to be protected was presumably to avoid or minimise the risk of being sued by disclosing that a consultant thought there had been sub-standard practice, or to limit any consequential damages, and to minimise the damage to the Trust's reputation.

2.204 There is, and was, guidance requiring trusts – and clinicians – to be open with patients and bereaved families about adverse incidents, and to offer them full explanations of what occurred. The emphasis on openness has undoubtedly increased since these events, but the guidance, both organisational and professional, available at the time, included very clear messages to the same effect. This should be a very significant factor to be taken into account in deciding where the interests of a trust lie. In such a context, concealment of an internal adverse opinion carries no benefit if the full picture has to be disclosed in any event. In such circumstances, the primary consideration should therefore be whether the information in the solicitor's possession would, or could, reasonably be considered to be of assistance to the Coroner, whether or not it showed the Trust in a poor light. It is my conclusion that, had the matter been looked at in this way, the only possible answer would have been that the report should have been disclosed, and the Trust Executive should have received appropriate advice to do so.

242 Knowles WS0000074656, para 66
243 Levy T131.141–142. For a detailed reference to guidance on openness see *Chapter 22 Openness, transparency and candour*
244 Levy T131.169

2.205 While Ms Levy set the scene for the non-disclosure, in the end it was her colleague, Mr Knowles, who had the final opportunity to consider the matter in the light of the circumstances immediately leading up to the inquest. Unlike her, he was not contractually bound as a manager to comply with the NHS Code of Conduct for Managers, and his only status was as a solicitor acting for the Trust. As such, however, he was obliged to inform himself of, and have regard to, the obligations imposed on the Trust, his client, and its executive officers, by the managers' code and the NHS guidance referred to above. He took it upon himself to make a decision on behalf of the Trust on this matter, relying on a narrow interpretation of his client's legal duties rather than taking instructions from, or offering advice to, the Trust on the issue. He has not claimed he has been hampered in explaining matters by legal professional privilege. He can therefore be criticised for not giving sufficient weight to the requirements of openness then existing. He denied the Coroner access to material that might have been of assistance to him.

2.206 However, as is clear from Ms Dolan's opinion, it is likely that many other solicitors acting for and advising trusts would have acted no differently. The conclusions set out here are not intended to be an examination of whether either of these solicitors complied with their professional code of conduct, but of what is the right course for a trust to take in a case such as this. There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.

Should Mr Phair have been asked to alter his report?

2.207 The reason advanced in Ms Levy's request to Mr Phair to alter his report was that his opinion might cause adverse publicity and "undue" distress to the deceased's family. So far as the first reason, Ms Levy's explanation of that point has been referred to above. It is difficult to see how any consideration of publicity could ever be a good reason for requiring removing a professional opinion from a report the author believed would be of assistance to a coroner. The public interest requires that a clinician asked to help in this way is free to express opinion as he sees fit. That is not to say his attention cannot be drawn to points he might wish to take into consideration, or to review his opinion, but that is not what happened here. It was not suggested to him he was wrong, only that it should be removed because it was adverse.

2.208 As for the suggestion that undue distress might be caused, that should have been addressed by offering the family appropriate support and explanations for what happened in a less traumatic setting than an inquest. This never occurred, either before the inquest, or later. The first inquiry report I categorised this reason for the request as "specious". That view still stands, after consideration of all the new evidence to this Inquiry.

2.209 While I am of the view that Ms Levy and Mr Knowles are open to criticism for their actions, it is only fair to point out that neither the alteration nor the non-disclosure is likely to have

affected the outcome of the inquest or the civil claim. The family had already obtained their own expert and highly critical report. Mr Phair's opinion would not in fact have added to their knowledge of the case. However, serious damage was caused to their trust and confidence in the Trust. The concealment of Mr Phair's report and his opinion caused more distress than disclosure could ever have done.

The Trust's response to the civil claim

2.210 Mr Knowles accepted in his evidence that his language in the email referred to above was inappropriate.[245] In fact, the manner in which he phrased the email is not considered to be a matter for criticism. The email was not intended to be seen by anyone other than the recipient, and it would be wrong to make the same requirements of sensitivity in such communications as one would for a letter being sent to a claimant. However, the conduct of the litigation on behalf of the Trust reveals some unfortunate characteristics all too common in clinical negligence claims:

- Although the claim was described without challenge as being indefensible and the opinion expressed that it would be "eminently reasonable" to settle the claim for a reasonable sum, and no expert opinion to the contrary was obtained, the Trust persisted in not admitting liability, a stance which negated its purported apology and caused further distress to the Moore-Robinsons.
- The pretext by those with conduct of the case that there was, or might have been, a defence to the action could only have been designed to assist in negotiating a lower settlement. There are of course cases where there is genuine uncertainty as to what the outcome would be because, for example, experts have expressed opposing views. This was not such a case. 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.
- The apology drafted for, and signed off by, Mr Yeates was formulaic, insensitive, patronising and likely to exacerbate wounds rather than heal them. Genuine apologies are constructive and essential, but they require real thought about the case and what would be most helpful to the recipients, rather than based automatically on a template. They are almost certainly better prepared by, or with the input of, a senior clinician, rather than being left to a lawyer or a junior manager.
- Perhaps of most concern is that Mr Knowles clearly did not appreciate the damage done by the way in which the matter had been conducted. In spite of the complaints of the Moore-Robinsons, he continued to believe, and advise the NHSLA, that the settlement had been a success.

245 Knowles T131.96

Finance

2.211 The overall financial performance of the Trust from 2000 is set out in the table below.[246]

Table 2.1: Financial performance of the Trust, 2000/01

	2000/01 £000	2001/02 £000	2002/03 £000	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000
Turnover	97,295	88,540	99,021	105,809	113,838	112,722	125,643
Surplus/deficit	28	14	8	(509)	(2,158)	478	1,126

2003/04 to 2004/05

2.212 After two years in which the Trust had effectively broken even, in 2003/04 there had been a deficit of £509,000.[247] In that year the Trust had undertaken a Cost Improvement Programme (CIP) of £1,975,000.[248]

2.213 In the planning for 2004/05 to 2008/09, which was done in January 2005, a financial gap of £7,032,000 was identified for 2004/05, of which £6,122,000 was recurring.[249] It was planned to address this by a recovery plan to achieve about £7.7 million recurrent cost savings,[250] this included proposals for a reduction in 180 whole time equivalent (WTE) staff posts[251] to be undertaken in two stages, one in January 2005 involving 98 WTE posts (this was achieved)[252] and a second, later in the calendar year. A vacancy scrutiny review was among a number of other cost saving measures planned. The plan included a model for the assessment of financial and clinical risk in relation to the proposals, but the plan document itself only contained details of the financial risk ratings.[253]

2.214 The deficit for the year 2004/05 was in fact £2,158,000.[254] The cumulative deficit going into the year had been about £2.5 million. Mr Newsham (Director of Finance from 1987 to June 2006) identified issues raised by the European Working Time Directive (EWTD) and a new national consultants' contract as among the contributing factors. He also identified costs arising at the Cannock Hospital site which turned out not to be covered by income from

246 Mid Staffordshire General Hospitals NHS Trust: Annual Accounts 2006/07, p29, para 23.1
247 Newsham WS320000011925, para 32
248 JN/3 WS0000011990
249 JN/3 WS0000011992, SCC00050000042
250 JN/3 WS0000011990
251 JN/3 WS0000011995
252 Newsham WS0000011927, para 39
253 JN/2 WS0000012023, SCC00050000074
254 Newsham WS0000011925, para 32

PCTs.[255] The Trust was kept afloat by "brokerage", a form of interest-free loan within the NHS system of £1.5 million,[256] which the Trust expected to repay within three years.[257]

2005/06

2.215 In the course of this year, considerable pressure was exerted on trusts in general to balance their books. Following a period of increased spending on the NHS there was concern that its costs were getting out of control. On 28 June 2005, Sir Nigel Crisp, then Chief Executive of the NHS as well as Permanent Secretary, wrote a letter to all NHS trust chief executives but addressed principally to those whose organisations had been in deficit in 2004/05.[258] He cracked the whip in no uncertain terms, referring to his requirement that each organisation's officers abided by the same requirements which he, as an accountable officer, had to for the whole NHS.

2.216 He pointed out that:

> *poor financial performance in a few organisations can erode public confidence in the management of the NHS as a whole.*[259]

2.217 Local delivery plans forecasting deficits or based on unrealistic assumptions would not be accepted.

2.218 Any transitional support offered by SHAs would be limited and only given where the impact on local services would be significant, where other avenues had been explored, and robust plans for improvement of financial performance were in place:

> *If planned recovery is not delivered, this represents a failure by their Boards to meet their duties ...*
>
> *... An aggressive pursuit of efficiencies, in the way we deliver our business and maximising productivity from the resources we consume, are essential parts of the contract we have with Ministers and the public we serve.*[260]

2.219 The letter included a list created by the Modernisation Agency of "Ten High Impact Changes" which it was suggested:

255 Newsham WS0000011925–927, paras 33–36
256 Newsham WS0000011327, para 36
257 SCC00050000044, Mid Staffordshire General Hospitals NHS Trust, financial recovery plan 2004/2005–2008/2009; JN/2 WS0000011985, para 7
258 DN/12 WS0000068078; Nicholson T127.54
259 DN/12 WS0000098078 Chief executive letter to PCTs and trusts in deficit, (28 June 2005)
260 DN/12 WS0000098079 Chief executive letter to PCTs and trusts in deficit, (28 June 2005)

... provides a well-evidenced approach to delivering better care for patients while reducing costs"[261]

2.220 Sir David Nicholson described the atmosphere at this time as "fevered" but denied that many managers would have forgotten about the need to deliver quality while balancing the books:[262]

Q. Is it going too far to say that, in this period, balancing the deficit was really the headline that all NHS senior managers were interested in?

A. Well, it was certainly the headline in every newspaper you wanted to read at the time. The criticism of our stewardship of the financial affairs of the NHS was under great scrutiny and great comment, and there is no doubt that the response of NHS management to all of that was to redouble their efforts to balance their financial position. But having said all of that, at the end of the day we are NHS managers. We manage healthcare. We don't manage factories and all the rest of it. And I don't know of many NHS managers during that period who would have said, "Hang quality, we're just going to go for the money".[263]

2.221 On 4 October 2005, Antony Sumara wrote to chief excutives in the West Midlands.[264] He referred to a need to take various measures including the need to review workforce spend with a view to restarting in most cases a workforce reduction programme. He emphasised that the proposed measures were not about compromising clinical services:

Indeed they are about improving productivity and clinical care to patients.[265]

2.222 As has been seen in the HCC report and the first inquiry report, this turned out not to be what happened at the Trust. However, Mrs Brisby told this Inquiry that she recalled attending a meeting led by Mr Sumara at which trusts were held to account for the fact that they were not reducing staff, which she felt was not the best way of handling matters. In the case of her own leadership, avoiding prejudice to patient care was "crucial" to her.[266]

2.223 Ms Karen Morrey, when asked about this letter, agreed that it evidenced pressure on the Trust to break-even and by implication to cut staff. She did not think much attention would have been paid to the injunction not to compromise standards:

261 DN/12 WS0000098080 Chief executive letter to PCTs and trusts in deficit, (28 June 2005)
262 Nicholson WS0000067659, para 96; Nicholson T127.55–56
263 Nicholson WS0000067659, para 96; Nicholson T127.55–56
264 DN/13 WS0000068083
265 DN/13 WS0000068083
266 Brisby T129.24–26

Q. Did this amount, you think, effectively to pressure being applied to organisations in the SHA region to shed staff?

A. Yes.

Q. Would you care to qualify that at all? Was it strong pressure?

A. I think it was in the overall pressure to deliver that financial balance, and given the fact that the highest proportion of an organisation's resources are on the pay bill, then it was notable that was going to be an area that was the focus of attention.

THE CHAIRMAN: The letter does state that it's not about compromising clinical services and indeed is about improving productivity and clinical care. How much emphasis, if any, was placed on that in the activities of the strategic health authority?
A. Not a huge amount, I don't think.

THE CHAIRMAN: Would you care to expand on that?

A. Certainly I think my experience at this time was that it was more around hitting the financial target, rather than necessarily concentrating on the clinical quality. [267]

2.224 Mr Peter Bell, a Non-Executive Director at the Trust, had been struck by the coincidence of the board-to-board FT diagnostic meeting in October with the departure of the board of a nearby trust over financial issues:

This is particularly pertinent; it sets the scene that as a board it was unacceptable not to balance the books. If we, as Non-Executive Directors, were overlooking an organisation where things were going wrong financially, we would probably have been expected to go if we couldn't demonstrate that we were in control.[268]

2.225 Mr Sumara characterised the SHA's approach as one of making "suggestions" rather than exerting pressure. He stated that this did not necessarily refer to staff cuts, but the SHA may well have identified staff numbers as an area for consideration.[269]

2.226 During the course of the year, the DH commissioned the accountancy firm KPMG to review about 100 trusts regarded as being the most financially challenged, eight of which were in West Midlands, but the Trust was not among them.[270]

2.227 In a further step, Sir David told the Inquiry that McKinsey were appointed by the DH to review the local delivery plans of all trusts in the country to ensure consistency.[271] This identified the

267 Morrey T61.33–34
268 Bell WS15 WS0000007728, para 15
269 Sumara WS0000005914, paras 18–19
270 Nicholson WS0000067659, para 99
271 Nicholson WS160 WS0000067680; DN/25 WS0000068312

Trust as having an accumulated deficit as at 1 April 2006. It suggested that there was a "high risk" to its delivery of the CIP based on historic performance and benchmarks, but it noted that the Trust had plans to address the issue and remove the risk by 2007/08. A large number of actions were recommended by McKinsey.

2.228 The NHS as a whole ended this financial year with net deficit of £547 million gross £1.3 billion[272] and 179 NHS organisations ended the year in deficit. This caused a governmental "crisis of confidence".[273]

2.229 Going into the year 2005/06, the Trust had a cumulative deficit of about £2.5 million from the previous two years.

2.230 Against this background the Trust's performance was superficially reassuring. It had a £478,000 surplus.[274] Its CIP was achieved to a total of £9.599 million (£4.222 million recurrent, £5.377 non-recurrent)[275]. A projected £3 million overspend was addressed by "rigid agency bank, and overtime control" and "rigorous vacancy recruitment processes".[276] However, this did not take account of the cumulative deficit. This included the "brokerage" which still had to be repaid.[277] Among various measures, the Trust had continued with its staff reduction plan, reduced the use of agency staff and slowed down recruitment.[278]

2.231 The Trust had continued to be subjected to pressures from the SHA as evidenced by a report made on 5 October by Mr Yeates to the Trust's Financial Performance Committee that David Nicholson:

> *... had made it very clear that he was expecting a break-even; there was a strong message to the Trust to resolve the situation.*[279]

2.232 This pressure translated itself into a perception that the Trust's Executive would ignore the concerns of clinical staff. Dr Durrans told the Inquiry:

272 Nicholson WS0000067638, para 31
273 CLO000000006 Closing submissions of West Midlands Strategic Health Authority, para 2
274 Newsham WS0000011928, para 41
275 JN/2 WS0000011983
276 JN/2 WS0000011983
277 JN/2 WS0000011983
278 Newsham WS0000011929, para 45
279 Newsham WS0000011931–932, para 52; DN6 WS000007581

Mr Yeates' style was quite dictatorial and one of the concerns amongst the clinical leads in and around 2005 was that the Hospital Management Board was simply viewed as a rubber stamping exercise. We were told what the Trust Board's vision was and I do not think we as clinical leads were good at questioning it. With hindsight I have no doubt that clinicians could have been better engaged."[280]

2.233 Dr Shaun Nakash also felt that the concerns of clinicians about the clinical floors reconfiguration, although raised, were ignored.[281] An ENT (ears, nose and throat) surgeon, Mr Verghese Cheeran David, said that it was difficult to raise concerns about this project but, if they were raised, they were ignored:

The thrust of the response from the senior management team, including the Medical Director at the time, Dr Suarez, was that things would be better once the Trust achieved Foundation Trust status. Nobody from senior management seemed bothered about what was happening on the floors at the time. Everyone was concerned about becoming a Foundation Trust.[282]

2.234 He was told by Mr Yeates that things would improve after FT status was achieved.

2006/07

2.235 The projected deficit for 2006/07 was £10 million if no corrective action was taken. This was made up of a number of factors including: £3.5 million in savings not made the previous year; a £4.7 million "tariff impact" (a measure which combined the routine efficiency gains demanded within the NHS, 2.5% for that year) and unfavourable tariff changes; £0.85 million not saved on staff turnover, because the turnover was declining; and £0.75 million required repayment of "brokerage."[283]

2.236 Mr Newsham agreed that, but for unexpected elements in the "funding gap", which he said included the tariff impact, and the withdrawal of PCT from the elective orthopaedic unit at Cannock, there would have been no continuing need for a workforce reduction programme at this point.[284]

2.237 The financial recovery plan for the year was therefore challenging, particularly as no more "brokerage" was available. The Trust had to make cost reductions of 8%.[285] This was the

280 Durrans WS0000005395, paras 9–10
281 Nakash WS0000005209–5210, para 10; WS0000005214, para 31
282 David WS0000042264, para 10
283 Newsham WS0000011932–933, paras 53–59
284 Newsham WS0000011933, para 59
285 Newsham WS0000011935–6, para 67

highest level of savings planned for any trust in the West Midlands, where the average was 5%.[286]

2.238 Income could not realistically be expected to increase as the Trust was dependent primarily on one PCT for income, which was unable to increase its own expenditure.

2.239 It was felt there was no option but to embark on another workforce reduction. This time, the target reduction was of 170 WTE posts. The number was arrived at by dividing the amount the Trust had to save by the average cost per employee:

> *It was as crude and unscientific as that.*[287]

2.240 Mr Newsham agreed that this number had to be considered to be in addition to some 200 vacancies that had not been filled. In other words, the staff establishment was in reality to be reduced by around 370 posts:

> *THE CHAIRMAN: Mr Newsham, the 170 posts here, Mr Kark's just asked about the vacancies, but was this in addition to or did it include the posts that had already been identified, which we saw I think in the previous rep?*
>
> *A. It's in addition to.*
>
> *THE CHAIRMAN: So we're now down 330 posts, approximately?*
>
> *A. Yes.*
>
> *MR KARK: This isn't just about not filling vacancies, is it? This is about removing –*
>
> *A. Reducing.*
>
> *Q. – people's jobs?*
>
> *A. Yes.*[288]

2.241 On 6 April 2006 Martin Yeates wrote to Phil Taylor, Director of Performance and Finance at SaSSHA, outlining the plan.[289] This included the following projected savings:

286 Shanahan T72.14–21
287 Newsham WS000001935, para 64
288 Newsham T60.127
289 JN/11 WS0000012118

Table 2.2: Projected savings

Front-line workforce reductions to be completed by May 2006	£2,245m
Back office workforce reductions by the same date	£2,202m
Surgical floors reconfiguration	£ 0.528m

2.242 Mr Yeates emphasised the delicate state of the Trust's finances:

> *It was critical to our long-term financial sustainability to engage at an early stage with the organisation internally to address this demanding financial challenge ... We have currently actioned a total recruitment freeze, agency ban and limited bank usage and overtime working restrictions to ensure non-recurring gains can offset the time lapse before the consultation exercise is realised.*[290]

2.243 The SaSSHA was involved in the plan to the extent that it received it and was consulted. Mr Newsham speculated that they may have been preoccupied with the transfer to the new West Midlands SHA (WMSHA).[291] He could not recall there having been any discussion with them about the plan or any aspect of it.

2.244 The workforce reduction plan did cause anxiety within the Trust. Mr Newsham recalled there being concerns raised about the proposed increase in unqualified healthcare support workers and the degree of supervision required:

> *I think we all had concerns in relation to the time that would be required to train the additional unqualified healthcare support workers that were to be introduced as a result of the alteration to the Medical Division's mix ratio.*[292]

2.245 At a Board meeting on 5 April 2006,[293] Mr Robin Bastin, as a member of the public, asked whether the Board was:

> *... aware of the deep concern that* [the announcement of job losses] *has caused in the local community, and questioned the assurance from the Board that patient services in the hospital would not suffer. He referred to the belief that the majority of redundancies would be amongst clinical staff and expressed concern regarding MRSA issues within the Trust. He asked if there was sufficient realisation among members that the talk of not affecting standards was not correct?*

290 HCC0017001562
291 Newsham WS0000007506, para 64
292 Newsham WS0000011938, para 78
293 JN/13 WS0000012126–12135; Newsham T60.136–137

2.246 Mrs Brisby replied without apparently addressing Mr Bastin's point with bland assurances. She said that the issue of redundancies was being taken "seriously" by the Trust and that the Trust "was by no means complacent":

> *The Trust was working hard to ensure that patients will not suffer and that hygiene standards are not compromised.*[294]

2.247 Mr Yeates "acknowledged" Mr Bastin's views and explained that these decisions were "tough" and were "to ensure a sustainable financial position" for the year. Delay would mean more severe measures. Of the job losses (said to be 150 rather than the 170 discussed elsewhere) he said two-thirds were from management and support services, and one-third from "ancillary services". There would be "discussions" with staff:

> *to ensure that the impact on patients and services was minimised, as the cleanliness of the hospital is critical.*[295]

2.248 It is notable that no clear statement was made as to the steps taken to assess the risk of the proposed reductions, and it is clear that, up to that point, no such assessment had taken place. This meeting was attended by Jan Harry, Director of Nursing, who could have been expected to raise the issue of risk assessments, but she did not do so. The Board did not enquire into or challenge the absence of such assessments. There is no evidence of any such risk assessment being conducted before Ms Harry's departure from the Trust in June 2006. While a consultation exercise was due to start on 7 April, the proposal for reductions was being made against a background of a previous recruitment freeze, a ban on use of agency staff and overtime restrictions.

2.249 The impact of reductions on top of the unfilled vacancies was left unconsidered. Therefore the Trust's approach was firstly to identify the number of vacancies needed to result in the required savings and then undertake some form of exercise to look at the impact, rather than from the outset asking the question of what was the minimum number of staff needed to ensure safety.

2.250 At a meeting of the JNCC on 15 June 2006 Mr Adrian Legan, the RCN Regional Officer, was recorded as saying he had contested the evidence based around the proposed changes in skill mix and:

> *made particular reference to short term saving and long term risks.*[296]

294 JN/13 WS0000012126–12135; Newsham T60.136–137
295 JN/13 WS0000012126–12135; Newsham T60.136–137
296 JN/14 WS0000012139

2.251 Mr Newsham, somewhat surprisingly, felt unable to deduce from the minutes that Mr Legan was referring to the risk of patients suffering due to the shortage of staff.[297] Mr Yeates was extremely keen not to prolong the consultation process but did agree to form a practice development team to focus on the medical division. The financial pressure appears to have been such that actual delay in achieving savings could not be tolerated even if legitimate concerns were raised. Indeed, Mr Newsham did not think that any detail of information about the clinical impact of the cost reduction plan ever came to the Board, although the Director of Nursing could have spoken about them.[298] Mr Peter Bell accepted that the Board had little precise information about the size of the establishment, and had not been aware that there had been a history of understaffing. He agreed that, with hindsight, such information might have led to him insisting on knowing what a "safe level" was for the nursing establishment.[299] It might have been expecting too much of his memory of the minutes of a meeting he had not attended, but it should be noted that at a Board meeting in August 2005 Ms Harry had reported that the number of nursing vacancies was "taking its toll" on the organisation.[300] Mrs Joan Fox, a Non-Executive Director, drew the link between this and the possible impact of the recovery plan and considered that the Finance and Performance Committee clinical members:

> *... needed to report on the qualitative aspects and this would provide assurance to the Board that quality is being maintained.*[301]

2.252 Sir Stephen Moss told the Inquiry that the Trust had been unable to find any evidence that the surgical floors reconfiguration plan had been risk assessed.[302]

2.253 Sue Adams, an RCN representative and Nurse Manager at the Trust told the Inquiry she had raised her concerns. However these had been ignored:

> *When I raised my concerns I was told by Jan Harry that the decision had been made at a higher level, that I was only a ward sister and that I should be positive about the change that was being recommended.*[303]

2.254 She also raised her concerns at a JNCC meeting but felt she was ignored:[304]

> *I felt that the Executive team were failing to involve the staff with their decision making process, and simply imposing decisions upon us no matter what we said about them.*[305]

297 Newsham T60.139–140
298 Newsham WS0000011939, para 85
299 Bell T53.76–77
300 TB/96 WS0008001014
301 TB/96 WS0008001014
302 Sir Stephen Moss WS000008838, para 48
303 Adams WS0000003860, para 30
304 SA/30 WS0000003932
305 Adams WS0000003860, para 31

2.255 Another union representative, Kath Fox of UNISON, felt the same about the concerns raised over staff cuts and skill mix changes:

> *The attitude of the union's representatives in the JNCC meetings was concern at how the Trust could reduce the number of staff when people were expressing concerns that they were already under pressure due to staff shortages. The attitude of the Trust was that they had to balance the books to achieve Foundation Trust status and were going to do that, come hell or high water. I think the management just went through the process of attending the JNCC meetings; what we were saying in the meetings would not have made the slightest bit of difference to them. They were going to make the staff cuts regardless.*[306]

2.256 The Trust sought a facility from the WMSHA of £1 million to cover the expected additional costs of the required redundancies, but in the event did not seek to draw this down. Mr Yeates felt able, in November 2006, to communicate in somewhat triumphal terms to WMSHA. Reporting a year-end projection of a £1 million surplus (as from month seven) he said:

> *I feel that the revised rating of 4 is correct and reflects the magnificent commitment of my Executive Team, Divisions and all staff within the Trust, to deliver the second biggest cost reduction programme in the West Midlands SHA, 'only one other Trust has posted a higher CIP'* (re: email Steve Allen, 9 August 2006) *within 6 months of commencement of the financial year ...*[307]

2.257 He confirmed that the consequences of redundancy had been contained within the Trust's "fighting fund" and claimed:

> *The final outcome of exit costs exceeded initial projections due to firm management control, minimal investment in voluntary redundancy and premature retirement and agreement of a number of compromise agreements.*[308]

2.258 He said that between March and September 2006 there had been a 258.73 WTE reduction in the funded establishment, amounting to 10.43% of the workforce. Headcount had reduced by 5.08%. He concluded his letter:

> *I am sure you will agree that this organisation's performance in terms of financial control, change management and delivery of its obligations has to date been exemplary and is a credit to the Board and all of the staff within the Trust.*[309]

306 Fox WS0000004499, para 21
307 MY/10 WS0000075071
308 MY/10 WS0000075071–2
309 MY/10 WS0000075073

2.259 Mr Yeates wrote to Mr Bennett, lead of the Cannock Chase Locality Group of the South Staffordshire Primary Care Trust's (SSPCT) Patient and Public Involvement Forum (PPIF) on 16 March 2007 in connection with the consultation on the Trust's FT application.[310] He referred to the Trust's achievement of its financial plan in glowing terms:

> *As we come to the end of the financial year I am delighted to say that our aspirations to break even have come to fruition. As you know this has been the subject of a great deal of hard work from all of our staff and our managers. This year has been particularly difficult as we have removed over £10m of recurring costs from the Organisation whilst still delivering on all of our targets. This together with our agreement on next year's* [Local Delivery Plan] *with the Primary Care Trust at an early stage has enabled us to develop a robust financial model on which to base our application for Foundation Trust status.*

2.260 Mr Yeates had no doubt that the WMSHA and SSPCT were fully aware of the Trust's financial plans:

> *Both the SHA and the PCT would have been absolutely clear as to the nature and depth of the cuts. Neither told me that the proposals were unacceptable, excessive or could be spread out over time. There was nothing being fed back to me at all to indicate that anyone had any concerns about the level of reductions that we were going to have to make at Mid Staffs in order to deliver the budget. There was (and remains) no doubt in my mind that the SHA and the PCT knew exactly what steps we were taking to ensure that the deficit was dealt with in the timescales set by the SHA.*[311]

2.261 As far as he was concerned, the WMSHA were prepared to let him get on with the job:

> *For the West Midlands SHA, in terms of where Mid Staffs featured on the difficulty scale, I would suspect it was fairly low down. I suspect they took the view that there was a competent team in place who were managing the situation – plans had been developed and signed off by the Unions and these had been shared with the SHA and the PCTs. Mid Staffs would not therefore have been at the top of their list of problems. It is fair to say that we did not beat their door down complaining about the situation; I did not see how this would help. The decisions had been taken nationally that all organisations within the NHS had to break even and that could not have been made any clearer.*

310 TRU00010008396, Letter from Martin Yeates to Carl Bennett (16 March 2007)
311 Yeates WS0000074937, para 57

I was clear we all had a job to do and whilst I may not have liked this aspect of it, as I have said, the deficit would have deteriorated greatly if not dealt with. It was normally the case (and this was particularly the case for 2006/7) that Chief Executives were given a very firm line from the SHA that we needed to achieve a budget of x or y and we were expected to get on with it. I firmly believed that taking action and trying to resolve the situation with as much "buy-in" as possible from all hospital divisions and departments, engagement with the Unions and information provision to the PCTs and the SHA was the way forward that was in the best interests of the hospital. Even with hindsight ... I still believe that we were given no choice other than to address the difficult financial situation ...[312]

2.262 The aftermath of these drastic cuts, without any adequate assessment of the impact on nursing services, became all too clear when Dr Helen Moss arrived at the end of 2006. As is related below, she initiated a skill mix review which was reported to the Board in March 2008 recommending the need for a very large investment in more nursing staff and a radical change in the skill mix. The review found that the Trust was some 120 WTE nurses short of what was required, nearly 13% of the total nursing establishment. At the Board meeting on 31 March 2008, directors asked whether it had been right to reduce the nursing establishment as part of the previous cost improvement programme. The Board was "reminded" presumably by the Chief Executive, that the:

... alternative had been a downward financial spiral.

2.263 It was not believed that the reduction had had a "large impact on the nursing establishment" which was a "historic issue". It had not been foreseen that there would be a sickness absence problem, and there had been difficulties with turnover and recruiting.[313] These superficial explanations overlooked the central point that no proper attention had been paid to the impact of the reductions on patient care.

2007–2009

2.264 The financial plan as included in the Trust's FT application (draft May 2007) was for a surplus of £0.236 million on a turnover of £134.627 million.[314] A CIP of £4.466 million was planned. Of this, £3.465 million was to be found from workforce reductions, employment changes, and modernisation of working practices.

Conclusion on Trust's management of its finances

2.265 Throughout the period with which this Inquiry is concerned, the Trust has suffered financial challenges. Indeed the history suggests that such difficulties were endemic.

312 Yeates WS0000074937–938, paras 60–61
313 TRU00010016163
314 DH00370000248–252, Mid Staffordshire General Hospitals NHS Trust: Foundation Trust Application – Integrated Business Plan

2.266 The Trust's financial recovery plan in January 2005 expected that the Trust would not reach surplus until 2008/09, for which year it predicted a modest surplus of £160,000.[315]

2.267 Nevertheless, the Trust's financial plan included in its FT application (draft May 2007) set out the Trust's expectation of an increase in income per year along with a growing surplus, with the exception of 2007/08 (due to the Trust's planned exit from its laundry business).[316] In 2008/09, the Trust now expected to have a surplus of £1,670,000 with a turnover of £136,218,200.[317]

2.268 In the five-year forecast in the FT application, the Trust was clear it would continue with its cost improvement savings. Workforce savings were expected to make a significant contribution to this. In particular, for the year 2007/08 total savings were projected to be £4.466 million of which £3.465 million was to come from workforce reductions, establishment reviews, employment changes and modernisation of working practices.

2.269 In parallel, the Trust owed £1.8 million to the PCT for support in previous years. In November 2007, the SHA that agreed the Trust needed to pay back only £678,000 of this, enabling it to break even by 2007/08.[318]

2.270 The Trust achieved a recurring balance by 31 March 2008[319] and during the HCC investigation remained largely on its predicted budget, with small slippages which were made up for in September 2008 with an increase in income.[320]

2.271 These pressures and fluctuations were regarded by managers, both inside and outside the Trust, as nothing particularly remarkable compared with other similar organisations, and it was never treated as a particular cause for concern on this score. Matters changed with the publication of the HCC's investigation of the Trust in March 2009. Implementation of the Trust's action plan immediately utilised the £0.7 million surplus that the Trust had accumulated and the Trust approached the PCT and SHA for a loan.[321] By the time of a meeting with Monitor and the PCT on 5 October 2009, the predicted deficit at the Trust was at £7.1 million[322] and on 27 November 2009 Professor Ian Cumming, Chief Executive of the WMSHA at the time, agreed a non-recurring loan of £4.5 million towards the transformational programme costs.[323]

315 SCC000500000044, Financial recovery plan 2004/05–2008/09 (enclosure to letter from Tina Randall, Staffordshire County Council to Mr C C Wilkinson enclosing financial reports dated 21 January 2005)
316 MON000400002724, Mid Staffordshire General Hospitals NHS Trust Foundation Trust Application – Integrated Business Plan – Version 3.5 (May 23 2007)
317 MON000400002724, Mid Staffordshire General Hospitals NHS Trust Foundation Trust Application – Integrated Business Plan – Version 3.5 (May 23 2007) at MON000400002843; MON000400002864
318 SHA0010000260
319 Newsham T60.180
320 MG/22 WS0000008369
321 Gill WS0000008127 para 145; MG/39 WS0000008584
322 Gill WS0000008131 para 157
323 Gill WS0000008131 para 160

2.272 By January 2010, the Trust's deficit was £5.2 million. By April 2010, this had increased to £7.5 million,[324] although the Trust's expectation, as set out by Antony Sumara, then Chief Executive of the Trust, in his witness statement to the Inquiry of 22 February 2011, was that "by 2013 the hospital will be in the black again."[325]

2.273 There is clear evidence that in the period of this Inquiry, up to the publication of the HCC's report, considerable pressure was placed on the Trust management to balance its books, but in this respect it was treated no differently from its peers. This remained the case, even when it was openly planning costs savings of 8% which, it was generally agreed, was among the higher recovery plans at the time.

2.274 That the Trust focused much of its attention on cutting staff costs as a solution to the need to cure deficits could not have been surprising. Such costs were always going to be a highly significant part of the budget and, as such, bound to be considered in this context. While the system as a whole appeared to pay lip service to the need not to compromise services and their quality, it is remarkable how little attention was paid to the potential impact of proposed savings on quality and safety. We have seen evidence of a clinical risk rating system, but almost none of its actual application. By contrast, there is much evidence of the application of the parallel financial risk rating scoring. Concerns expressed internally about the effect of establishment reduction and skill mix changes were met with expressions of understanding but little if any evidence of effective consideration. Externally, neither the WMSHA nor the SSPCT seem to have expressed any substantive interest in the issue, and indeed it is difficult to discern any evidence that a potential link was made between financial difficulties and their effect on standards. It can only be concluded that, following the exhortations not to diminish the quality of the service, there was a general assumption among national and regional leaders of the NHS that provider organisation boards would naturally ensure preservation of such standards without any specific external oversight.

2.275 I have no doubt that the economies imposed by the Trust Board, year after year, had a profound effect on the organisation's ability to deliver a safe and effective service. With hindsight it is possible to discern an ever more desperate situation. Even so, it is difficult to understand why Board members individually and collectively did not realise the need to satisfy themselves that standards were not being compromised. Unfortunately they appear to have been too easily satisfied by superficially persuasive assurances from the executive that such matters were being attended to without any adequate evidential base being presented to them. The result was the trumpeting by Trust leaders of their financial management as being a great success. Tragically, it was a success achieved only at the expense of a great deal of suffering by too many patients, as well as an unacceptable burden imposed on their staff.

324 Gill WS0000008133 para 168
325 Sumara WS0000005928 para 75

2.276 One measure of the gap between the perception that the savings made were acceptable and the grim reality has been the Trust's financial experience since 2009. It has been the recipient of very large quantities of additional financial support, and increases in staff, but appears to be slipping into deeper deficits. While some of this can be attributed to the direct adverse impact of the scandal that has engulfed the Trust, it must also be an indication that it was in retrospect from the plan set out impossible to provide the required level of service from the funds available.

2.277 The Board of the time collectively must bear responsibility for allowing the mismatch between the resources allocated and the needs of the services to be delivered to persist without protest or warning of the consequences. It was or should have been the directors' primary responsibility to ensure either that they did deliver an acceptable standard of service or, if this was not possible, to say so loudly and clearly, and take whatever steps were necessary to protect their patients. However, they were able to fail in this way because of deficiencies in the system around them.

2.278 From national, regional and local levels, pressure was continually exerted to balance the books. While this is of course a necessary objective in any publicly funded service – and the DH did put in place practical support and advice for finanicially challenged providers – the very special responsibility in healthcare of ensuring delivery of a service which is safe and to a minimum level of quality, was not emphasised sufficiently or at all. In the financial context, the issues of safety and quality where more or less ignored. Pronouncements from the DH and from the SHA did refer to the objective of improving or preserving the quality of care, but the effect at trust level in Stafford has been described earlier. Assumptions in this regard were left unspoken; being implicit rather than expressed, they were forgotten. Financial issues were all too easily separated from safety and quality issues without any proper consideration of the obvious affect of one on the other.

Nursing numbers and skill mix

2.279 As observed earlier, it became apparent to Dr Moss, very shortly after her appointment in 2006, that there were real concerns about: the ability of the nursing staff to deliver a proper standard of basic nursing care; the establishment numbers; and the skill mix. She told the Inquiry that she first recognised there were insufficient numbers of nurses by March 2007.[326] It will be apparent from what has been said above in relation to finance that this had resulted from a chronic staffing deficiency exacerbated by the need to meet financial targets. It is undoubtedly to Dr Moss' credit that she raised these matters with the Board, and obtained approval for steps to address the issue, but the overall time taken to achieve the review and even some progress towards correcting the problem was too long.

326 Moss T62.17–21

2.280 So far as Mr Yeates was concerned, such issues were "news", as he had never received any suggestion of a problem from Jan Harry. He had known of problems on some wards but understood this to be due to recruiting issues.[327]

2.281 In her business plan submitted to the board in April 2007, Dr Moss included a proposal for a skill mix review[328]. It was part of her plan for the review to assist in "unpicking" the clinical floor reconfiguration initiated under Ms Harry's leadership, of which Dr Moss did not approve.[329] In fairness to Ms Harry, it must be pointed out that the project was not implemented until after she left the Trust in June 2006, six months before the arrival of Dr Moss.

2.282 Dr Moss decided she needed external help to undertake the skill mix review, partly for capacity reasons and partly because she feared the Trust staff did not appreciate the needs of the organisation, and she held a perception that she was not supported in the Trust by the sort of corporate infrastructure she had been used to in her previous post.[330] To obtain such help, she raised the issue with Peter Blythin, Director of Nursing at the WMSHA. This occurred in a series of contacts between July and October 2007.[331] He introduced her to an external reviewer. However it is not clear that she explained to Mr Blythin the extent of her concerns about staffing issues, or indeed that he asked her for much detail.[332] Dr Moss told the Inquiry that the work of the review in obtaining background information probably started between July and August 2007, and that Miss Boon arrived between then and October 2007.[333]

2.283 The Board was made aware at its meeting in July 2007 that there was a shortfall in filled, funded nursing posts of 102.64 WTE.[334]

2.284 The review was not completed until some time between December 2007 and February 2008 and was not shared with the Board until March 2008, after the Trust had obtained FT status. It showed that the Trust was some 120 WTE nurses short of what was required, nearly 13% of the total nursing establishment. Medicine accounted for 70 of the shortfall and surgery for 30. The total projected cost of replacing this number of staff was over £3.2 million. The report recommended the immediate investment of £1.7 million although that would leave a gap of £1.5 million.[335] The review also recommended that the skill mix of 40:60 skilled (qualified) nurses to unskilled (support workers) be reversed to 60:40. The Inquiry heard from no witness

327 Yeates WS0000074953, para 107
328 Moss WS0000009464, para 33
329 Moss T62.47–48
330 Moss T62.25–26
331 See *Chapter 1: Warning signs*, for a further analysis of the evidence of the timing of these events.
332 Moss T62.53; Blythin T69.125–134
333 Moss T62.26–27
334 TRU00010014353, Mid Staffordshire General Hospitals NHS Trust, Report to Trust Board by Director of Finance and Planning (5 July 2007)
335 Helen Moss T62.27–30; HM/2 WS0000009579

who was prepared to condone the original skill mix figure, with both the Chief Nursing Officer and the Chief Executive of the RCN indicating that the mix was unlikely to be appropriate.[336]

2.285 The time taken to deliver this report to the Board was the subject of some scrutiny at the Inquiry.

2.286 Given Dr Moss' almost immediate concerns about nursing following her arrival, and the vital importance of a sufficiently staffed, well-performing nursing establishment to patient welfare, it does not appear that either the arrangements for, or the delivery of, a nursing skill mix review were carried out with sufficient urgency.

2.287 Dr Moss denied that there was a deliberate decision to defer the completion of the report or its delivery to the Board until after the board-to-board interview in December 2007 which was part of Monitor's assessment of the Trust's FT application. Her explanation for the delay was that:

> *I think there was no hurry for the board to receive it ... because the investment required was significant ...*
>
> *Q ... how did you get the impression that there was no hurry to receive the report?*
>
> *A. I think from discussions with the chief executive.*[337]

2.288 Mr Yeates said that he had agreed with Dr Moss that what was required was a thorough review leading to long-term changes rather than a "knee jerk reaction".[338] This could not justify the time taken from first realisation of the problem until the matter was finally put before the Board. While it is suspiciously fortuitous that the report was delivered so shortly after the achievement of FT status, there is insufficient evidence to conclude that there was a deliberate delay for this reason. However, the evidence of Dr Moss, cited above, is of almost equal concern, namely that delivery was deferred because of the projected expense. The Board was thereby deprived of an earlier opportunity to consider what in those circumstances was required to protect patients' welfare. Given the challenges that a trust can in any event face in attempting to recruit substantial numbers of nursing staff, the planning and organisation of such a step needs to be taken at the earliest indication that staffing is inadequate.

336 Beasley T117.72; Carter T52.88; Carter T52.88
337 Helen Moss T62.36–38
338 Yeates WS00000074953, para 107

2.289 In fact, even when on 31 March 2008 in the private part of its meeting, it finally received the report, the Board agreed an investment of only £1.15 million.[339] Directors asked whether the recruitment programme could be speeded up, as even the current intention of fulfilling the planned recruitment in 12 weeks was considered to be too long. No explanation was recorded in the minutes as to why the full amount recommended by the review – which was for the minimum acceptable level for the nursing establishment – was not authorised. The Board was not told that the shortfall was having an impact on the care patients received, and Dr Moss accepted, albeit only with hindsight, that they should have been.[340] It has to be presumed that the Trust did not have the financial resources. Coming just a month after the Trust had been granted FT status, this does not say very much for its real financial standing at that time.

2.290 The Board of Directors agreed a further £0.7 million investment in May 2008, over and above the investment agreed at the March Board meeting for additional nursing staff.[341]

2.291 In October 2008, the Heart of England peer review of the A&E department identified nursing shortage as one of the serious issues it was concerned about (see *Chapter 1: Warning signs*). Dr Moss told the Inquiry that it remained difficult to recruit nurses.[342]

2.292 In March 2009, the Board was informed that even on this level of funding there was still a shortfall against budget of 37 WTE and in any event the budgeted establishment still fell short of the level recommended in the review by 32 WTE.[343] Work was still said to be "ongoing" to adjust the skill mix in line with the recommendations. A further investment of £400,000 was authorised. It was said this reduced the "gap" to 16.8 WTE when compared with the professional judgement model used in the review. A further shortfall of 8.84 WTE was identified due to vacancies which had not yet been filled.[344] In July 2009, the skill mix was still said to be "moving from" 40:60 to 60:40.[345]

2.293 It appears from recent evidence from the Trust that it took until around the beginning of 2011 to reach a level at or above the 2008 nursing review recommended level.[346]

2.294 Therefore, the increase in the funded divisional establishment for nurses to the level recommended in this review has been glacial. Table 2.3 shows what has happened.

339 TRU00010016163, Minutes of Private Meeting of the Mid Staffordshire NHS Foundation Trust (31 March 2008)
340 Moss T62.43
341 RES0000000074 *Report to the Board of Directors by Helen Moss regarding nurse recruitment* (31 March 2009), Background Paragraph
342 Moss T62.46
343 RES0000000076
344 RES0000000092 Report to the Board of Directors by Helen Moss regarding nurse recruitment (28 July 2009)
345 RES0000000093 Report to the Board of Directors by Helen Moss regarding nurse recruitment (28 July 2009)
346 RES0000000070 Email from Katie Price to Mid Staffs Inquiry Legal Team (7 October 2011)

Table 2.3: Increase in funded divisional establishment for nurses

Year	Funded establishment WTE	Comments
Feb 2007	954.17	Table 1 of Dr Moss' skill mix review.[346]
2008/09	901.24	Table 2 of Dr Moss' skill mix review.[347] It was this level which was found to be 120.30 WTE short of what was required.
Early Jan 2009	901.81	The Trust informed the Inquiry that at the beginning of 2009 there were 901 WTE in wards, departments and A&E.[348]
End Mar 2009	952.06[349]	The then budgeted establishment was 989.42; therefore there was a shortfall of 37 on the budgeted level and 69.57 on the review recommendation.
2010	985.69	The Trust's figure for the beginning of 2010.
2011	1046.79[350]	The Trust's figure for the beginning of 2011.

2.295 Martin Yeates considered that Dr Moss had done an excellent job and considers she has been unfairly vilified. In his view she had been "absolutely determined" to see that the necessary changes were well thought out and for the long term.[352]

Conclusion

2.296 It is impossible to avoid the conclusion that there was an unacceptable delay in addressing the issue of shortage of skilled nursing staff once the problem became apparent after Dr Moss' appointment. While many excuses have been put forward, such as difficulty in recruitment, there is no evidence of any sense of urgency about this problem or of an appreciation that such a shortage was likely to have an adverse impact on the standards of care being offered to patients.

2.297 Even when the Board received the detailed report and became aware that there must have been a deficient approach to the issue of staff cuts when they approved them as part of the CIP, the lack of a sense of urgency was such that they did not authorise or allocate the full sum necessary to remedy the shortfall, but only part of it. They did not ask for information about the impact on the quality of care, and they failed to make any connection between what they were now being told and the concerns implicit in the high mortality figures, the HCC's decision to launch an investigation or the myriad of complaints which were now surfacing. Their attitude is exemplified by the doubtless genuine indignation expressed by Mr Yeates at the treatment of Dr Moss, and his view that at the time the HCC investigation started, the Trust was "starting to turn the corner" and was "well on the way" to recruiting

347 SHA0015000055–058, Report to the Board of Directors by Helen Moss regarding Skill Mix Review (31 March 2008), Table 1
348 SHA0015000059, Report to the Board of Directors by Helen Moss regarding Skill Mix Review (31 March 2008), Table 2
349 RES0000000070 Email from Katie Price to Mid Staffs Inquiry Legal Team (7 October 2011)
350 HCC0066000241, Report to the Board of Directors by Helen Moss regarding nurse recruitment (31 March 2009)
351 RES0000000070 Email from Katie Price to Mid Staffs Inquiry Legal Team (7 October 2011)
352 Yeates WS0000074954, para 108

the "first 100 additional nurses" required.[353] The figures set out above show that this was far from the true position.

2.298 There can be little doubt that the reason for the slow progress in the review, and the slowness of the Board to inject the necessary funds and a sense of real urgency into the process, was the priority they gave to ensuring that the Trust books were in order for the FT application. The result was not only to deprive the hospital of a proper level of nursing staff without any appropriate assessment of the risks involved, but a misleading picture of the financial health of the Trust was presented to Monitor and was material in the achievement of FT status.

2.299 It is not without significance that the review report was received by the Board in a private session, meaning that public access to the document was likely to be limited.

Accident and Emergency and Emergency Admissions Unit concerns

2.300 Dr Nakash worked as a locum consultant in A&E and the EAU from May 2005 to May 2008. During that time he had concerns in relation to inadequate staffing levels on the EAU. He communicated these to senior managers and provided guidance from the website of the Society of Acute Medicine that suggested that for every six acute beds there should be at least one trained nurse, or possibly more depending on the nature of the patients. While some effort was made to increase numbers, escalation of the concerns to Jan Harry and to the senior medical management team "had no effect."[354] However, he said that he had not seen anything placing patients at risk and therefore had not expressed concerns externally.[355]

2.301 In light of what is now known about staff shortages at all levels, Dr Nakash's observation in relation to patient risk cannot have been representative of the experience of many others. He produced minutes demonstrating these issues being raised at an emergency care meeting on 9 March 2007.[356] These recorded that for adequate cover to be provided in A&E a further 3.5 emergency nurse practitioners were needed.[357] A year later, in April 2008, Martin Yeates told him he could have the resources he wanted to address staffing levels and other spending and granted his request to have three more consultants in A&E. Indeed Dr Nakash said Mr Yeates had "bent over backwards" to provide the required resources, having been "surprised" at being told of the lack of staff.[358] While Dr Nakash recollected his offer was made before the start of the HCC investigation,[359] he put the date of this offer as being April 2008, which would have been after the investigation started. If the date is correct, it is difficult to escape the conclusion that Mr Yeates' offer was influenced by the HCC's interest in the Trust.

353 Yeates WS0000074954, para 108
354 Nakash WS0000005209, para 10; WS0000005214, para 31
355 Nakash WS0000005222, paras 72–73 and para 75
356 SJN/1, WS0000005225
357 SJN/1, WS0000005227
358 Nakash T49.39
359 Nakash WS0000005211–5212, paras 13–14 and 16–17

2.302 Dr Chris Turner's perception of the problems in A&E was that they were considerably more fundamental than described by Dr Nakash. Dr Turner came to the Trust in October 2007 as a Specialist Registrar in Emergency Medicine after two years at the University Hospital of North Staffordshire. Although still a trainee, he brought with him a wide experience of emergency departments in Manchester, Birmingham and Australia. He was capable of acting up as a consultant. He thought that A&E was "an absolute disaster". A detailed quotation from his evidence is set out in *Chapter 1: Warning signs*, but in summary he was particularly critical of:

- The culture of bullying and harassment of staff, particularly the nursing staff, to the extent of witnessing nurses emerging from bed management meetings in tears in fear of losing their jobs;
- The quality of the service which was very much below what he had seen at Stoke;
- The lack of a senior nurse leader;
- The direct exposure of junior staff to managerial pressures;
- The dangerous use of a clinical decisions unit and EAU to avoid breaches of the A&E four-hour waiting time target without properly managed transfers;
- An unsafe level of staffing in A&E and the EAU, in particular in relation to qualified nursing staff;
- The disempowerment of the consultants;
- Insufficient numbers of A&E consultants (as opposed to acute medicine consultants).

2.303 Dr Turner raised his concerns with his educational supervisor within the Trust, the Senior Consultant in A&E, Mr Phair, and Dr Nakash, but without effect. His efforts to draw the matter to the attention of external authorities is set out out in *Chapter 1: Warning signs* and in the Whistleblowing section later in this chapter.

2.304 At some point in the middle of 2008, Mr Yeates addressed a meeting of EAU doctors. Although only a trainee, Dr Turner stated his unhappiness with the skill mix and asked whether Mr Yeates was content with it. Mr Yeates appeared to be angry, but Dr Turner stood his ground, and he received support at the meeting from Mr Phair. After the meeting, the Chief Executive approached him in a friendly and constructive manner. He procured a further consultant and promoted Dr Turner to acting consultant.[360] Arguably this apparent change of heart was too late. As Dr Turner said, it should not have been down to him, a trainee, to take on the burden of challenging the Trust leadership over this issue. He may have been emboldened by the fact that he had already been interviewed by the HCC investigating team at this stage.[361]

360 Turner T50.19–21; WS0000005888, paras 27–32
361 Turner T50.25

2.305 Dr Turner was also made clinical lead for A&E and became responsible for clinical governance. This was a bold move by Mr Yeates, as it involved promoting Dr Turner over the heads of others. Dr Turner's priority was commendably clear:

> *That practice* [of bullying by management] *changed gradually, mainly because we were able to say "I'm sorry, but this patient is not moving from the department until we have X, Y and Z in place, and they will move once we have handed over care". And we accepted that that meant that we, perhaps, wouldn't attain the four-hour target, but that the quality of care that the patient received would be improved ... we made a clear philosophical decision that we would change nothing unless we felt that it improved patient care.*[362]

2.306 The pressure from management faded away because by this time, according to Dr Turner, it was realised and accepted that the department had huge problems. This empowered clinicians to resist pressure.

Clinical governance

Awareness of issues

2.307 As has been seen in *Chapter 1: Warning signs*, effective clinical governance was frequently noted as an issue for the Trust. This was well known internally. When Martin Yeates arrived in September 2005 he considered there to be two fundamental problems: the managerial structure and clinical governance. He thought that most of the most basic clinical governance structures to which he had been accustomed in his previous Trust were missing:

- There were no systems in place for systemic appraisals of clinical quality or of staff;
- Information gathering was "inept" and coding was "dreadful";
- The staff were not "gripped" by the importance of clinical audit;
- There was no culture of self-analysis;
- There was little analysis of complaints, or incidents;
- The risk register was not kept up to date.[363]

2.308 He told the Inquiry that he had so much else to attend to, particularly during his first six months, in addition to the developing financial crisis, that in retrospect he accepted that he should have done more about this area.[364]

362 Turner T50.34
363 Yeates WS0000074925, paras 16–17; WS0000074930–31, paras 33–38
364 Yeates WS0000074930, para 35

2.309 However, Dr Suarez told the Inquiry it was a "complete shock" to her when she took over in 2006 to find that there was "nothing substantial" in place.[365] There were considerable difficulties in persuading clinicians to embrace the concept:

> *I think at the point at which we started there was a slowness to appreciate that clinical governance didn't apply to everybody else, it applied to the individual and they had a responsibility, not just to themselves and their patients, but this embraced a more teamwork approach. There was a reluctance, on the parts of some consultants, particularly, to think that they needed to change practice, to become in line with what would be nationally regarded as acceptable. So the concept of following guidelines and protocols was more difficult to instil in some than in others, and it sounds as though everybody was very reluctant. That is not necessarily the case. But sometimes when people were presented with "This is the way that the recommendation is", there would be, "Well, I don't want to do it because of these reasons". So there was a lot of discussion around quite a number of initiatives, and that made implementing change slow.*[366]

2.310 Dr Coates was appointed Clinical Governance Lead in 2006 and continued until 2009, when he resigned from the post. By his own account, he had no particular experience qualifying him for his role, and there was no clear set of tasks that he was expected to conduct.[367] He did not believe he was adequately qualified or educated to do the job at the time and was not aware of any specific training that he could undergo to qualify him for a job like this one.[368] He went further than Dr Suarez in describing the Trust's culture in relation to clinical governance. He told the Inquiry that:

> *The overall effect of this sceptical culture was that I found it almost impossible to implement clinical governance procedures.*[369]

2.311 He detected a "suspicion" among consultants about clinical governance, which he attributed in part to the experience of the management style of Jan Harry, the predecessor of Dr Moss as Director of Nursing (whom he said consultants had disliked "with a passion").[370] He said Ms Harry had been very unpopular and under her leadership clinical governance had not been supported in large part because she had failed to involve clinicians in it.[371]

365 Coates T50.122
366 Suarez T59.24
367 Coates WS0000004851, paras 7–8
368 Coates T50.133–134
369 Coates WS0000004858, para 30
370 Coates WS 0000004850, para 6
371 Coates T50.121–122

2.312 However, this was not the only reason. Dr Coates said:

> *There was a definite feel amongst some consultants that they did not want to be told what to do by someone else, e.g. NICE.* [372]

2.313 He gave as an example the difficulty he had in implementing a NICE guideline on deep-vein thrombosis, which took two and a half years because some consultants reacted by saying they had never practised in the manner proposed and saw no reason to change. Another example was the surgical division, from which he found it impossible to obtain a collective opinion.[373]

2.314 Dr Turner described clinical governance structures at the Trust as "absolutely opaque" with a multiplicity of committees onto which matters would disappear without trace.[374] Clinical governance in A&E was "immature". Assurance activity was carried out without the necessary changes being implemented to ensure improvement of patient care. There were no reviews of mortality. Some audit was undertaken but no learning taken from the exercise. Dr Turner played a large part in changing this, and was instrumental in creating a system for reviewing the cases of all patients who died within 24 hours of contact with the department.[375]

Reviews of systems

2.315 These concerns must have been confirmed by the Bentley Jennison internal audit for the year ended March 2006. It was only able to give:

> *Limited assurance ... as weakness in the design, and inconsistent application of controls, put the achievement of the organisation's objectives at risk in a number of areas reviewed.*[376]

2.316 Among the findings were:

- No regular flow of assurance provided to the Board throughout the year;
- The lack of an assurance framework did not provide a means of assurance that there was an effective system of internal control to manage the Trust's principal risks;
- Fundamental weakness in the risk management processes to the extent that the appropriate core standards in *Standards for Better Health* (DH, 2004) were not met;
- Lack of adequate policies and procedures and inadequate monitoring;

372 Coates WS0000004857, para 29
373 Coates WS0000004858, para 31
374 Turner T50.41
375 Turner T50.38–39
376 SHA0001000383 *Internal Audit Annual Report of the Trust for year ending 3 March 2006*, Bentley Jennison Risk Management Ltd, para 2.1

- A failure to determine the significance in relation to non-compliance with the core standards in terms of risk to patients and the public of non-compliance.

2.317 The audit resulted in the auditor making three "significant" recommendations in respect of governance, two "fundamental" and 13 "significant" recommendations in relation to risk management, and three "significant" recommendations in relation to the processes supporting the *Standards for Better Health* final declaration.

2.318 Mrs Brisby did not find anything new in this report, asserting that the issues mentioned had already been identified and were being addressed.[377]

2.319 Quite properly, there was some emphasis from 2006 on setting up clinical governance systems. Unfortunately, the focus may not have been sufficiently on using the systems effectively to examine actual performance at the Trust. Dr Suarez accepted that they focused on process rather than results and that they were not as quick as they should have been to pick up on the fact that the system was not being effective. For example, there were action plans but they were not followed up sufficiently assiduously. She also accepted that by 2009 the process was improved but was not as good as it should have been.[378] Indeed, she went so far as to say that at the time the decision was made to apply for FT status:

> *We knew that we did not have the appropriate systems in place with regard to clinical governance.*[379]

2.320 According to her, there were two schools of thought: one that FT status would help in getting proper systems in place; the other that they ought to be put in place before an application was made. She adhered to the first opinion, which has been criticised in the first inquiry report as being prevalent in the Trust.[380] Along with Dr Coates, she was surprised that Monitor did not detect the flaws in the system: she expressed this to be her retrospective view, but if she knew that the system was defective at the time of making the application, that is difficult to accept. She recalled being "disappointed" that more clinically focused questions were not asked during the FT application process,[381] although there appears to have been some consideration of clinical audit at least.[382] She was party to the application and to meetings with Monitor and was silent about these concerns.

2.321 Dr Moss had responsibility for clinical governance from the time of her arrival as Director of Nursing in December 2006, but she pointed out that the Medical Director was responsible for clinical audit and effectiveness, leading to a lack of clarity about roles. She noted that the

377 Brisby WS0008000130, para 495
378 Suarez T59.29–30
379 Suarez WS0000012513, para 142
380 Suarez T59.175
381 Suarez WS0000012516, para 152
382 Suarez T59.183

committee structure had too many levels, distancing information from the Board. This was eventually simplified.[383] Dr Suarez felt that the revised structure was not as clear as it might have been,[384] a view with which Dr Coates agreed,[385] but Bentley Jennison in a report on the Trust's assurance framework in April 2007 opined that its design and operation was "sound" and would enable assurance with regard to internal controls to be provided.[386]

2.322 Clearly, there may be a number of different systems capable of delivering effective assurance and governance. Monitor examined the system in place as part of its assessment of the FT application process and, subject to some recommendations, approved what was in place.[387] However, as with so much of the consideration of this issue, the focus was on the systems as opposed to any check that they were actually working.

Clinical audit

2.323 Clinical audit was not effectively managed at the Trust, and was found by the HCC in its investigation to be under-developed; a finding repeated by the first inquiry. When Dr Suarez assumed responsibility for it, she found there was a lack of central coordination of the audits that were being undertaken and standards were variable. She developed an audit plan, but this was not in place until the end of 2007.[388]

Incident reporting

2.324 When Dr Moss arrived in December 2006, there was a large backlog of complaints and incidents: some eight months of reports of complaints and incidents had not been entered on the system. Dr Coates felt that there was an insufficient focus on ensuring that the lessons from incidents and reports were applied effectively. There was a tendency for the central committees to look at high-level figures and refer matters back to divisions without any follow-up. In addition, the system did not give useful focused information to the Board, but rather diluted the nature of the problems. Dr Coates disagreed with the structures that Dr Moss put in place but "simply got on with them". He had a good relationship with her. [389]

2.325 There were many incident reports highlighting a lack of nursing staff as a relevant factor. The Inquiry was presented with a comprehensive spreadsheet of all SUIs between January 2005 and December 2009 in which staffing levels had been recorded as a factor.[390] This was prepared by the Trust for the Inquiry. During the period January to March 2007 a total of 88 such incidents were reported; about one per day.

383 Moss T62.59; WS0000009497, para 117
384 Suarez WS0000012491–92, paras 54–56
385 Coates WS0000004851, para 9
386 MC/5, WS0000030752
387 Moss T62.60
388 Suarez WS0000012488–91, paras 41–53
389 Coates WS0000004852, paras 11–12; T50.135–140
390 TRU0012000001 Spreadsheet of 1772 Serious Untoward Incidents between 2005 and 2009

2.326 The potential consequences of understaffing for the care of patients and the intolerable demands made of nursing staff are made very clear in some of these, on occasion vividly phrased, reports. Two examples follow:

> *A&E: CDU* [clinical decisions unit]*: 2 trained nurses on Ward 14 for night shift. One staff nurse from Ward 14 was seen, against her better judgement, to charge CDU overnight by the Bed Manager. She had never worked on CDU before, had no handover and was working with a bank HCSW* [healthcare support worker]*. During the night the staff nurse had queries surrounding the discharge of two patients which involved an ambulance crew, a surgical HO, and an unobtainable registrar. Two patients were recovering from taking overdoses, and one wanted to self-discharge, but was stumbling around and talking of taking her life. The S/N thought the pt should see the crisis team first. At 05.00hrs The bed manager informed the staff nurse that she had been given the wrong info re staffing and that the staff nurse need not have been moved from Ward 14. No replacement team came on to the unit at 07.00hrs and there was confusion between the Senior Nurse and A&E as to about who was responsible for providing staff ... The pt who was wandering went off the unit and was found getting into a taxi ...*[391]
>
> *... Ward 2: While I was working ward, I was the only trained* [nurse] *in ward as the other nurse was sick, one bank staff nurse came to give half an hour help in morning and lunch time. Ward was very heavy with 11 bed baths, 1 chemotherapy, 4 blood transfusions, 3 discharges and Two patientsients* [sic] [with haemoglobin] *was only 6–7. One patient had malaena* [sic]*. With the dependency of patient* [I was] *unable to provide necessary care for the patients.*[392]

2.327 Yet this does not appear to have triggered any degree of urgency in the staff review process initiated by Dr Moss. Dr Coates felt that if money was required to correct a problem, action would not be taken.[393] In fact, it seems unlikely that the Board was ever given information in sufficient detail to allow it to appreciate how constant the stream of incidents potentially linked to staff shortages was. Dr Moss accepted that the system of reporting "top themes" did not necessarily capture this and that, in hindsight, this should have been drawn specifically to the Board's attention.[394] Such information was clearly relevant to the consideration of staff cuts, and was likely to have influenced the decisions taken in this regard.

2.328 Throughout the period under review, the Trust had policies and systems in place which in theory required not only the reporting and recording of adverse incidents and "near misses" but the use of that information to ensure the elimination of hazards to the health and safety

391 TRU0012000001 Spreadsheet of 1772 Serious Untoward Incidents between 2005 and 2009, at TRU0012000071
392 TRU0012000001 Spreadsheet of 1772 Serious Untoward Incidents between 2005 and 2009, at TRU0012000075
393 Coates T50.139
394 Helen Moss T62.42–43

of patients, staff and others.[395] The first inquiry heard complaints from staff that there was little feedback to those reporting incidents and that at times there was discouragement to record staff shortage as a factor. This was confirmed by the evidence to this Inquiry. Dr Suarez stated that when clinical incidents occurred and clinicians filled in adverse incident report forms, they did not always receive a response or know what action had been taken.[396]

2.329 The lack of feedback to the frontline was compounded by a perceived lack of feedback or action from the WMSHA in relation to SUIs recorded on the Strategic Executive Information System (STEIS).

2.330 In *Chapter 1: Warning signs*, an account is given of the striking and distressing example of Mrs Astbury's case, where no attention of any description was paid to a tragic death by the WMSHA for years. This was clearly not uncommon. Trudi Williams, who had responsibility in the incident reporting system, said:

> *When SUIs were put on to STEIS they would have to be closed off by the SHA but we got very little interaction and feedback from them at this time ...*
>
> *I recall there being some SUIs on the STEIS system which were not closed off and they had been on there for a number of years with no one appearing to be questioning us about them.*[397]

2.331 With regard to the inaction in the Astbury case she said:

> *It doesn't surprise me, because we weren't chased for action plans, we weren't chased for reports once it was reported onto the STEIS system. It was only much later that that started to happen, once the Healthcare Commission actually came in and started to do their investigation.*[398]

2.332 The problems seem to have been compounded by a lack of understanding about what constituted an SUI or adverse incident, even if the guidance itself was clear.[399] Another concern expressed to the Inquiry was that of Dr Turner who believed that managerial staff would change the degree of seriousness attached to an incident report. He was aware of cases in which an incident considered to be a SUI by the clinician reporting it had been downgraded by a manager.[400] On a more mundane practical note he and others found the requirements for completing an incident report by computer were cumbersome and time

395 See for instance ESI100044757 *Adverse Incident Reporting Policy* (May 2007), also quoted at CLO000003425 Counsel to the Inquiry's closing submissions, Chapter 9, para 123
396 Suarez WS0000012493, para 60
397 Williams T133.6–7; Williams WS0000019171, paras 30–31
398 Williams T133.15–23; WS0000001358 *Incident Investigation Report relating to Gillian Astbury*
399 Suarez WS0000012493–94, paras 61–61
400 Turner T50.43–44

consuming.[401] To the extent that this is the case, it must discourage busy professionals from embarking on the process.

Complaints

2.333 During the first inquiry, distressing experiences of many patients and their families were heard and reproduced in the second volume of the report of attempts to bring about change through the complaints system. Some of that evidence was repeated to this Inquiry. There were a number of themes which can be illustrated from the evidence of just one complainant, Mrs Dalziel:

- Lack of information about the system: Mrs Dalziel complained that her family had not been given any information on the person to whom a complaint should be addressed, and had not been told about the Patient Advice and Liaison Service (PALS).[402]
- Lack of effective processing of complaints: Mrs Dalziel had the experience of repeated enquiries as to whether they would like their complaint investigated.[403]
- Failure to address all the points of complaint made: When finally an investigation was undertaken, the letter of response did not address clearly relevant issues about the alleged attitude of nurses to complaints of pain, or an alleged failure to provide further pain relief after an epidural had become dislodged. The initial hospital response also failed to address a complaint that the patient had been lost to the system, delaying treatment which his family thought might have saved his life.

2.334 As with a number of responses I have seen, this one exhibited a tendency to recite uncritically the account given by hospital staff.[404] Unless there is a real and persuasive response to each and every point complainants wish to raise, they will not begin to accept or trust in the response that is made. As Mrs Dalziel said:

> *I don't think anything ever satisfied us, really, because we never, ever got the answers that we really wanted. It was always "We're going to look into things". So, no, we just didn't feel that we were satisfied at all.*[405]

2.335 The complaints system failed to take sufficiently into account the distress and grief of many complainants, particularly the bereaved. The feelings of relatives who have lost loved ones are very strong and lead to deep seated grievance unless great care – not readily provided in formulaic responses – is taken in dealing with their complaints and concerns. Insufficient thought is given to the impact of letters sent to grieving people:

401 Turner T50.44–46
402 Dalziel T11.165–166
403 Dalziel T11.69–70
404 Dalziel T11.72–78
405 Dalziel T11.78

Well, I think at the time, when I was getting this letter, nothing really satisfied me at all because I was grieving for my husband, and I don't think I really took in everything that they were saying. It was mainly my daughter and my son-in-law that had done most of the communications for me. I just can't explain how I feel. I just felt anger every time I read anything.[406]

2.336 Indeed the result of not getting the complaint process right is that complainants may feel obliged, as did Mrs Dalziel, to launch into legal proceedings when all they wanted was an acknowledgment of fault, a genuine apology, and real assurance that the relevant lessons had been learned and remedial action taken. Mrs Dalziel described the long-term injury, distress and confusion caused by the absence of these things:

Q. It sounds like it has taken quite a long time to get to the stage you're at now.

A. Yes, it's taken three years.

Q. Is that a process that you have found easy or difficult?

A. It's been very – it's been a long time in coming. I found it very, very hard because to be perfectly honest I will never, ever have a closure to what happened to my husband, because they've actually said that he died of a – what do they call it? – a pulmonary oedema and bronchial pneumonia. Inside they've got down that he had a cardiac arrest. And in another part they've said that they don't know why he died. So no matter what's happened in all the court cases, whatever's happened, I will never have closure on what happened to my husband and why he died.

Q. It is obvious that from your point of view the legal proceedings have achieved something.

A. Yes, they have to a certain extent.

Q. But is that the way you wanted to go, in terms of pursuing your grievance against the hospital?

A. Yes, I wouldn't take it any further now against the hospital. That is finished. I can probably start my own grieving process now, which I haven't been able to.[407]

2.337 Dr Coates told the Inquiry that in 2004 and 2005 the Trust had no effective processes for dealing with complaints or for making the changes shown to be necessary by them.[408]

2.338 Sharon Llewellyn, who arrived at the Trust in the late 1990s and worked there as a Complaints Manager, told the Inquiry that at that time there was no governance structure. At the time,

406 Dalziel T11.76
407 Dalziel T11.87–88
408 Coates WS0000004852, paras 11–12; T50.137–140

the complaints department consisted of her and a secretary, with an assistant being added later. She was responsible to the Head of Corporate Services and the Chief Executive. She introduced a Complaints Review Group which included two non-executive directors and reported direct to the Board. While the Chief Executive, Mr O'Neill, would check all response letters, the shortness of the required response time meant the:

> *... system was driven by timescale rather than quality.*[409]

2.339 If complainants were unhappy with the response, meetings with the relevant directorate were offered so that the complainant could discuss the complaint with the staff involved. If the complainant remained unhappy, the matter could be referred to an independent review panel which included an independent chair, a clinical assessor, and a representative of the PCT. The panel would produce a report. If the complainant remained dissatisfied they could go to the Parliamentary and Health Service Ombudsman (PHSO).[410]

2.340 In 2004, when the regulations governing complaints changed, the review group was abolished and replaced by a Quality Monitoring Group on which no directors sat. The reason given was the panels were taking up too much of the directors' time. The independent panels were abolished and second stage complaints were referred to the HCC. For a time, management of complaints was made more complicated by the removal of the complaints department off site. This made contact with relevant clinical staff and investigations generally more difficult.[411] The pressure of complaints referred to the HCC overwhelmed that organisation, leading to a large backlog.

2.341 Ms Llewellyn said that by 2005 the pressure on the Complaints Manager, and an understaffed and under resourced department, was "horrendous". She was required to produce reports for the Quality Monitoring Group, which she regarded as statistical without any level of detail. Little time was spent at meetings discussing complaints.[412] One problem appears to have been the adherence to the DH categorisation of complaints, required for reporting purposes. These were very broad indeed, one being "all aspects of clinical care".[413] Ms Llewellyn set about breaking this down into more useable categories, aligning these with the standards of the National Patient Safety Agency (NPSA).[414] In light of her evidence, there appears to be a case for a more analytical approach, which may mean reviewing the way in which complaints are categorised and making this more flexible. The information reaching the Board about complaints was sparse and unhelpful. According to Peter Bell, specific complaints were never considered, and reports were largely numerical and referred to broad categories. If the

409 Llewellyn WS0002000459–60, paras 9–13
410 Llewellyn WS0002000460–1, paras 15–19
411 Llewellyn T29.60–61
412 Llewellyn WS0002000467–8, paras 45–47; T29.52–544
413 Llewellyn T29.57–58
414 Llewellyn T29.58–60

numbers changed, the Director of Nursing would be questioned, but assurances seem invariably to have been given.[415]

2.342 Ms Llewellyn also disapproved of the greater standardisation of response letters and reports which were designed to align with the regulatory requirements. This led to reports being very similar to each other, and often identical in respect of particular issues. She felt, correctly, that complainants preferred personalised responses.[416]

2.343 Martin Yeates was clear that when he arrived the system for responding to complaints and taking remedial action was deficient, but that it improved after the arrival of Dr Moss at the end of 2006. She vetted responses and, he thought, ensured that required actions were taken.[417]

2.344 Dr Turner, once appointed clinical lead for A&E, had to deal with complaints about that department. From that perspective, he thought the Trust was not good at explaining why something that had happened had been a matter of clinical judgement which will not always produce the perfect outcome for the patient. He thought complaints handling was very reactive in a way which produced the assumption that if a complaint was made there would never be a recurrence of the incident. In some cases, such as the choice of drug causing a rare adverse reaction, it would be wrong to give the impression that the drug was not going to be used in future. He felt that the Trust was not good at producing explanations which complainants could understand.[418]

2.345 The Inquiry heard that PALS ceased to work well after the complaints department was merged into customer services in mid 2007. Experienced staff left and a reduction in resources meant fewer staff of any type. As a result, it became overwhelmed. Sometimes matters became so desperate that a person with a question would be advised to make a formal complaint as they might obtain a quicker response. Because staff were relatively junior they could only report back to a caller what they had been told rather than exercise any judgement about what was said.[419] A little discussed value of PALS is the support that a well run service can offer to patients and others who have a concern but do not want to be involved in a formal complaint. Many people are unduly diffident about formal processes of that kind, but their concerns should be as valued and respected as those who do make formal complaints.

National Patient Safety Agency Alerts

2.346 Between April 2008 and June 2010, the Trust received six letters from the NPSA indicating a cause for concern about compliance with patient safety alerts. Such letters were intended to

415 Bell WS0000007742–43, paras 64–66
416 Llewellyn WS0002000487, para 128
417 Yeates WS0000074942, para 74
418 Turner T50.75–76
419 Llewellyn WS0002000495, para 156.6

relate to the 1% most serious incidents, and only 10–20% of trusts received any such letters.[420] Although Trudi Williams had responsibility for collating information about compliance and investigating non-compliance, when this was drawn to her attention, she had a limited understanding of how exceptional such expressions of concern were. One case from February 2008 involved a patient in septic shock whose survival was seriously threatened because of a three-hour delay in administering antibiotics. The NPSA requested details of the investigation, but it turned out there had been none. An investigation only occurred as a result of the NPSA letter. At the time, it was the responsibility of the line manager to decide whether an incident warranted escalation to senior management for investigation.[421] A system which relies on a manager who may be potentially affected by an investigation to make a judgement of whether there should be one, is clearly deficient.

Lack of effective input from the regulatory system

2.347 A key weakness of the regulatory system was highlighted by Dr Coates: while they may have been ineffective, the fact that systems for addressing complaints and incidents existed enabled the Trust to appear compliant with the required standards. He expressed astonishment at the nature of the answers given in some regulatory returns, and made it clear that although he was the governance lead he was not consulted on them.[422]

2.348 Dr Moss said this about the lack of impact of regulation:

> *Their main concern in relation to governance would have been to determine that there was a governance structure in place, which there was. However, I could see from a structural point of view, as well as a cultural point of view, changes were required. I think that the HCC would only have been concerned with whether we had governance routes in place and not whether things flowed through the system effectively. It appeared that the extent of process was of concern, not the quality of reporting.*[423]
>
> *You can put processes in place and they are there designed to work, but you have to change the hearts and minds and culture as well to go along with it.*[424]

2.349 The result was that when the Trust declared compliance to the HCC with standards which included clinical audit and review of clinical services it was able to produce satisfactory evidence in support of its claim. It is clear that this resulted from a focus on systems rather than the outcome of those systems. This was the prevailing attitude at the time, and it is not accepted that a failure to declare non-compliance because of a lack of effectiveness, even if there were concerns about that, amounted to dishonesty. There was a system to comply with

420 Williams T133.28; Woodward T102.62
421 Williams T133.3133
422 Coates WS0000004857–58, para 29, T50.142–147
423 Moss WS0000009480 para 78
424 Moss T62.62

and those like Dr Moss were doing their best to fulfil what was seen as a bureaucratic requirement. As she put it:

> *I think we were making good progress with the governance arrangements and we were getting more engagement with the staff and also we were getting – we were seeing increased reporting, we were seeing things that were going in the right direction ...*
>
> *... We were compliant against what were the requirements of the – of the submission ...*

2.350 She accepted that in hindsight compliance should not have been declared in all areas where it was but:

> *It comes back to ... the requirements ... from the Healthcare Commission of what was – what did compliance look like.*[425]

2.351 This attitude would have been reinforced by the fact that when the HCC undertook an inspection of governance, it confirmed compliance.

Conclusion

2.352 It seems quite extraordinary that the general acceptance of the importance of clinical governance, and in particular clinical audit, which had been recognised nationally from the time of the Bristol Royal Infirmary Public Inquiry report in 2000, if not before, had failed to permeate sufficiently into Stafford to result in a functioning, effective system by 2009. The evidence fully supports the description of the Trust's clinical governance process throughout the period with which this Inquiry is concerned as "vestigial".[426] The absence of such a system meant that the leadership of the Trust was bound to be blind to many concerns which it took the HCC to uncover by its investigation. It is clear that there was insufficient appreciation of the urgency of putting right the deficiencies in governance of which those in charge were aware. As Dr Suarez accepted in relation to the A&E department, where it was known not only that governance protocols were not in place but the department was grossly understaffed with only one consultant, the lack of effective clinical audit could lead to the development of an unsafe service quite quickly.[427] This seems the equivalent to a ship's captain putting to sea in a fog knowing the radar is not working.

2.353 An important element of any clinical governance system is the system for handling and processing complaints and incidents. The evidence shows that there were many deficiencies in both. Issues remained unaddressed, learning opportunities were denied through lack of feedback, and reporting to the Board and beyond failed to reflect the gravity of what the

425 Moss T62.69–72
426 CL0000003416 *Counsel to the Inquiry's closing submissions,* Chapter 9, The Trust, para 100
427 Suarez T59.40–41

complaints and incidents were capable of revealing. Most importantly, patients and those close to them were left with unresolved grievances, sometimes to fight on through appeals or litigation or to abandon hope of any constructive outcome, but often to suffer the insult, and sometimes injury, of being effectively ignored.

Patient surveys

2.354 The 2005 survey, published in 2006, indicated that the Trust was in the worst 20% of hospitals with regard to patient feedback on whether there were enough nurses on duty to care for them,[428] and also the question "After you used the call button, how long did it usually take before you got help?" It scored only about 4/100 in answers to the question "While in Hospital were you ever asked to give your views on the quality of your care", although even the best performing hospital only scored 23/100.[429] However, it was not in the bottom 20% with regard to patients' overall rating.

2.355 In 2006, the Trust was in the bottom 20% in respect of 10 out of 66 questions asked, including doctors and nurses washing their hands, nursing numbers, and a number of information related issues. It remained outside the bottom 20% on patient assessment of the overall quality of care.

2.356 In the 2007 survey, the Trust was in the bottom 20% in its patients' answers in over 46% of the questions asked (32 out of 69). Low scores were seen in relation to the cleanliness of A&E, doctors and nurses' hand hygiene, various communication issues, response to call buttons, respect and dignity and the overall quality of care.

2.357 The 2008 survey showed, on the face of it, an improvement: the Trust scored significantly low marks in only 12.7% of the questions (9/71), but these included nurse staffing levels, respect and dignity, doctors and nurses working together and overall quality of care.

2.358 2009 produced very bad results: the Trust's scores were in the bottom 20% in nearly 49% of the questions. Nurse staffing continued to show up as an issue, as did hand hygiene, confidence and trust in doctors, pain control, discharge delays, and doctors and nurses working together. The Trust scored the lowest mark in the range of scores for patients wanting to complain. The score for overall quality of care was also very low.

2.359 This type of statistical exercise has limitations. For example, it might be expected that some patients would fail to understand entirely reasonable explanations, or be hypercritical of hygiene or cleanliness standards, or simply forget or misunderstand the true nature of their experience. It might be argued that the 2009 figures were bound to be affected by the adverse publicity to which the Trust was subjected that year. However, the 2008 results were

428 SHA0021B000036
429 SHA0021B000038

little better. Of course, in the case of very few scores was the Trust actually bottom of the table, and the range of scores for some questions was in a narrow band at the higher end of the scale suggesting general compliance. To take reassurance from that would, however, be to accept tolerance of potentially unacceptable practice in a relatively small number of cases. For example, to score 20/100 as the Trust did in 2009 for receipt of hospital letters, when the range was between 90/100 and 10/100 does suggest at the very least a serious administrative problem. It is unlikely that the score can have been significantly affected by patients misunderstanding the question. A score of 86/100 for confidence in the doctors and 81/100 in the nurses suggests an alarming proportion of patients who did not have confidence. It should be no comfort at all that the majority of patients trusted the healthcare professionals attending them.

2.360 The HCC and the Picker Institute also conducted a series of patient surveys focused on those who attended A&E. In 2003, the Trust came in the bottom 20% in relation to 14 out of 34 (41%) questions asked.[430] These included trust and confidence in the doctors and nurses and waiting time for assessment of priority. In the 2004/05 survey, that figure had risen to 23 out of 40 (57%).[431] Notable were the negative comparative response rate in relation to pain control and the overall rating of care. The next survey took place in the first three months of 2008 and was published later that year.[432] While the proportion of response rates in the lowest 20% was reduced to 11/38 (28.9%), patients were negative in terms of trust for doctors and nurses, cleanliness, pain control and overall care.

2.361 While these figures showed consistent cause for concern, as Peter Bell pointed out there were limitations to the use to which these figures could be put, as they were published quite a long time after the survey had been taken. While the delay appears to have reduced in the latter part of the period, many months elapsed before the Trust had access to the results. He said:

> *We were concerned that patients' surveys were not rating the Trust very highly. We thought we had taken steps to improve the patients' perception of the hospital care. I think the last survey took place in approximately September/October 2007 and related to patients who had been treated some four months earlier than the survey took place, with the results being issued to us six to nine months later. Accordingly, when we saw the results, we were looking at historic information. How could we measure such feedback when the data was so old?*[433]

430 SHA0021B000001 *CQC Reports and Initial Analysis on Patient Satisfaction, NHS Acute Trusts Survey of Emergency Departments 2003*
431 SHA0021B000018, *Patient Survey Report 2004/2005 – Emergency Department Survey,* An HCC analysis [HCC0023000735] suggested that the figure was 22 out of 36 questions, but the effect is the same.
432 SHA0021B000074, *Patient Survey Report 2008 – Emergency Department Survey;* see *Annex X*
433 Bell WS0000007741, para 59

Staff surveys

2.362 In addition to the patient surveys considered above, the HCC commissioned surveys of staff opinion and experience. These, too, showed a concerning picture.

2.363 The 2005 NHS National Staff survey revealed that only 53% of the Trust's staff had received an appraisal in the previous 12 months. Derek Thomas, Head of Medical Staffing, explained that this was the figure for all, not just medical staff, and did not necessarily reflect the appraisal rate for medical staff, who were required to have one annually.[434] However, a mere 32% of staff "felt that patient care or service users are the Trust's top priority".[435]

2.364 In 2006, the survey showed that 47% of respondents from the Trust did not want to be treated in their own hospital.

2.365 The response internally was complacent. The 2006 result was reported in the Trust Board minutes[436] and in the JNCC minutes of 12 April 2007 (see paragraph 7), but the JNCC minutes recorded only positive results, and no consideration of the significance of the negative ones. As Cure the NHS said in their closing submissions to the Inquiry:

> *The Trust's response appears to have been to commission an internal staff opinion survey to rebut that of the HCC – a response not unlike that to the mortality figures in 2007.*[437]

2.366 References to the survey seem to disappear from the minutes until it is resurrected at paragraph 5 for the minutes of 14 August 2008, in which Ms Gynane, the HR Manager, suggested a further survey to be undertaken, this time of "culture", and Mr Legan, an RCN representative, said that this will get an even lower staff response than the annual staff survey.

2.367 The 2007 survey (published in 2008) was not encouraging. A report to the Trust's Hospital Management Committee on 21 July 2008 indicated that out of 26 "key score areas" there had been no statistically significant improvements and a significant deterioration in five areas including:[438]

- Fairness and effectiveness of procedures for reporting errors, near misses or incidents;
- Availability of hand washing materials;
- Staff job satisfaction;

434 Thomas T49.102
435 TRU00010002910 *Human Resource and Organisational Development Strategy* (2007–2012), at TRU00010002938
436 TRU00010011706, Minutes of the Trust Board Meeting, (3 May 2007)
437 TRU00010002542, Minutes of meeting for Joint Negotiating and Consultative Committee (14 June 2007) at para 7 TRU00010002543; TRU00010003003, Minutes of meeting for Joint Negotiating and Consultative Committee (11 October 2007) at para 6, TRU00010003006
438 ESI00046876 Report to Government of Results of NHS Staff Survey 2007 by Head of HR (16 June 2008)

- Work pressure felt by staff: a mere 17% of respondents felt there were enough staff to do their job properly and 52% said they did not have time to carry out all their work.

2.368 In 14 areas the Trust fell into the bottom 20% for acute trusts including, as well as the ones listed above, the following:

- Incidence of staff appraisals;
- Support from senior managers: only 47% were satisfied with support from immediate managers and 21% with the extent to which the Trust valued their work;
- Harassment, bullying and abuse from staff;
- Perception whether Trust action on harassment and violence was effective.

2.369 Despite this wide-ranging catalogue of staff concerns, the proposed action plan was intended to address only the four areas where the Trust was in the bottom 20% and the results that had deteriorated since the 2006 survey. The proposed remedy for work pressure was increased investment in nursing and support worker staff levels, the lack of progress on which is documented elsewhere in this chapter.

2.370 The staff surveys continually gave signs of substantial staff dissatisfaction with the way the Trust was run. Trust management reacted to this with various action plans, but dissatisfaction persisted, albeit not always in response to the same questions. Such surveys were not of as much assistance as they might have been because of the delay before the results became available, but they could and should have indicated to the wider system that all was not well on a persistent basis. That the results caused no very significant external reaction could be due to inattention, but it is more likely due to the lack of importance accorded to this source of information.

Whistleblowing

Nurses

2.371 The Inquiry has examined a series of "whistleblowing" policies adopted by the Trust during the period under review.[439] It is unnecessary to set out the detail here, but they all had the clear objective to empower employees to raise concerns and to ensure that those concerns, where valid, were acted on. Employees raising issues were to be protected and supported, where possible, by measures including respect for confidentiality.

2.372 As has been remarked earlier, Mr Newsham was for some of the material time the Executive Director with responsibility for whistleblowing and was the first point of contact for about five or six cases. Before then he had commissioned the highly critical report from Dr Robina Barry

439 TRU00000001060; CLJ/2 WS0000057107

in response to an approach from a whistleblower. My criticisms of his approach to the matter have also been made evident earlier. There is no evidence that the whistleblower received any support.

2.373 While it has been commented on with surprise that very few members of staff seem to have expressed their concerns – a criticism which has less force when the large number of incident reports is looked at – the experience of Helene Donnelly illustrates one reason why they may have been deterred from seeking to exploit the so-called protection available to whistleblowers.

2.374 Ms Donnelly was a most impressive and courageous witness to the Inquiry, visibly still suffering from the effects of what she had experienced while employed by the Trust. As described in *Chapter 1: Warning signs*, she had witnessed repeated poor and even fraudulent practice in A&E, but ascribed her initial reluctance to report it or complain about it to fear of the repercussions and a lack of visible support or feedback when concerns were raised:

> *The fear factor kept me from speaking out, plus the thought that no one wanted to know anyway, due to the lack of response to the Incident Report forms I had logged. I felt that external bodies would have told me that it was necessary to exhaust all internal mechanisms first before they would fully consider my complaints.*[440]

2.375 When she did summon up the courage to raise her serious concerns, initially the response was positive, but the way in which the investigation was conducted was not encouraging to potential complainants and witnesses. Obvious invitations for interview were left in nurses' pigeon holes and they had to leave shifts in front of colleagues to attend. Little thought was given to the effective protection of anonymity.[441]

2.376 The sisters against whom she complained were returned to the department and were publicly described by the Director of Operations (Karen Morrey) as the "A-team", although apparently Ms Morrey remained in ignorance of the investigation or the disciplinary process. The Trust accepts that there is no complete record of the disciplinary process and no formal determination appears to have been made about whether Staff Nurse Donnelly's allegations were accepted or not. The evidence before the Inquiry suggests that the Trust did not take her complaint seriously. Even if that was not in fact the case, it was inevitable that the impression given to those who knew a complaint had been made was that it was not worthwhile doing so.

2.377 Ms Donnelly was offered no adequate support. She had to endure harassment from colleagues and eventually left for other employment. Clearly such treatment was likely to

440 Donnelly WS0000022299, para 12
441 Donnelly T133.138–140

deter others from following her example, and she was aware of colleagues on whom her experience had this effect.

> *... threats were made, both directly and indirectly, friends of hers and the other sisters would make threats to me. People were very often coming up to me in – trying I think in a helpful way to tell me to, I quote "watch my back", ... and people were saying, "Oh, you shouldn't have done this, you shouldn't have spoken out". And then physical threats were made in terms of people saying that I needed to – again, watch myself while I was walking to my car at the end of a shift. People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where I had to at the end of a shift ... at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.*[442]

2.378 This behaviour continued even after she reported it:

> *It was slightly more subversive and I think people were slightly more guarded in how they were doing it. You know, on one particular occasion another staff nurse followed me into the toilet which was also our locker room and locked the door behind her, locking me in, and demanded to know if I had a problem with her and if I was going to say anything about her, and basically threatening me not to do so if I did. And I immediately then reported that to Paula Gardner at the time, saying that this had happened. So people were still doing things, but not so publicly, in terms of sort of in the middle of the department where other people could perhaps hear. They were doing it slightly more discreetly, I suppose.*[443]

2.379 She sought support from her union, the RCN, through Adrian Legan, a full time officer, who, without disclosing it to Ms Donnelly, had assisted the nurses against whom she had complained. His advice was to the effect that she should "keep her head down" when the nurses were reinstated. Effectively, he told her there was little which could be done. When Ms Donnelly found out that he was representing the others, she was understandably upset:

> *I felt completely on my own.*[444]

2.380 Predictably, Ms Donnelly only remained in the Trust's employment for a further few months. She felt, rightly or wrongly, that management had known about the practices in A&E, of which she was complaining, of massaging records to comply with targets. The references of Karen Morrey to the nurses in question as her "A-Team" did not help.[445]

442 Donnelly T133.134
443 Donnelly T133.137–138
444 Donnelly WS0000022303–4, paras 26–30
445 Donnelly T133.149–150

2.381 Since she has left the Trust remaining colleagues have told her they have felt deterred from raising concerns because of what happened to her. Her evidence exposed the hollowness of the promises in the whistleblowing policy:

> *Even perhaps being aware of a Whistleblowing policy, it's all very well to write that down and have that as the policy, but my experience and their witnessing my experience was such that what actually happened in reality wasn't what was, I suppose, offered within the Whistleblowing policy ... You can have those policies in place, but if they don't actually act in reality, then people are not ever going to feel that they can come forward and voice concerns without fear of repercussions.*[446]

2.382 She was able to contrast her experience at Stafford with the approach at her current employer. There was an open door policy and a positive response offered to any expression of concern. There was constant support, supervision, regular team meetings, and proper appraisals.[447]

2.383 In spite of her experience Ms Donnelly said she would do the same again if necessary and advised others to do so:

> *I think you'd asked me the question of what really – what spurred me to act, and I think it was because I'd seen people die, needlessly I think in some cases, but certainly with a lack of dignity or respect, and that was so distressing to me and it wasn't just once or twice that happened, it was relatively frequently, and that was really for me what upset me then and now but was really the reason I had to speak out.*[448]

2.384 Sue Adams, an RCN representative, and herself a senior manager in the Trust in the day unit, suggested that staff were deterred from raising concerns because of the bullying culture in which the impression was given that people should be careful what they said. When she herself raised issues, she was made to feel as if she were whingeing and she did not feel she was treated with respect. She alleged that Karen Morrey would tell staff that unless they stopped moaning, they would lose their jobs.[449] Ms Morrey vehemently denied that allegation with obvious emotion, telling the Inquiry that the only person she said might lose her job was herself and that she went out of her way to be accessible to staff generally and to liaise with Sue Adams in particular.[450] It is not possible to be satisfied on an issue where there is such a direct conflict of evidence that Ms Morrey did directly threaten people, as alleged by Ms Adams. While the latter was far from a robust trade union representative, it is difficult to believe that, if she had been directly bullied she would not have complained about it. What is

446 Donnelly T133.172–173
447 Donnelly T133/161–162
448 Donnelly T133.178
449 Adams WS0000003871, para 72
450 Morrey T61.127–128

more likely is that the general conduct of management, driven as it was by the perceived importance of targets, conveyed the impression that jobs would be lost if they were not met and no complaints about the means to get there would be welcome.

Doctors

2.385 Doctors who sought to raise issues of concern fared little better than the nurses. Consultants, being professional leaders governed by a code of conduct and professional oath requiring them to put their patients' well-being as their first priority, might have been expected to act robustly in the face of hindrances to their ability to provide safe and effective treatment. There seem to have been a relatively small number of doctors who took any action at all to pursue concerns of this nature.

2.386 The efforts made by Dr Daggett to raise concerns have already been considered above. He was constantly raising issues with senior management from 2001 to 2008 and beyond. The response was one of apparent indifference and certainly included no effective action to address the points he made. He told the Inquiry that there were four or five consultants who tended to raise complaints, but they were seen as "naughty boys".

2.387 While the evidence supports what was heard during the first inquiry regarding the disengagement of doctors, it does not explain why no clinician (even amongst those who did raise matters internally) appears to have taken his or her concerns outside the Trust to a regulator, the PCT or the SHA. Dr Daggett's only explanation was that he had no current understanding of the roles of these various bodies.[451] He felt unable to go to his MP at the time, Mr David Kidney, because Mr Kidney had expressed favourable views of the Trust after doing work experience there. He did not approach the General Medical Council (GMC) because he considered the problem was with the organisation as a whole rather than there being an issue about a doctor's fitness to practise.[452]

2.388 Dr Daggett even suggested that he was unaware of the existence of the HCC. A number of other bodies, not including the HCC, were mentioned in the Trust's whistleblowing policy, but he felt that none of them were appropriate recipients of concerns about staffing levels, and in any event a degree of deterrence existed by the reference to disciplinary procedures. [453]

2.389 Dr Pradip Singh, a Consultant Gastro-Enterologist, was particularly preoccupied with the lack of secretarial support, but also about the lack of availability of nurses to accompany consultants on ward rounds, a matter he regarded (with some justification, given what is now known about the deficiencies in record-keeping and nursing handovers), as causing clinical risk for patients.[454] Yet on an occasion when he noticed particularly poor care of a friend he was

451 Daggett T46.86
452 Daggett WS0000003785–786, paras 45–49
453 Daggett T46.32–33
454 Singh WS0000004740–742, paras 39–46

visiting, he did not, as he accepted in evidence, do anything about it. His explanation was that he was not visiting the patient as a consultant and he had raised general issues in his letters. He also felt inhibited in raising concerns directly because he felt the Trust had an atmosphere of not welcoming criticism.[455]

2.390 Another matter of concern for him was the performance of an individual surgeon. He had not raised his concerns outside the Trust because he felt that would have been an exceptional thing to do, and that he had done all he could by communicating his concerns through his line management. He said he had not been aware of what the HCC did. However, five months after the start of the HCC investigation, he had gone to them on his own initiative to report his concerns to them; he could not explain why he had waited for that period.[456] With regard to the PCT and the SHA, he felt these organisations were either too remote or changeable to be approachable. He did know about Monitor and the fact that it was assessing the Trust for FT status and in hindsight thought it possible he should have approached them.

2.391 In answer to the question why he had not done more to voice his concerns about patient care he in effect said he was brave but not brave enough:

> *Q. How do you answer the criticisms that I suppose might be made that if you'd cared more you would have gone outside the hospital and raised, as one might put it, merry hell?*
>
> *A. I would have then ended up becoming either a stroke or a heart attack, and being on the road.*
>
> *Q. You mean out of a job?*
>
> *A. Yes. Clear and simple. And I am brave – I mean, what I did take a lot of guts – takes a lot of guts to do. But I'm not Nelson Mandela ... You're always watching your back. At the end of the day, I'm a human being. I might make a mistake and that could be the end of my career, because it will be used against me. Because the kind of job we're in, things will occasionally go wrong. It doesn't matter how good you are, and then that will become the excuse for destroying your career.*[457]

2.392 The impression given by this witness was of a professional who felt he had done his best to raise issues, but when that failed to have any effect he became disillusioned and gave up, focusing on getting on with his job, in part for fear of the effect on his career of continuing to make a fuss. Dr Singh's feelings in this regard are likely to have been influenced by his experience in March 2009[458] of having been suspended following an incident in which he

455 Singh T46.143–144
456 Singh T46.145–149
457 Singh T46.150–151
458 Singh WS0000004752, para 94

complained to nursing staff about not being accompanied on a ward round.[459] He was reinstated after the arrival of Dr Obhrai as Medical Director immediately with an apology.[460] The suspension appears to have been in response to a complaint about his behaviour at the time of the incident, with an allegation of abusive language and behaviour against staff.[461] He has alleged that this was victimisation due to him raising concerns.[462] However, while his belief in that is probably genuine, it is not possible, on the evidence presented, to confirm that there was any ulterior motive in the action, however unwise it might have been. This is an example of something seen all too often in the treatment of complainants raising concerns relevant to patient safety. A greater priority is instinctively given by managers to issues surrounding the behaviour of the complainant, rather than the implications for patient safety raised by his complaint.

2.393 A doctor who was not a consultant at the time, but only a trainee and a newcomer to the Trust (albeit a relatively senior one) was more proactive than many of his more senior colleagues. Dr Turner was clearly appalled at what he found on arriving at the Trust's A&E department. What he did is described in *Chapter 1: Warning signs*, and in the A&E section in this chapter. Even though it might be thought that a trainee was more vulnerable to fears about the affect on his future career, he clearly went to anyone he could think of to voice his concerns, including a representative of the College of Emergency Medicine and the HCC. It appears to have been contact with the former which resulted in his being approached by the Deanery for feedback. He was not put off by negative responses.

2.394 Dr Turner did not regard himself as a whistleblower:

> *I regarded myself as a professional who was attempting to understand if it was just me that felt that this was an unacceptable state of affairs, and whether or not other people were saying "No, actually, this is – this is okay and you can do this, this and this, and this will help to change the direction".*[463]

2.395 He turned to the HCC because he felt he was not being listened to elsewhere:

> *By that point I felt as though my voice was, if not a lone voice, my voice wasn't really being heard and that it was difficult, if not impossible, for me to have an impact upon the culture that existed within the emergency department.*[464]

459 Singh WS0000004754, para 102
460 Singh WS0000004755, para 105
461 PS/10 WS0000004828
462 Singh WS0000004755, para 104; PS/10 WS0000004827
463 Turner T50.24
464 Turner T50.26

2.396 He derived support from this contact as it appeared that what he was telling them was consistent with other information they had received. It is also fair to record that Dr Turner experienced no recriminations from within the Trust since he communicated his concerns to the HCC.[465] His promotion to consultant confirms that.

2.397 Many would regard Dr Turner as having been particularly brave, given his junior status, to take the highly visible steps that he did to bring the appalling state of affairs to the attention of others. However, he did not see what he did as anything other than what should be expected of all doctors:

> *THE CHAIRMAN: If I may say so, not everyone, I imagine, who comes in like that would be as willing as you were to put your head above the parapet and express the views that you have, or would you say that you would expect that of colleagues of that level of seniority?*
>
> *A. To be honest, I would expect it. I would expect doctors of that level to recognise what they saw as good and to stand up and say when they did not feel that the quality of care that was being delivered was good enough. And I would be surprised if people didn't.*[466]

Conclusion on whistleblowing

2.398 Much has been said at this Inquiry about "whistleblowing". The experiences described here do not suggest that, whatever system is in place, it will be easy for staff to raise concerns which are not accepted by those for whom they work. Theoretical protection is provided by the Public Information Disclosure Act 1998, but this is unlikely to be of much reassurance to staff who have to face the wrath of their colleagues. Julie Bailey thought that nursing staff would be "petrified" to come forward.[467] The then Chief Nursing Officer, Dame Christine Beasley, thought that it was very difficult to persuade staff to come forward, particularly without strong individual support:

> *I don't think we've got enough individual support for people who whistleblow. I think it's a very stressful experience. It's often a very difficult journey you go down. It feels to me organisations need to be much more explicit about what the support – I mean, obviously some places do, as ever, but what support individuals need in order to go through that process. Perhaps not for every bit of whistleblowing, but when it's very, very serious, it's very, very difficult.*[468]

465 Turner T50.89
466 Turner T50.82
467 Bailey T10.58
468 Beasley T117.143

2.399 This was demonstrated by Dr Whitehouse, a junior doctor not employed at the Trust, who gave some general evidence in support of a relative and showed a considerable degree of anxiety about doing so even though objectively it might have been thought he had little to fear:

> *Q. How easy has it been to come here, as it were, and to give evidence? ...*
>
> *A. It's been a big burden to hold... it's a difficult question to answer, in the sense that I am a relative. However, I must appreciate I am also a doctor and in the eyes of the public I'll always be a doctor, one would hope. But it's been very difficult. I have been advised on by many different people, by many different senior doctors, healthcare professionals that I need to be careful. And whether or not that's paranoia, I'm not sure, but we're all conscious of our vulnerability as healthcare professionals.*[469]

2.400 Ken Lownds of CURE made the point that regardless of protective legislation and policies it was the culture that mattered. Without a positive culture it would never be easy to raise concerns. Peter Walsh of AvMA made a similar point.[470] They are correct: whistleblowing is only necessary because of the absence of systems and a culture accepted by all staff which positively welcomes internal reporting of concerns. If that culture is absent then raising concerns external to the system is bound to be a difficult and challenging matter exposing the whistleblower to pressure from colleagues. Therefore the solution lies in creating the right culture, not in focusing on improvements to whistleblowing legislation, important though such protection is.

469 Whitehouse T13.109
470 Lownds T20.101; Walsh T23.149

Summary of recommendations

Recommendation 12

Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.

Recommendation 23

The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations.

The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff:patient ratios.

Recommendation 274

There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.

Chapter 3
Complaints: process and support

Key themes

- The reluctance of patients and those close to them to complain, in part because of fear of the consequences, and other barriers to organisations receiving complaints need to be addressed.
- Support for complainants, whether or not they are specifically vulnerable, with advice and advocacy still requires development; in particular, it should be clear that advocates can offer advice on the substance of the complaint that is required, and information should be provided on available support organisations.
- The feedback, learning and warning signals available from complaints have not been given a high enough priority.
- Information about the content of complaints should, where permissible, be made available to and used by commissioners and local scrutiny bodies; the Care Quality Commision (CQC) should use material from complaints more widely.
- There is a case for independent investigation of a wider range of complaints.

Introduction

3.1 The receipt of and processing of complaints from patients, their families, carers and other representatives is, or should be, at the heart of any system for ensuring that appropriate standards of care are maintained. A health service is not only for their benefit, they are most likely to know whether the service has met their needs. A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment.

3.2 A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service.

3.3 In the case of Stafford, although the complaints of individuals were many in number, and provided graphic proof that something was seriously wrong at the Trust, the complaints were

received into a system that failed to draw the necessary alarm signals from them, let alone the relevant lessons. As pointed out by Action against Medical Accidents (AvMA), it was only the activities of Cure the NHS (CURE) which brought the enormity of the message to be gained from them to the attention of the healthcare system.

3.4 It is therefore necessary to undertake some analysis of how the complaints process operated over the period under review and the nature of the support available to those who complained.

General comments about the complaints system

3.5 A comprehensive history of the reforms to the NHS complaints system in so far as it related to the provision of primary care was set out by Dame Janet Smith in the Fifth Report of the Shipman Inquiry, published in 2004.[1] A number of points remain relevant today in the context of the NHS system as a whole.

3.6 Dame Janet referred to 1996 and 1999 research evaluations of the system, as it then existed. These pointed to a number of concerns which included:

- A lack of fair procedures;
- Failure to investigate complaints properly;
- Failure to give adequate explanations;
- Failure to take account of the inherent imbalance of power between healthcare professionals and patients, including the patient's fear of retribution;
- Lack of impartiality in organisations investigating their own conduct;
- Absence of accountability to an external body;
- Complaints handlers' lack of necessary skills;
- High levels of dissatisfaction among complainants with all levels of the system.[2]

3.7 Dame Janet also referred to a 2001 Commission for Health Improvement (CHI) report into a case concerning the conduct of a GP which had criticised "an NHS culture that did not listen to complaints or treat them inquisitively [and] ... an NHS complaints system failing to detect issues of professional misconduct".[3]

3.8 Criticism in a similar vein led to the 2003–2004 reforms in the NHS complaints system.

1 *Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, www.shipman-inquiry.org.uk/5r_page.asp
2 *Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, Chapter 7, paras 7.45–7.58, www.shipman-inquiry.org.uk/5r_page.asp
3 *Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, Chapter 7, para 7.59, www.shipman-inquiry.org.uk/5r_page.asp

Policy and legislative framework

3.9 *NHS Complaints Reform: Making Things Right* was published in April 2003. It stated:

> *2.8 Patients and staff have told us – informally, and formally through an independent evaluation study and subsequent listening exercise – that this is often their experience of the NHS approach to complaints at the present:*
>
> - *it is unclear how, and difficult to, pursue complaints and concerns;*
> - *there is often delay in responding when concerns arise;*
> - *too often there is a negative attitude to concerns expressed;*
> - *complaints don't seem to get a fair hearing;*
> - *patients don't get the support they need when they want to complain;*
> - *the Independent Review stage doesn't have the credibility it needs;*
> - *the process doesn't provide the redress patients want; and*
> - *there does not seem to be any systematic processes for using feedback from complaints to drive improvements in services.*[4]

3.10 It also commented:

> *2.7 In a patient-centred NHS, patients should feel able to express their views – positive and negative, complaints and concerns – about the treatment and services they received, in the knowledge that they will be:*
>
> - *taken seriously;*
> - *given a speedy and effective response;*
> - *that their views will inform learning and improvements in service delivery; and*
> - *that there is a system for taking action to address the full range of problems which occur – from minor difficulties to major failures in treatment and care.*[5]

3.11 Between 1996 and 2004, the complaints system comprised three stages:

- Stage 1 – Local resolution;
- Stage 2 – Independent Review Panels (IRPs). IRPs were composed of an independent lay chairman, a coroner, and for trust panels, a representative of the purchaser;[6]
- Stage 3 – the Parliamentary Health Service Ombudsman (PHSO).

3.12 The Health and Social Care (Community Health and Standards) Act 2003 then provided for the establishment of the Healthcare Commission (HCC) and for that body to have a role in handling individual NHS complaints.

4 HCC0039000204, *NHS Complaints Reform: Making Things Right* (3 April 2003), Department of Health, para 2.8
5 HCC0039000204, *NHS Complaints Reform: Making Things Right* (3 April 2003), Department of Health, para 2.7
6 Bostock WS0000056088, paras 9–10

3.13 The 2004 NHS complaints regulations came into force in July 2004 and provided the structure for the complaints system until 2009.[7] There were three stages available in the complaints procedure laid down by the 2004 regulations:

- Stage 1 – Patients or their representatives make a complaint to the relevant trust;
- Stage 2 – If patients or their representatives were not satisfied with the relevant trust's response, they had the option of contacting the HCC which would investigate the complaint and the trust's response;
- Stage 3 – If patients or their representatives were dissatisfied with the HCC's decision, they could then ask the PHSO to consider the complaint.

3.14 Certain matters were excluded; a complaint could not be brought in relation to any matter about which the complainant had stated in writing that he or she intended to take legal proceedings.[8] Complainants had six months from the time the event happened, or from when the complainant became aware of the event, in order to complain. However, there was a discretion to investigate a late complaint if the complaints manager (at the relevant trust) considered the complainant had good reason for not making the complaint within the relevant period and it was possible to investigate it efficiently.[9] The substantive response to the complaint, normally to be signed by the Chief Executive, was required to be sent to the complainant within 25 working days unless the complainant agreed to a longer period.[10] The response had to be one which, "summarises the nature and substance of the complaint, describes the investigation under regulation 12 and summarises its conclusions".[11]

3.15 There was no provision in the regulations for primary care trusts (PCTs) either to receive or be notified of complaints or to have any other form of involvement. Trusts were required to prepare quarterly reports on complaints for their boards and to send an annual report about complaints to their strategic health authority (SHA) and the HCC.[12] PCTs may have had access to a trust's complaints data by virtue of the fact this information was reported to a trust's board, but there was no obligation on trusts to provide this data to PCTs.

3.16 If the complainant was not satisfied with the response or if no response was received within the relevant time limit, he or she could refer the matter to the HCC.[13] It is right to record,

7 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], www.legislation.gov.uk/uksi/2004/1768/contents/made
8 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Reg 7(h), www.legislation.gov.uk/uksi/2004/1768/regulation/7/made
9 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Reg 10, www.legislation.gov.uk/uksi/2004/1768/regulation/10/made
10 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Reg 13(3), www.legislation.gov.uk/uksi/2004/1768/regulation/13/made
11 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Reg 13(1), www.legislation.gov.uk/uksi/2004/1768/regulation/13/made
12 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Regs 21, 22, www.legislation.gov.uk/uksi/2004/1768/regulation/13/made
13 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Reg 14, www.legislation.gov.uk/uksi/2004/1768/regulation/14/made

bearing in mind the dissatisfaction that has been expressed since, that the proposal to introduce a second stage involving the HCC had general support at the time.[14]

3.17 Subject to a number of exclusions, including a written intent to bring legal proceedings, and after consulting with a range of stakeholders, the HCC could decide:

> *(a) to take no further action;*
>
> *(b) to make recommendations to the body which is the subject of the complaint as to what action might be taken to resolve it;*
>
> *(c) to investigate the complaint further in accordance with regulation 17, whether by establishing a panel to consider it or otherwise;*
>
> *(d) to consider the subject matter of the complaint as part of or in conjunction with any other investigation or review which it is conducting or proposes to conduct in the exercise of its functions under the 2003 Act;*
>
> *(e) to refer the complaint to a health regulatory body;*
>
> *(f) in the case of a complaint about an NHS foundation trust which falls within regulation 15(2), to refer the complaint to the Independent Regulator; or*
>
> *(g) to refer the complaint to the Health Service Commissioner in accordance with section 10 of the Health Service Commissioners Act 1993.*[15]

3.18 In 2009, the second stage was removed:

- The first stage involved attempted local resolution: patients or their representatives could raise the matter (in writing or in person) with the practitioner, eg the nurse or doctor concerned, or with the relevant trust. The relevant trust was required to have a complaints manager work with the individuals concerned to attempt to resolve the complaint and to ensure that the lessons learned from the complaint were used to improve the service;
- If local resolution failed, the complainant could refer their complaints to the PHSO who would decide whether to investigate matters further.[16]

3.19 The NHS Constitution outlines what staff, patients and the public can expect from the NHS.[17] It explains the rights of a patient, including the right to complain if things go wrong.

14 *Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, Chapter 27, para 27.13, www.shipman-inquiry.org.uk/5r_page.asp
15 National Health Service (Complaints) Regulations 2004 [SI 2004/1768], Reg 16(2), www.legislation.gov.uk/uksi/2004/1768/regulation/16/made
16 Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309, www.legislation.gov.uk/uksi/2009/309/contents/made
17 *The NHS Constitution: The NHS belongs to us all* (8 March 2012), Department of Health, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf

3.20 The NHS Constitution states that patients have the right to:

- Have a complaint dealt with efficiently and properly investigated;
- Know the outcome of any investigation into a complaint;
- Take a complaint to the independent Health Service Ombudsman if not satisfied with the way the NHS has dealt with a complaint;
- Make a claim for judicial review if they believe they have been affected by an unlawful act or decision of an NHS body;
- Receive compensation.[18]

Complaints processing at the Trust

3.21 A description of the experiences of some patients and their families when complaining to the Trust can be found in *Chapter 2: The Trust*.

3.22 The Trust Board was limited in the learning it received from complaints. In particular, it did not receive details of any individual complaints and, indeed, Mrs Toni Brisby, Chair of the Trust, did not review any of them personally. Her reason for this remote approach was that:

> *As far as complaints are concerned, ... individual complaints always risk giving a biased and partial view of what's happening in the trust. A complaint that's investigated properly and resolved is then put to bed and doesn't need to come to the attention of the hierarchy in the organisation, actually. The complaints that aren't resolved and end up with the chief executive have a further route to go, which is to the Healthcare Commission and the ombudsman. We got headline figures of those and there were actually very few and, if I remember, almost none upheld by the Healthcare Commission, which actually suggests that the complaints process was doing what it should do, to deal with complaints.*[19]

3.23 Such an approach completely ignored the value of complaints in informing the Board of what was going wrong, and what, if anything, was being done to put it right. It is difficult to believe that anyone hearing the stories of some of the complaints reviewed by this Inquiry, and the first inquiry, would not have been concerned that there were serious deficiencies in the operation of the Trust's services. In any event, Mrs Brisby's approach appears to assume that the only way a complaint became resolved and concluded at the Trust was by a proper investigation. As has been seen this was far from the case at the Trust.

3.24 However, it is far from certain that a more penetrating look at complaints would have shaken her confidence in the management of the Trust because her instinctive reaction to complaints

18 *The NHS Constitution: The NHS belongs to us all* (8 March 2012), Department of Health, page 8, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf
19 Brisby T129.42

appears to have been a combination of scepticism about their substance and a tolerance, borne of a belief that such complaints were not uncommon in the NHS. She told the Inquiry about the complaints of which she had read in part two of the first inquiry's report:

> *... I have no doubt that some people received poor care in the hospital. I don't think that's in question. I think people get their facts wrong. So whether it's all true, I couldn't say. Most of these complaints haven't been – weren't investigated in detail, because the – Julie Bailey's group didn't want to talk to us, and so I have no idea.*
>
> *... there seem to be two sets of reactions to the part 2 of Mr Francis' report. One is the one that you're I think voicing now, which is that it is really profoundly shocking, and I can absolutely see that. The other is a reaction that I've had from quite a lot of people within the NHS, which is actually that's the sort of thing that goes on in virtually all hospitals, and there but for the grace of God go we. Now, I'm not saying that to defend poor care, because I think poor care is indefensible, but I am saying that Stafford is not a peculiar hospital in spite of the shocking nature of part 2 of the report.*[20]

3.25 Lying behind what Mrs Brisby said was a concern that neither this Inquiry nor the first inquiry had investigated in detail the complaints made by patients, but had accepted the evidence of patients and their families as the truth without testing it against the clinical notes and an examination of the relevant staff. While that is indeed how the two inquiries have approached the evidence of individual cases, this is because in almost every case, the complaints of which evidence was given had already been subjected to consideration by the Trust's complaints process which had resulted in the complaint being accepted. Most of the cases had also been considered by Dr Mike Laker's Independent Case Note Review process which had found cause for concern. In addition, as a perusal of the cases summarised in volume two of the first inquiry report will show, the sheer number and consistency of accounts of poor care from individuals who had no prior access to the complaints of others, in itself, suggests that there is an underlying truth in the totality of the testimony of these witnesses. One of the reasons that it is so important for boards to be confronted with the accounts of the experiences, given personally by those who suffered, is that it gives no room for escaping from the effects of genuine human suffering into the comfort of statistics, trends and action plans.

3.26 Other issues that were apparent from the evidence included:

- The development of a backlog of complaints in 2007;[21]
- Reports into the governance structure were of a high level statistical nature with little, if any detail, and only a short period of discussion;[22]

20 Brisby T129.44–45
21 Llewellyn WS0002000466, para 37
22 Llewellyn WS0002000468, para 47

- As indicated above there was little interest at Board level in complaints and its reports were limited to the categorisation required by the Department of Health (DH). This included all clinically related complaints under the heading "care and treatment";[23]
- While there were improvements in the governance structures after the arrival of Martin Yeates, Chief Executive in 2006, reports remained focused on high level statistical information rather than offering a picture of the human consequences of the concerns raised in the complaints;[24]
- The process of investigating complaints was delegated to divisions with the Trust's Complaints Manager becoming a coordinator. This led to incomplete and inconsistent reports being prepared by overworked and stressed front-line staff.[25]

3.27 It appeared that matters improved to some extent in 2009 following the change in management. Review panels were set up in each division, including both management and clinical staff. All complaints were routed through the central complaints team, whose manager reported directly to the Chief Executive of the Trust; he personally checked the response before it went out, and if there were recurring themes referring to the same individual, this would be noted.[26]

3.28 Ms Sharon Llewellyn told the Inquiry that from her experience at the Trust, what was important was:

- Making sure that actions were followed up to ensure the improvements that were needed occurred;
- Making sure complaints handlers had the support of senior managers;
- Senior managers had to listen to what was being said in the complaints process;
- Complaints handling needed to be properly resourced.[27]

3.29 In spite of some improvement, it is clear that more progress was required. Julie Hendry discovered this when she became responsible for complaints in August 2010:

- There was a large backlog of 216 complaints waiting to be dealt with. This appeared to be because of deficiencies in the coordination of investigations and the failure to hold staff to account for failing to respond to complaints properly.[28]
- There was no consistent mechanism for identifying the concerns raised in complaints and escalating them as required.[29]

23 Llewellyn WS0002000468, para 48
24 Llewellyn WS0002000469, para 51
25 Llewellyn WS0002000473, para 67
26 Llewellyn WS0002000482, paras 104–106
27 Llewellyn WS0002000492, paras 149–150
28 Hendry WS0000002964, para 14
29 Hendry WS0000002964, para 13

- The responses sent out by the Trust were "mechanistic, defensive and lacking in apology".[30]
- Complaints staff were preparing responses from statements made by clinical staff without understanding them or obtaining the necessary assistance from the clinicians who were insufficiently engaged in the process.[31]

3.30 Ms Hendry told the Inquiry that the Chief Executive now sees not only the response but the complaint, the questions asked and the answers given. A stronger system for ensuring that the learning from complaints is actually implemented is in place.[32] Board reports now contain a much more detailed analysis of trends, themes, and quotations from individual complaints to illustrate problems.

3.31 A project has been undertaken with the Patients Association (PA), under which, among other things, patients can obtain advice that the Independent Complaints Advocacy Service (ICAS) advocates are unable to give.[33] Ms Hendry told the Inquiry that some local people find it difficult to trust publicly funded assistance of the type provided by ICAS, but would trust advocates recruited from the local community. The Trust also offers external investigation of complaints as another means of seeking to restore confidence in the system.[34]

3.32 Detailed quarterly reports on complaints are now provided to South Staffordshire PCT (SSPCT). In addition, it receives a monthly analysis of numbers, response times and information about the lessons learnt.

3.33 This is in stark comparison to the situation prior to 2008 where Geraint Griffiths from SSPCT stated:

> *At the time there was no requirement under the contract for the Trust to provide us with complaints information however I know that Stuart Poynor wrote to the Trust in 2008 and thereafter we received the backdated complaints for 2005/8 from the Trust.*[35]

3.34 That the Trust was not required to provide information upon complaints to the SSPCT was accepted by Yvonne Sawbridge as a feature of the system:

> *The culture within the NHS at that time was trusts were responsible for dealing with their own complaints and there was no expectation that any other body would be provided with copies of any complaints. This culture was reflected in statute.*[36]

30 Hendry WS0000002964, para 15
31 Hendry T52.153
32 Hendry WS0000002970–972, paras 34–40; WS(2) WS0000007279, paras 3–7
33 Hendry WS0000002988–989, para 100
34 Hendry WS0000002990, para 103
35 Griffiths WS0000014891, para 148
36 Sawbridge WS0000013405, para 57

3.35 Upon receipt of the backdated complaints data, Stuart Poynor became aware of the problems with the complaints system:

> *We were not alerted to systemic poor care. Whilst the high HSMR rates could be seen as an alert to a potential issue with care, this was not explicitly linked to the types of experiences patients and relatives were having. Once it became apparent that concerns were not routinely shared with the PCT, the PCT quality team set about developing systems to capture this soft intelligence and identify trends as well as follow up issues.*[37]

3.36 The SSPCT for its part attempted to address this issue prior to the changes to the national contracts:

> *We sought to include some quality elements within our contracts prior to the introduction of the national contract. For example, we had recognised the importance of access to complaints as an indicator of quality. Accordingly, we used the draft version of the national contract (which was ultimately not introduced nationally until 2009/10) and made a local agreement to include a requirement for Trusts to issue reports on patient complaints.*[38]

3.37 However, the information that was provided was generally thought to be unreliable and was a source of frustration between the SSPCT and the Trust:

> *We raised the fact that the Trust was unable to provide accurate information on patients waiting to be admitted at the hospital at our contact meetings with the Trust and indicated that we could pay people to put the data right if it was not accurate. It was not clear to me whether it was a case that the Trust did not have this information or the fact that that they had it and were not willing to share it with us. I found this whole situation extremely frustrating as I felt that we were asking for basic information which we were being provided by other Trust's without any issues.*[39]

37 Poynor WS0000014329, para 200
38 Sawbridge WS0000013422, para 114
39 Griffiths WS0000014891, para 152

3.38 The information that was shared with the SSPCT did not highlight the true scale of the issues unfolding at the Trust. Yvonne Sawbridge was shocked by the patient stories she heard first hand when she met with members of CURE:

> *Prior to our meeting with Cure the NHS, Julie Bailey and her fellow members had not been on my radar. Whilst we had no authority to investigate complaints made against another Trust if people had written to me at the PCT in relation to issues at the Trust I would have raised this directly with them. In fact following on from a PCT public engagement event in 2007, a patient did raise concerns about his experience, which was passed to me. I forwarded this information to Helen Moss.*[40]

3.39 The effect of the 2004 complaints arrangements was that the SSPCT was not in a position to receive or act on complaints information in any meaningful way. It received few if any complaints about the Trust directly, and its access to complaints information generally was limited. Consequently, it is not entirely surprising that the SSPCT was not more deeply involved in this regard and was left unaware of the scale of problems that might have been evident from a deeper analysis of what patients were complaining about.

Patient Advice and Liaison Service

2000 proposal

3.40 In the *NHS Plan*, published in 2000, the Government announced proposals to reform the complaints system, including the creation of a Patient Advocacy and Liaison Service, later changed to Patient Advice and Liaison Service (PALS). The function of this new service was described as follows:

> *Patients need an identifiable person they can turn to if they have a problem or need information while they are using hospital and other NHS services. Usually situated in the main reception area of hospitals the new patient advocate team will act as a welcoming point for patients and carers and a clearly identifiable information point. Patient advocates will act as an independent facilitator to handle patient and family concerns, with direct access to the chief executive and the power to negotiate immediate solutions. In mental health and learning disability services, the Patient Advocate and Liaison Service team will build on and support current specialist advocacy services.*[41]

40 Sawbridge WS0000013430, para 141
41 *The NHS Plan: A plan for investment, a plan for reform* (1 July 2010), Department of Health, para 10.18, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

3.41 The aim of PALS was to "steer patients and families towards the complaints process where necessary" and to fulfil the functions previously handled by Community Health Councils (CHCs). Changes in the complaints procedure were said to be under consideration.[42]

3.42 In September 2001, a Government consultation paper proposed, in addition to Patient and Public Involvement Forums (PPIF) and PALS, a locally based complaints advocacy service, ICAS.[43] Together these bodies would be a "key means of ensuring that patients' concerns would be dealt with rapidly and to everyone's satisfaction".[44] PALS would provide immediate advice and help for problems, and ICAS would provide assistance in pursuing a complaint.

3.43 In 2003, the Association of Community Health Councils published a survey of the performance of PALS, whose conclusions were accepted by Dame Janet Smith in the Shipman Inquiry.[45] Of 100 calls made to different hospitals requesting access to PALS, only 51 calls resulted in a personal response.

3.44 In the same year, the Government's proposals for complaints reform described the function of PALS:

> *... staff will listen and provide relevant information and support to help resolve users' concerns quickly and efficiently, there and then, if at all possible. They will liaise with staff and managers, and, where appropriate, with other PALS services, health and related organisations, to help resolve complaints so avoiding the need for patients to make a formal complaint in most cases. They will also act as one of the gateways to independent advice and advocacy support for people wanting to pursue formal complaints and act as a force for change and improvement within the organisation as a whole.*[46]

Patient Advice and Liaison Service at the Trust

3.45 A description of the Trust's PALS and its problems can be found in *Chapter 2: The Trust*. The general impression to be gained from the evidence of Sharon Llewellyn is that initially it worked quite well but that significant problems began in 2007. Among these problems were:

- Staff reductions and resulting loss of skills and experience in the office.[47] The number of staff was not sufficient to ensure that telephone messages were returned promptly. This

42 *The NHS Plan: A plan for investment, a plan for reform* (1 July 2010), Department of Health, para 10.19, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf
43 *Involving Patients and the Public in Healthcare: A discussion document* (3 September 2001), Department of Health www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088803.pdf
44 *Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, Chapter 7, para 7.63, www.shipman-inquiry.org.uk/5r_page.asp
45 *Shipman Inquiry 5th report, Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, Chapter 7, para 7.66, www.shipman-inquiry.org.uk/5r_page.asp
46 *NHS Complaints Reform: Making things right* (3 April 2003) Department of Health, para 3.17 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4069009.pdf
47 Llewellyn WS0002000465, para 33

led on occasion to callers being advised to make a formal complaint in order to get a response;[48]

- The lack of skills meant that staff did not have the authority to challenge what they were being told by front-line professional staff; therefore, they were reduced to reporting back what had been said to complainants.[49]

3.46 One important point made by Ms Llewellyn was that not all serious issues led to a complaint. She cited an example of someone who had compiled an eight-week diary documenting multiple failings in the care of a relative. This person did not want to make a formal complaint.[50] It appears that a significant number of people with adverse experiences to report did not want to complain, some out of fear of the consequences, others because they wanted to get on with their lives. This suggests that it is important for trusts to document and follow through concerns raised informally as well as those which are the subject of a formal complaint.

3.47 Since the arrival of the new management team, improvements have been made to PALS at the Trust. The office, which is in the main entrance hall, is open plan and more welcoming. Through experience, rather than specific training, the staff are said to be clear when a concern communicated to them should be escalated into a formal complaint.[51]

3.48 There was evidence that PALS did not share information about complaints with the local Overview and Scrutiny Committee (OSC) which, in turn, had not asked for it. Thus, DH guidance suggesting that information about complaints would be of "crucial input to the scrutiny process" was not fulfilled.[52]

Independent Complaints/Advocacy Services

3.49 The Health and Social Care Act 2001 placed a duty on the Secretary of State for Health to make independent advocacy services, defined as advocacy services by way of "representation or otherwise", available to people wishing to make a complaint against the NHS.[53] This service was required to be, so far as practicable, independent of any person or organisation subject to the complaint. In a 2001 consultation paper, the Government commented: "We will need to ensure that this support is provided in a way that delivers a consistent and high quality service across the country and between organisations."[54]

48 Llewellyn WS0002000466, para 39
49 Llewellyn WS0002000466, paras 37–41
50 Llewellyn WS0002000485, para 116
51 Hendry WS0000007287, paras 45–50; Hendry T53.6
52 Philip Jones T36.40–42
53 Health and Social Care Act 2001, section 12; inserting section 19A to the National Health Service Act 1977, www.legislation.gov.uk/ukpga/2001/15/section/12
54 *Involving Patients and the Public in Healthcare: A discussion document* (3 September 2001), Department of Health, para 4.9, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088803.pdf

3.50 At the time of the Shipman Inquiry hearings in 2003, contracts for advocacy services were still being agreed. At the time of the report, evidence as to its operation was not available, but Dame Janet commented:

> *There is a need for complainants to have access to free, independent and well-informed advice. It is not sufficient that a complainant is told how to proceed. He or she need someone with whom to discuss the issues and the merits of the complaint. He or she needs advice about whether, and exactly how to proceed. He or she needs someone to support him or her at a hearing, if any. If ICAS is indeed able to provide such advice and support, its work is to be very much encouraged.*[55]

3.51 In pursuance of the statutory provisions the advocacy service was set up by the DH as from September 2003, by making contractual arrangements with independent providers.

3.52 In Staffordshire, ICAS provision was provided from 1 September 2003 to 31 March 2006 by the Citizens Advice Bureau and from 1 April 2006 to date by People of Hertfordshire Want Equal Rights (POhWER), an independent charity run as a membership organisation devoted to supporting inclusion and empowerment of people in their interaction with systems and society generally. POhWER employs over 170 staff, has a turnover of over £7 million and contracts with over 20 local authorities and private providers in six regions of England. It is now one of three organisations contracted to provide advocacy services under the ICAS scheme, the others being the Carers Federation and SEAP (Support, Empower, Advocate, Promote).[56]

3.53 Peter Walsh, Chief Executive of AvMA, expressed concern that the association between ICAS and the DH compromised the independence of the service due to concerns providers might have about future contracts.[57] While this Inquiry has revealed certain limitations of the service, as described below, it has seen no evidence to suggest that the relationship between the DH and providers has resulted in that sort of issue. Indeed the current arrangement has an advantage in separating the funding of the advocacy service from the localities where the service is provided.

The scope of support for complainants

3.54 The Inquiry heard evidence to the effect that ICAS advocates cannot offer advice to complainants about the merit of a complaint or the response provided. In its provisional statement, POhWER made it clear that this was its understanding of advocacy:

55 *Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future* (9 December 2004), Command Paper Cm 6394, Chapter 7, para 7.68, www.shipman-inquiry.org.uk/5r_page.asp?ID=4638
56 POhWER WS (Provisional), POW00000000003–4
57 Walsh WS (Provisional), AVMA0001000019, para 41

ICAS is a patient centred service delivering support ranging from the provision of self help information, through to the assignment of a dedicated, specialist advocate able to assist individuals with more complex needs and/or complex complaints. ICAS has no power to investigate complaints or express its own views ... Its core purpose is to provide independent support that enables complainants to obtain information, express concerns and find their way through the system.[58]

3.55 This appeared to be confirmed in a report published by all three ICAS providers which contained the following:

An advocate will never give advice, express a personal opinion, make judgements or attempt to persuade an individual to take a particular course of action. Whilst an advocate can provide a sympathetic ear it is not his or her job to provide counselling. An advocate's role is not to mediate on a client's behalf but to support him or her through the NHS complaints process.[59]

3.56 However, on the same page in the report an ICAS advocate was quoted as saying:

But our team agreed that we are, in fact, a 'critical friend' as we are not afraid to encourage clients to be realistic about their expectations.[60]

3.57 Ms Valerie Harrison explained the limits of what ICAS advocates will do:

An ICAS advocate will work through with the complainant what they want to say, what they feel they want to complain about, what its effect has been on them, their family or the person who has suffered a hurt, whatever it is they feel they want to achieve. We will ask people how much input they would like from us, in terms of formulating the complaint, and we might well discuss with them if they've thought about the complaint from every possible angle that we can think of, but we don't at the end of the day tell people what to write in their complaint. That is their right to make as their own decision as a person with capacity.

... If it's a ... sort of speculative query – "What do you think?" – what we would probably do is spend ... spend some time with people and say "Well, let's explore this. Let's work through it. Let's try and understand what's gone on", and at the end of it to work with the client to see whether or not they wish to make a complaint from it.[61]

58 POhWER WS (Provisional), POW00000000006
59 *ICAS Impact Report: Putting You in the Picture* (September 2009), Carers Federation, POhWER, SEAP, page 14, www.pohwer.net/our_services/putting_you_in.html
60 *ICAS Impact Report: Putting You in the Picture* (September 2009), Carers Federation, POhWER, SEAP, page 14, www.pohwer.net/our_services/putting_you_in.html
61 Harrison T28.14–16

3.58 This approach seems to be inconsistent with the views expressed by Dame Janet Smith in the Shipman Inquiry report.

3.59 Clearly advocates can and do give advice on procedural matters such as what, if any, avenues a complainant can explore if dissatisfied with a response, but this does not extend to expressing an opinion, for instance on whether a response appears to be correct or justified. This section explores the issue of what an advocate can and cannot do in this respect.

3.60 Associated with the absence of a facility to advise clients about the merits of their complaint is the lack of any expert clinical opinions to assist complainants in evaluating their complaint and the response. POhWER has a contract with an organisation that provides a service to assist advocates in understanding medical terminology. The organisation obtains advice from clinicians and then relays it corporately to POhWER. This assistance may extend to pointing out that a trust's response has not answered a question by, or on behalf of, the complainant. Therefore, there appears to be an uncomfortable and ill defined boundary beyond which expert advice is not meant to stray:

> *THE CHAIRMAN: But hypothetically, if the doctor behind the company reading, say, a response has a clear view that it is rubbish medically, the company is not allowed to tell you that?*
>
> *A. They could point out that they think the questions have not been answered and there might be the following questions that should be put instead.*
>
> *THE CHAIRMAN: It's not quite the same.*
>
> *A. Not quite the same, no.*
>
> *THE CHAIRMAN: Do you have a view on that gap, if it is a gap?*
>
> *A. I suppose the responsibility for ICAS is to work within the existing complaints system, and it would be at the stage of the ombudsman that the complainant would get external scrutiny by another body of doctors. I think the objective of being able to access medicolegal* [sic] *advice for us is to try and – or one of the objectives is to try and identify those cases that we need to – to push forward to that stage. An alternative that sometimes we have used is to go back to the trust and say 'This just doesn't seem right. Can we agree with you and the client to find another expert who might look at this and provide a report that you can both look at together, and see if that resolves matters' ...*

I hope that through our systems we are able to pick out worrying cases sufficiently quickly to be able to move them forward. But I agree with you, in terms of being able to refer to an independent – a body of independent advice to say 'Can you take a look at this? What do you think?' we don't – we don't have that sort of facility to be able to offer a complainant.[62]

3.61 Ms Harrison agreed it would be helpful for ICAS to have access to an independent panel of experts.[63]

The work of advocacy services

3.62 POhWER/ICAS becomes involved in only 8%–10% of complaints. It receives some 40,000 advocacy-related calls a year of which some 7,000 involve conversations lasting more than an hour. After many such calls, callers feel able to take over the running of cases themselves.[64]

3.63 It appears from evidence that advocacy focuses on support for vulnerable patients:

The focus of our advocacy tends to be on people with disabilities, physical disabilities, learning disability, a mental health problem, physical disability, dementia. Somebody with a frailty of some kind or another that I haven't covered there. Anybody really who might, I suppose, in fairly general terms, be in one of the equality groups, or somebody who by virtue of bereavement or some other stress or strain is having a difficulty expressing a view, or gathering information that perhaps under normal circumstances they would be able to do for themselves.[65]

3.64 The service seeks to enable such persons to exercise their right of complaint in the same way as a person without disabilities:

... to ensure that people are able to have the same information as an ordinary member of the public might be able to obtain, to know their rights, to be able to make informed decisions and to have help to express a view, and make choices, so it is enable – to enable people to access public services or other services on the same basis as anybody else.[66]

3.65 The service provided extends to preparing letters and making telephone calls on behalf of clients.

62 Harrison T28.126–127
63 Harrison T28.128
64 Harrison T28.4–5
65 Harrison T28.4
66 Harrison T28.5–6

3.66 While the service is available to all, there appears to be resource pressures resulting in different approaches towards clients without disabilities. Ms Harrison explained:

> *... if there was a resource constraint, and clearly there is because demand has increased over time but funding hasn't, the focus of the service was to be towards 75 per cent for people with great needs and 25 per cent for people perhaps who are more able to support themselves. So as a result, we've built-up capacity over time to offer a range of different support to people who might not have a disability. But that said, we always have a proportion of people who are very distressed because of grief, bereavement or just very, very upset about what has happened to them, who perhaps just can't get hold of their thoughts, don't know quite what to do, have exhausted friends and relatives, and will often use the full ICAS service in those circumstances.*
>
> *THE CHAIRMAN: But you offer self-help packs and so on, and obviously that must be a good thing, but is it your policy to encourage people to do it themselves with the information you provide or not?*
>
> *A. Not really, no. I mean, we would just explain what is available. And I think its – I think it is the fact that ICAS is available that helps.*[67]

3.67 In its annual report for 2009/10, POhWER recognised that it was not just those with recognisable disabilities who could suffer disempowerment when being provided with healthcare:

> *Usually people begin by talking about support for people with disabilities or who are at a perceived disadvantage – and it is true that much of our work is with people for whom disempowerment can be a daily experience.*
>
> *It doesn't take long before the partner in our conversation realises that feelings of disempowerment affect most of us – and that they tend to come at points when we feel overwhelmed by systems and circumstances. Once looked at this way our experiences of empowerment and disempowerment become things that bind us together rather than things that set us apart. Our feelings become the markers of our common humanity. For these reasons, the concept of empowerment is at our heart and the skills and tools to empower all people are principles that are fundamental to our brand of advocacy.*[68]

3.68 Ms Harrison told the Inquiry that following the change in the complaints procedure in 2009, which encouraged a more flexible local approach and informal resolution of complaints where possible, ICAS has been able to become involved at an earlier stage.[69] Advocates feel free to

67 Harrison T28.26–27
68 *POhWER, Advocacy and Making Your Voice Heard, Annual Report 2009–2010*, POhWER, page 8 www.pohwer.net/about_us/annual_reports.html
69 Harrison T28.9–10

suggest informally to trusts that a complaint might be better addressed by informal means or mediation rather than formally.

3.69 ICAS/POhWER focuses on support for the individual client and avoids a campaigning or lobbying role, as there is a fear that this might deter some persons in need of an advocacy service from coming forward.[70]

3.70 The annual report referred to above reported that feedback had been given to the Trust about POhWER's experience and staff have been provided with training. A new service, branded Advocacy Plus, has been developed to assist trusts and patients with apparently intractable cases.[71]

3.71 POhWER provided statistics showing the extent of its involvement with complaints about the Trust between 1 April 2006 and 31 March 2009:[72]

Table 3.1: POhWER's involvement with complaints about the Trust

Requests for assistance	102
People provided with information pack who did not ask for further assistance	28
Persons provided with one to one advocacy support	74
Of which: Clients satisfied by Trust's first response	22
Clients stating intention to take legal action	11
Clients not wishing to take cases further	14
Cases referred to the HCC and/or ombudsman	12

3.72 The Inquiry was told by Ms Harrison that the mix and type of complaints about the Trust with which it assisted did not appear to be atypical when compared with those relating to other trusts, but POhWER does not generally undertake formal comparative analysis.[73] This, in part, would have been due to the fact that ICAS sees a relatively small proportion of complaints.

3.73 Similarly, the difficulties experienced by complainants with the handling of their complaints by the Trust, in terms of adequacy of reason and time taken, were similar to ones seen with a large number of trusts. However, this Trust did stand out in its unwillingness to hand out information about ICAS.[74] POhWER also found it difficult to persuade the Trust to engage with

70 Harrison T28.13
71 *POhWER, Advocacy and Making Your Voice Heard, Annual Report 2009–2010*, POhWER, page 12 www.pohwer.net/about_us/annual_reports.html
72 POhWER WS (Provisional), POW00000000007–8
73 Harrison WS0003000086–088, paras 18–23; Harrison T28.135–136
74 Harrison WS0003000088, para 24

it in improving the Trust's complaints handling procedures and staff training.[75] It was also noted that during 2008–2009 there was a dramatic increase at the Trust in complaints involving clinical treatment where ICAS had been involved in comparison to two nearby analogous trusts. POhWER drew this to the Trust's attention at the time.[76]

3.74 POhWER also provided an analysis of the 12 cases in which it was involved and which were referred to the PHSO. Features of these cases included:

- Extensive delays in review by the HCC;
- Cases referred back to the HCC after purported completion following delays.[77]

3.75 Following the HCC report POhWER was invited to assist the Trust by, among other things, providing training sessions to its staff in complaints processes.[78] The sessions, which took place in November 2009, included an opportunity for staff to discuss the continuing concerns they had. The matters about which they expressed anxiety to the POhWER trainers included:

- A lack of basic equipment (pillows, thermometers);
- A lack of more expensive specialist equipment (incubators);
- Poor communication across the Trust, both vertically and horizontally;
- A lack of regular structured supervision and support;
- A lack of structured induction or training.[79]

3.76 POhWER reported these concerns back to the Trust; but also to the DH for passing on to Dr David Colin-Thomé who was undertaking his review at the time.

Liaison with other organisations in Stafford

3.77 Valerie Harrison informed the Inquiry that there were issues about the sharing of information about complaints with the Local Involvement Networks (LINks) and, before them, the PPIFs. ICAS/POhWER were under instructions from the DH not to breach or jeopardise patient confidentiality. This constrained the amount of information they could share without risk of identifying individual patients. The problem was that PPIFs and LINks were populated by local people familiar with healthcare issues and this increased the risk that disclosure of the circumstances of individual complaints would identify the patient concerned. However, they did prepare "outcome registers". Not all forums took these up.[80] Another issue may have been

75 Harrison WS0003000088–91, paras 25, 27 and 33
76 Harrison WS0003000087, para 21
77 POhWER WS (Provisional), POW00000000008
78 POhWER WS (Provisional), POW0000000009
79 POhWER WS (Provisional), POW0000000010; Harrison T28.149–150
80 Harrison WS0003000084, para 10

the way in which the PPIF and LINks were run. Ms Harrison's impression of the Stafford LINks and PPIFs was that they were "chaotic".[81]

3.78 There had been little interaction with the local authority OSCs.[82]

3.79 Ms Harrison stated that there had been some contact with CURE, but that this organisation had made it clear that it was not interested in further contact unless POhWER joined it in lobbying for change, which was not POhWER's function.[83]

3.80 It appeared that ICAS in general, and POhWER in particular, had no contingency plan for dealing with a sudden surge in demand from patients of a trust where widespread serious deficiencies had been exposed.[84]

Healthcare Commission

3.81 The HCC's involvement in the complaints procedure has been reviewed in *Chapter 9: Regulation: the Healthcare Commission*.

3.82 The three-stage system that operated from 2004 provoked widespread dissatisfaction as described by Ms Harrison:

> *... I think there was a loud and clear voicing of frustration about the extent of delay that was being caused by the Healthcare Commission and the three-stage process, and the fact that, you know, things would go up to the ombudsman, get referred back to the Healthcare Commission for the Healthcare Commission to learn, and in the meanwhile there was no gain for the patient.*[85]

3.83 She elaborated on the cause for dissatisfaction, saying it was delays caused by an excessive case load at the HCC:

> *... certainly I recall two or more years of the Healthcare Commission not being able to deal with the volume of complaints that came in, not having the skills to deal with the complaints that came in. There was a – a lot of pressure on them to improve delay. So it wasn't uncommon for – I think, a quick skim of the complaint, deciding there was something that the trust could do that they hadn't yet done, so sending it back to the trust. Something would happen locally. It would come back into the Healthcare Commission. It could sit for quite a long time again.*[86]

81 Harrison WS0003000084, para 12
82 Harrison WS0003000085, para 13
83 Harrison WS0003000085, para 12
84 Harrison T28.146
85 Harrison T28.40–41
86 Harrison T28.112

3.84 Ms Harrison was also critical of what she perceived as a tendency of the PHSO to accept the clinical view of a case presented by a trust rather than to obtain independent advice.[87] She described, based on her three years' experience at the office of the PHSO as Head of Health Investigations, the procedure whereby, if it was thought that there was more a trust could do, cases were referred back to the trust rather than investigated at PHSO level. Ms Harrison expressed some concern at the potentially negative effect this had on the complainant's experience of the process.[88] However, she suggested that a greater proportion of the cases supported by ICAS, which go to the PHSO, are retained for investigation because they are well researched and prepared.

Parliamentary Health Service Ombudsman

3.85 The statutory role of the PHSO in relation to health service complaints is as follows:

> *On a complaint duly made to the Commissioner by or on behalf of a person that he has sustained injustice or hardship in consequence of –*
>
> *(a) a failure in a service provided by a health service body,*
>
> *(b) a failure of such a body to provide a service which it was a function of the body to provide, or*
>
> *(c) maladministration connected with any action taken by or on behalf of such a body, the Commissioner may, subject to the provisions of this Act, investigate the alleged failure or other action.*[89]

3.86 The PHSO's remit covers all NHS bodies, including SHAs, and foundation trusts (FTs). As Ms Abrahams, PHSO at the time of the Inquiry hearings and throughout the period under review, explained, before she can uphold a complaint she must be satisfied not only that there has been a failure of service but also that the failure has caused an injustice or hardship. The second limb of the test was often more difficult to establish. She has no power to initiate an investigation in any other circumstances.[90]

3.87 Ms Abrahams told the Inquiry that when she took over the post of PHSO in 2002 she considered that the complaints process was not fit for purpose because it focused on process not outcomes, did not provide proper remedies and took too long.[91]

3.88 The PHSO sees only a tiny proportion of complaints as a whole and, of those, only a small proportion are subject to a PHSO investigation. Thus between 1 April 2005 and 31 March 2009

87 Harrison T28.123; Harrison WS0003000086, para 16
88 Harrison T28.132–134
89 Health Service Commissioners Act 1993, section 3(1), www.legislation.gov.uk/ukpga/1993/46/section/3
90 Abrahams T108.35; Abrahams WS0000053704, para 4
91 Abrahams T108.64

the PHSO received 2,142 inquiries about NHS hospital, specialist and teaching trusts in England.[92] Peter Walsh of AvMA was concerned at how few cases are investigated by the PHSO:

> *According to the ombudsman's review of complaints handling by the NHS in 2009–2010, entitled 'Listening and learning', she considered over 15,000 health complaints, of which she found that 58% had not been properly made or were premature. 346, or just 2%, were accepted for investigation. 219, or 4%, were resolved through intervening with the relevant body, and nearly 27% were not accepted on a discretionary basis.*
>
> *These are depressing statistics. They confirm AvMA's view that complaints resolution is still not a priority for the Government. They reinforce the need for the core standards I've identified and particularly for an earlier stage of independent intervention and one which is more readily accessible.*[93]

3.89 During the same period the PHSO received 17 inquiries about the Trust. Since March 2009 there has been a large increase in the number received, owing to the abolition of the second stage of the complaints process.[94]

3.90 From the complaints received by the PHSO, themes and learning points are identified and included in either the annual report to Parliament or special reports on individual themes.

3.91 The first annual report on complaints handling was published in October 2010 providing data of all complaints received in 2009–2010.[95] The report's primary conclusion was that "the NHS needs to listen harder and learn more from complaints".[96]

3.92 An example of a thematic report was the report of the PHSO on investigations into the NHS care of older people. The report included the results of 10 investigations across the country and published a damning conclusion of NHS care. The PHSO's report said:

92 Abrahams WS0000053724, para 74
93 AvMA closing submission T134.13
94 Abrahams WS0000053724, paras 74–79
95 *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2009–10* (October 2010), Parliamentary and Health Service Ombudsman, http://nhsreport.ombudsman.org.uk/
96 *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2009–10* (October 2010), Parliamentary and Health Service Ombudsman, page 4, http://nhsreport.ombudsman.org.uk/

I encourage Members of both houses to read the stories of my investigations included in this report. I would ask that you then pause and reflect on my findings: that the reasonable expectation that an older person or their family may have of dignified, pain-free end of life care, in clean surroundings in hospital, is not being fulfilled. Instead, these accounts present a picture of NHS provision that is failing to respond to the needs of older people with care and compassion and to provide even the most basic standards of care.[97]

3.93 A more detailed breakdown of inquiries received about the Trust and the outcomes appear in the tables below:[98]

Table 3.2: Inquiries received by the PHSO about the Trust

Time period	Inquiries received by the Ombudsman	Inquiries closed as not made in line with legislation	Inquiries withdrawn by the complainant	Premature inquiries returned to the Trust or the HCC	Inquiries for which the Ombudsman used its discretion not to investigate	Complaints accepted for investigation by the Ombudsman
1/4/05–31/3/09	17	2	2	8	1	2
1/4/09–31/3/10	33	12	3	13	5	0
1/4/10–30/6/10	12	3	0	5	2	0
Total	**62**	**17**	**5**	**26**	**8**	**2**

3.94 Inquiries relating to the HCC handling of complaints against the Trust:[99]

Table 3.3: Inquiries received by the PHSO about the HCC handling of complaints about the Trust

Time period	Inquiries received by the Ombudsman	Inquiries closed as not made in line with legislation	Inquiries withdrawn by the complainant	Premature inquiries returned to the Trust or the HCC	Inquiries for which the Ombudsman used its discretion not to investigate	Complaints accepted for investigation by the Ombudsman
1/4/05–31/3/09	14	0	1	3	5	4
1/4/09–31/3/10	1	0	1	0	1	0
1/4/10–30/6/10	0	0	0	0	0	0
Total	**15**	**0**	**2**	**3**	**6**	**4**

97 *Care and Compassion: Report of the Health Service Ombudsman on ten investigations into NHS care of older people* (February 2011), Parliamentary and Health Service Ombudsman, page 5, www.ombudsman.org.uk/care-and-compassion/
98 Abrahams WS000053719, para 62
99 Abrahams WS000053721, para 66

3.95 There was nothing about the complaints the PHSO received concerning the Trust that made it stand out from others.

3.96 Ms Abrahams thought that, although there could always be questions over the numbers of complaints that she ought to be investigating, and the resources required to achieve that, the priority was to drive improvements in the complaints process without drawing in large numbers of complaints.[100]

3.97 The Inquiry heard that the PHSO now has a protocol with the CQC whereby if particular concerns come to her attention, she will notify the CQC about them.[101]

3.98 Ms Abrahams, Dr Tony Wright (ex-MP for Cannock Chase), who sits on the PHSO Board, and Valerie Harrison of POhWER, consider the complaints system has improved now that there is opportunity for earlier access to the PHSO following the removal of the second stage.[102]

3.99 Sir Hugh Taylor, former Permanent Secretary at the DH, considered that the removal of the HCC stage was likely to be a powerful incentive for trusts to get their process right first time, given the powers of the PHSO and the exposure that consideration at that level entailed: "You take a great deal of notice of what the ombudsman has to say."[103]

3.100 The PA did not consider the PHSO an adequate final stage of the complaints process:

> *... most complainants do not pursue this avenue, discouraged by the significant timescales and effort often already dispensed in making the original complaint. The elapsed time also makes it difficult for the PHSO to conduct an effective investigation and provide a prompt response. The PHSO can be perceived as an "establishment" organisation, without links with local communities reducing its ability to gain the confidence of complainants. Furthermore the PHSO only accepts a very small proportion of complaints for review.*[104]

Patient support organisations

Action against Medical Accidents

3.101 AvMA has a helpline through which assistance and advice can be offered to patients and their families who wish to complain about healthcare services.

100 Abrahams T108.59–60
101 Wright T38.85
102 Wright T38.127; Harrison T28.46, T28.132–133
103 Hugh Taylor T126.62–63
104 PA WS (Provisional) PA0000000015, para 71

3.102 The organisation's involvement in cases concerning the Trust had been limited prior to the HCC report, but it has provided significant assistance since, in part through the helpline. Of the people who contacted AvMA concerning the Trust, 45 individuals were subsequently supported by AvMA caseworkers. They were provided with assistance in pursuing complaints through the NHS complaints procedure and with referring health professionals to their professional regulatory bodies. They were also offered advice on the prospects of taking legal action to obtain compensation and, where appropriate, they were referred to specialist solicitors. AvMA also supported 13 families through the Independent Case Note Review process. This involved AvMA casework staff travelling to Stafford to meet with families to help prepare for review meetings, reviewing complaints information and medical records, attending review meetings with the families, and subsequently reviewing the report from the Independent Case Note Reviews and discussing it with the clients concerned.[105]

3.103 The value of such support was clear from the evidence of Mrs Janet Moore-Robinson:

> *In the early stages we received little to no help from anyone or an organisation and have felt very let down by the whole process. Recently we were contacted by Action for Victims of Medical Accidents (AvMA)* [sic] *and they have given us guidance and support and continue to do so, for which we thank them.*[106]

Patients Association

3.104 The PA's principal activity is to campaign on behalf of the patient's interest. It is a small organisation; until recently it had the equivalent of two and a half full time employees. This increased to six and then to seven staff in 2010.[107]

3.105 The PA has a helpline. It receives referrals from other organisations and provides a general advisory service. It does not become involved in individual cases beyond advising callers of other organisations that can provide such assistance.[108] Some 5,000 calls a year are received. The information gained from such calls is fed into the evidence which informs its campaigning, but as presently constituted, it is clearly not an organisation able to provide assistance to support complainants in the pursuit of their complaints.

3.106 More recently, the PA has been working with the Trust on the matter of complaints as part of its Speaking Up Project.[109] One of the elements of this project involves peer review panels consisting of magistrates, clinicians, community members and complaints managers convening every quarter to review a sample of complaints and examine how they were handled by the Trust. The results of the peer review for September and October 2011 showed

105 Walsh AVMA0001000010, para 14
106 Robinson WS0000000056, para 70
107 Mullan T24.7
108 Mullan T24.4–5
109 Further information on the Staffordshire Complaints Project is available at: www.patients-association.com/Default.aspx?tabid=232

areas where the Trust, and in all likelihood other trusts, should focus in order to better handle complaints. The findings from the peer review report showed that complaints handling within the Trust has not moved on as far as one would perhaps have hoped. However, there were a number of areas that were highlighted as areas of positive practice. This included:

- 89.3% of cases received a written acknowledgement letter within the three-day time frame; others received phone calls confirming details of the complaint;
- 82% of complainants were offered the opportunity to discuss the outcome of the hospital findings.[110]

3.107 The report focused on nine recommendations which, if implemented, should improve the way that the Trust handles complaints. These recommendations included:

- Every investigation should have an identified lead investigator and decision-maker and a clear management plan;
- Introduce a standardised template for collating interview notes and statements.[111]

3.108 The report also refers to 12 standards of good complaints handling, which will be included in a guidance document for use by the NHS. These standards are:

- Standard 1 – The investigation of the complaint is impartial and fair;
- Standard 2 – Individuals assigned to play a part in a complaint investigation have the necessary competencies;
- Standard 3 – The roles and responsibilities of the complaints handling team are clearly defined;
- Standard 4 – The governance arrangements regarding complaint handling are robust;
- Standard 5 – The Complainant has a single point of contact in the organisation and is placed at the centre of the process;
- Standard 6 – Investigations are carried out in accordance with local procedures, national guidance and within any legal frameworks;
- Standard 7 – The investigator reviews, organises and evaluates the investigative findings;
- Standard 8 – The judgement reached by the decision-maker is transparent and reasonable, based on the evidence available;
- Standard 9 – The complaint documentation is accurate and complete. The investigation is formally recorded, and the level of detail is appropriate to the nature and seriousness of the complaint;

110 *Results of the Peer Review Panels September and October 2011* (April 2012), The Patients Association and Mid Staffordshire NHS Foundation Trust, page 11, http://patients-association.com/Portals/0/Public/Files/AdvicePublications/PeerreviewreportFINAL%2026%20April%202012.pdf

111 *Results of the Peer Review Panels September and October 2011* (April 2012), The Patients Association and Mid Staffordshire NHS Foundation Trust, page 35, http://patients-association.com/Portals/0/Public/Files/AdvicePublications/PeerreviewreportFINAL%2026%20April%202012.pdf

- Standard 10 – The organisation responds adequately to the complainant and those complained about;
- Standard 11 – Learning lessons from complaints occurs throughout the organisation;
- Standard 12 – The organisation records, analyses and reposts complaints information throughout the organisation and to external audiences.[112]

General comments

3.109 It is clear that until the crisis provoked by the HCC investigation, there was minimal external scrutiny of the complaints received by the Trust.[113]

Independent complaints management

3.110 The Inquiry heard evidence to suggest that patients might benefit from complaints about service provision being handled by an organisation external to the provider:

- Antony Sumara, former Chief Executive at the Trust thought that the only way of regaining public confidence in the complaints process was for it to be "separate" from the Trust;[114]
- Stuart Poynor of the SSPCT considered that external management would be an advantage although he acknowledged there were contrary arguments. He thought that such an arrangement would remove the conflict of interest inherent in internal complaints management and add a degree of transparency. An external body could also be given responsibility for ensuring that the provider implemented the learning from complaints. The opposing arguments were, he thought, that removing that responsibility from the provider might reduce the sense of confidence in it and promote a negative culture;[115]
- Councillor Matthew Ellis pointed to the risk of providing multiple channels for complaints in that it tended to reduce their impact:

> *... the more opportunities and different ways you have of making a complaint, firstly, the greater the chance, I suppose, of it being lost or misplaced. Secondly, the greater the chance of it actually not being connected to a series of other things that are related that make a very different picture when you take them holistically than if you take them individually.*[116]

112 *Results of the Peer Review Panels September and October 2011* (April 2012), The Patients Association and Mid Staffordshire NHS Foundation Trust, page 9 http://patients-association.com/Portals/0/Public/Files/AdvicePublications/PeerreviewreportFINAL%2026%20April%202012.pdf
113 Hendry WS0000002977, para 59
114 Sumara WS0000005927, para 72
115 Poynor T65.205–206
116 Matthew Ellis T34.117

3.111 Councillor Ellis told the Inquiry that the County Council was considering whether a mechanism could be set up to channel all health and social care complaints through one organisation. He did not approve of the present system:

> *... I don't like the complaints system anyway. I think it's a nonsense that you have people who work for the organisation you're complaining about ... I have a fundamental issue with officials who may be the subject organisationally of a complaint actually investigating the complaint*[117]

3.112 In particular, he was concerned with a system which relied on the organisation complained about to treat a vulnerable adult self-reporting the issue to the Safeguarding Board. Other evidence included:[118]

- Professor Sir Liam Donaldson told the Inquiry that following the abolition of CHCs he had proposed the creation of a national patient bureau with local branches run by patients and patient representatives. He still considered it an idea worthy of consideration although it would need careful thought;[119]
- Professor Kieran Walshe raised the alternative of exploiting interests which already existed within an organisation. He cited practice from nursing home regulation of requiring it to maintain a residents or family council which could be a conduit for communicating concerns to the regulator;[120]
- The PA also thought that complaints management should be handled independently of provider trusts. It considers that an internal investigation generates the possibility of conflicts of interest for the investigating team:

> *We see frequently an expression of "well they would say that wouldn't they", quite sensibly highlighting that investigators may have a vested interest ... in not finding in the complainants favour should that result in negative publicity or other negative consequences for the Trust of which they are an employee. The Patient Association consider that there should be much sooner independent involvement in complaints investigations when they relate to accusations of serious harm or death. As the PSHO* [Ombudsman] *base*[s] *its initial decision over whether or not to provide an independent review of a complaint largely on the original investigation response from a trust we would also question whether it is able to ensure the many complaints it does not take up are in fact being dealt with satisfactorily by the trust.*[121]

117 Matthew Ellis T34.103, T34.110
118 Matthew Ellis T34.111
119 Donaldson T122.169
120 Walshe T8.153
121 PA Provisional Statement PA0000000016–17, paras 77–79; Mullan T24.42

Support for complainants

3.113 Another concern was the lack of support available to complainants. AvMA was critical of the fact that complainants were not made aware of its existence and the resources it could offer. Mr Peter Walsh told the Inquiry:

> *It is particularly worrying that the reported attempts by patients* [and] *their families to get their concerns addressed failed ... We believe an important reason for this is the lack of availability of appropriate advice and support for people in pursuing their concerns or complaints. This is an area which AvMA considers is in need of urgent reform. We believe that had individuals been empowered through access to independent specialist advice and support, and had there been a body able and willing to act on the collective concerns which they were hearing from patients/families, then the problems at the Trust may have been identified and acted upon earlier than they were.*[122]

Barriers to complaining

3.114 Mr Walsh also expressed concern about PALS becoming a barrier to complaints being made. He accepted the value of PALS as an in-house department intent on finding solutions to problems for patients and their families as a means of avoiding complaints, but he was concerned at any suggestion that some form of process with PALS had to be gone through before a formal complaint could be lodged:

> *And where there are problems is where PALS become almost another barrier to actually getting serious concerns addressed. For example, in some trusts literature, the clear implication is made that if you have a concern you need to go through PALS first, and if it can't be resolved by PALS, then you get advised to make a complaint. In some circumstances, that's just not appropriate. Some things are so serious and obviously in need of formal investigation, backed up by the statutory framework of the complaints procedure that no time should be lost in getting them registered as complaints. And that's the kind of perception that we've had fed back to us about the trust, and that we see in other parts of the country in some instances that PALS in effect are another tier that people feel they have to go through.*[123]

122 Walsh WS (Provisional) AVMA0001000017, para 31
123 Walsh T23.79–80

3.115 In Mr Walsh's view, PALS should be separated from complaints handling:

> *In our view PALS needs to be seen as distinct from the complaints procedure. PALS should seek to resolve problems wherever they can and explain people's rights to complain formally without making this any more difficult for people. People should not feel that they have to go through PALS before they can complain. Moreover, it is vitally important that PALS and complaints staff readily advise people of where they can get independent advice.*[124]

3.116 Patients who wanted to complain about their experiences at the Trust found PALS "did not want to know" and that eventually PALS would refer them to Julie Bailey and CURE in any event.[125] Gillian Peacham found that:

> *Although the frontline staff at PALS were very helpful, nothing happened when they tried to transfer the complaint up through the chain. PALS did not seem to have the power to do anything about it.*[126]

3.117 During a meeting with the clinician she was trying to complain about, the PALS representative was asked to leave the room and Ms Peacham did not see the representative again. While the staff were well intentioned, Ms Peacham's involvement with PALS left her feeling that there was a barrier to complaining. Her impression was that, "I did not feel that I was allowed to follow up my complaint."[127]

3.118 Other patients found PALS to be unhelpful and merely referred them back to staff on the ward, which they did not want to do as they were frightened it would impact on the care that they or their family members received.[128]

3.119 Beverly Howell described a catalogue of appointments, unanswered correspondence and failings by PALS at the Trust. She found dealing with PALS to be an, "extremely frustrating and distressing experience".[129] Her view of the role of PALS was to prevent complaints being pursued:

> *I think the PALS office is run on the basis that 90% of people will just become so frustrated and worn out by the complaints process that eventually they will give up. Once they give up, PALS take the view 'Well, if you are not pushing this then neither will we.'*[130]

124 Walsh WS(2) WS0000002086, para 42
125 Dalziel WS0000000021, para 55
126 Peacham WS0002000063, para 13
127 Peacham WS0002000063, para 17
128 Cowie WS0000000162, para 77
129 Howell WS0002000004, para 18
130 Howell WS0002000008, para 38

3.120 Similar to Gillian Peacham's experience, she felt that PALS acted as a block to complaints:

> *The current process drains all of the energy out of you. Eventually, I felt that with my complaint I had literally come to the end of the road and there was nothing more I could do to get an answer.*[131]

Use of information about complaints

3.121 There was evidence suggesting that, in order for complaints information to be useful whether at the provider, board level or externally, more than mere numbers and high level classification was required:

- Professor Ian Cumming observed:

  ... to look at complaints properly you need to, first of all, look at the – the content of the complaint, because although a complaint is a complaint, it means somebody is dissatisfied with the health service, there is a difference between a complaint that says "The food [in the] *hospital wasn't very good", or "You charge too much for car parking", and a complaint that says "We actually believe that something fundamental went wrong in the quality of care that was being delivered to myself or my relative", and – and I think they require a different form of investigation. You also have to look at complaints in terms of whether they're upheld, not upheld or partially upheld by the organisation concerned.*[132]

- Councillor Ellis of Staffordshire County Council, while noting that the examination of complaints had not been thought to be within the remit of its Health Select Committee, noted:

  ... the detail of the complaint or a trend in complaints can inform what to question and examine.[133]

- Professor Sir Liam Donaldson acknowledged the vital importance of complaints information in deciding which organisations required additional scrutiny. Recalling his days as a regional medical officer, he said about complaints:

  ... I always found them a very, very rich source of information. And not only can it help you to focus on individual institutions that are – or individual doctors who are not performing well, but also it can allow you to look at things thematically, so you can see if particular areas of care are resulting in complaints.[134]

131 Howell WS0002000008, para 40
132 Cumming T67.67
133 Matthew Ellis WS0000002764
134 Donaldson T122.95

- However, he warned of the difficulties in expecting a national regulator to scrutinise all complaints, given the large numbers involved. He thought the challenge was one of devising a method for harvesting and analysing the information from complaints into something useful. In his view the challenge was something it was important to overcome;[135]
- Professor Kieran Walshe considered that it was not only common for regulators to review and assess the processing of complaints by regulated organisations, but that it was important for them to do so;[136]
- Peter Walsh of AvMA, in comparing the functions of CHCs and what ICAS provided now, thought that more use needed to be made of complaints information:

  ... where I think there is potential for ICAS to do much more is in being more proactive about looking at learning from complaints and things that need to happen. When I was referring to community health councils I said that they were more joined-up, that the two functions were combined, which meant that directly data from complaints could feed into the monitoring and the intervention by the CHC. We've lost that in the fragmented system. It's almost as if ICAS is seen as in a side ... , as being advocacy in a purer sense. And what we would like to see more of is the ability to translate that learning into actual action to improve things and make them safer for patients.[137]

Standards for complaints procedures

3.122 The PA was critical of the absence of national standards for complaints handling and of the fact that there is currently no systematic, effective measurement of performance of complaints handling or the quality of investigations being undertaken at trust level. The time taken to respond to the complaint is the only national measure that is recorded and the PA feels that this provides a very limited insight into the quality of complaints handling at a trust.[138]

3.123 AvMA considers that there should be national guidance published and that the guidance should set out core standards relating to complaints handling.[139]

135 Donaldson T122.95–97
136 Walshe T8.124
137 Walshe T23.86
138 PA WS (Provisional), PA0000000016, para 73
139 Closing submissions, T134.11

Conclusions

Imbalance of power

3.124 It is clear that patients and their families can be reluctant to make or pursue a complaint, or even venture critical comment about care. A number of causes for this are possible including:

- A desire not to appear ungrateful for good care received;
- A wish to put a distressing experience behind them;
- Uncertainty about whether there was true cause for complaint;
- A fear of an adverse reaction from those criticised and their colleagues.

3.125 Reluctance for these reasons, particularly perhaps the last, can be found across the social spectrum and not only among sections of the community who might be regarded as disadvantaged. Even those with medical qualifications may be reluctant to complain if they fear that this will lead to a deterioration in the way that their relative is cared for. Fears such as these are, in part, the result of the imbalance of perceived power between the patient and the organisation. The inpatient is on his or her own, apart from visits from family and friends, for large parts of the day. There may be a feeling that the organisation will always defend its own. Patients and their families may sense that something wrong has occurred without being sure of what that might be through lack of relevant expertise, which they know that the organisation will have available to it.

3.126 An observation to emerge from the Inquiry seminars was that the current system was too orientated towards complaints and not sufficiently towards opportunities to make comments and suggestions in a neutral setting.[140]

3.127 Complainants may be understandably reluctant to add to the experience of a harrowing stay in hospital with the stress of complaining against a powerful organisation. They may be tempted to accept the dubious assurances of an action plan rather than to prolong the unhappy experience by referral to a higher stage in the process.

3.128 The obstacles to receiving the feedback they need have to be removed by organisations providing a service to the public. If they are not, the service is deprived of vital information on what it is that requires attention. Furthermore, recipients of the service who have received substandard care will receive no redress and will remain a potent source for reducing the reputation of the organisation and its standing in the community. A complaint that is not heard by the organisation is more damaging than a complaint that is received, acknowledged and remedied.

140 *Report from the Forward Look Seminars* (18 November 2011), Dr Sarah Harvey, page 24, www.midstaffspublicinquiry.com/sites/default/files/uploads/Report_from_Forward_Look_Seminars_-_tagged_for_website.pdf

3.129 What needs to be done to redress this imbalance of power?

- Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process.
- It should not be a barrier to the investigation of a complaint at any level that litigation is intended or in progress. It may be prudent for parties in actual or potential litigation to agree to a stay in proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation. Proper handling of complaints will reduce the need for litigation.
- Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints. Constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.
- While patients rights to have a matter treated as a complaint must be respected, feedback which suggests cause for concern should be the subject of investigation and response of the same quality as if a formal complaint had been made, whether or not the informant has indicated a desire to have the matter dealt with as a complaint.
- Comments or complaints which describe events amounting to an adverse or serious untoward incident should be treated as such.
- It is vital that complaints are dealt with promptly and effectively at a local level. No additional, national tier is going to make up fully for deficiencies at local levels. It is an intrinsic feature of a national level of oversight, such as that provided by PHSO, that it can only deal with a very limited proportion of cases, and that its procedures will add to the burdens already suffered by complainants. While the points made in this regard by the PA are valid, they should be seen as the inevitable consequence of local deficiencies, rather than as a criticism of the PHSO. On the other hand, the power of exposure to Parliamentary and public scrutiny implicit in an intervention by the PHSO is a valuable incentive to better local practice.

Support for complainants

3.130 The advocacy services provided for ICAS by POhWER are a laudable start to the steps necessary to empower patients wishing to lodge a formal complaint, but they are not sufficient. The special needs of the vulnerable and incapacitated patient require the focus that POhWER has offered, but all patients should be entitled, should they wish it, to active support in the pursuit of their complaint going beyond what is currently offered. Many patients and their families will be suffering emotional distress or recovering from the effects of illness and be less than ideally equipped to pursue a complaint to their satisfaction. While conscientious, skilled and well trained complaints handlers can go a long way in assisting a complainant,

their association with the organisation complained against may act as an inhibition to a complaint being presented to best possible effect. In any event, not all trusts have good complaints handlers. Not infrequently there is a complete breakdown in trust and confidence that makes complainants reluctant to engage personally with the organisation.

3.131 The lack of clarity about the extent to which advocates can provide advice to clients is concerning. While the advice provided on procedural points is obviously valuable, as is assistance in drafting letters and identifying precisely what the client wants to say, there should be no inhibition preventing properly trained and experienced advocates offering advice, where the client wants it, on matters of substance. Advice does not have to be followed, and it may be offered with caveats, but to the isolated complainant with little understanding of the NHS system, or clinical standards or practice, advice on the merits of a complaint could be a significant reassurance and encouragement to pursue with justified concerns.

3.132 Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support, whether or not they suffer from a disability.

3.133 ICAS advocates and their clients would benefit from access to expert advice in complicated cases. Without such a resource, complainants are likely to be at a disadvantage when faced with a trust that will have its own in-house expertise readily to hand. Without expert support, a complainant will find it difficult to assess or respond to justifications and explanations offered in response to complaints. Such expert support will not always need to be direct advice from an independent clinical expert, but could often be of a more generic type supplied by the advocacy service itself or patient support organisations such as AvMA.

3.134 Advocacy is not the only type of support a complainant may need. Organisations such as AvMA provide much help to people who have suffered in their contacts with the healthcare system. While it would be wrong to require service providers and commissioners to provide information amounting to a recommendation of a particular support organisation, it should be required to provide a list of such resources to all patients in general information about the service, and again to all those lodging complaints. Such information ensures that complainants know how to access completely independent sources of support, should that be necessary.

The lack of external scrutiny of complaints

3.135 The complaints system in the NHS relies understandably on trusts resolving complaints themselves and taking responsibility for identifying and implementing the learning to be gained from them. The sooner a complaint is resolved to the complainant's satisfaction, the less likely is further injury to be caused by the process. Practically, remedial action is likely to be more effective and prompt if devised by the trust itself. However, this assumes a well run

organisation which is open to the positive effect of complaints rather than one which is, or is becoming, defensive and closed in its culture.

Commissioners

3.136 It is a striking feature of the Stafford story how little involvement the commissioners of care have in scrutinising complaints. It is the commissioners who arrange for the service and pay for it. A justified complaint of poor service is by definition an instance of non-compliance with the arrangements and the standards included in them. It is an instance of a service for which they have paid, but which has not been delivered properly. Yet PCTs took little interest in individual complaints and made only passing reference to high level figures of complaints. As in so many other aspects of NHS oversight, PCTs appear to have been more concerned with the existence of processes than outcomes. Commissioners have a legitimate interest in complaints: it need not detract from the primary responsibility of provider organisations to process complaints for commissioners to be willing to be more proactive in overseeing that process, with the interests of patients firmly in mind.

3.137 Commissioners should require access to all complaints information as and when complaints are made. While it would be unreasonable to expect them to oversee the management of individual complaints, there will be some which give rise to particular concern, either because of their intrinsic gravity or because of a pattern, where they could properly undertake their own investigation or take part in that organised by the trust. There may be others where commissioners could usefully engage with complainants, either to support them in the pursuit of the complaint, or to assist in mediating a resolution. These are roles it might have been reasonable to expect a patient's GP to undertake, but now that the Government's intention is that commissioning groups are to be clinically led, they should be well equipped to assume this responsibility on behalf of all their GPs.

3.138 Commissioners should therefore be required by the NHS Commissioning Board to undertake this support and oversight role, and be given the resources to do so.

Local scrutiny bodies

3.139 OSCs and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.

Care Quality Commission

3.140 As already remarked it would be impracticable for the national systems regulator to become involved in individual complaints on a routine basis. However, it is clear that one of the triggers for the HCC investigation, and the course it took, was the enormity of the individual complaints of which it became aware in early 2008. There is therefore a need for a level of scrutiny of complaints that goes beyond high level statistics and categorisation.

3.141 If the suggestion made above, that complaints or comments suggestive of a serious untoward incident are treated as such, be implemented, the CQC should have a means of ready access to information about the most serious complaints. Its local inspectors should be charged with informing themselves of such complaints and the detail underlying them. Not all will require intervention, particularly if satisfactory steps are being taken by the provider trust and the commissioners, and if the complainant is satisfied in this way. This is not a suggestion that a three-tier complaints procedure should be introduced, but a recommendation that the CQC as a regulator should use the material provided by complaints in a more proactive way in enforcing compliance with standards.

Lack of independent element in process

3.142 Since the demise of CHCs, complaints are only likely to have been the subject of some form of independent investigation if the trust itself in its discretion decides to support one, or if a higher tier in the complaints process, previously the HCC or the PHSO, now only the latter, determines investigation is necessary.

3.143 It is not every complaint which requires independent investigation; some are, even from the complainant's point of view, relatively minor. Others are resolved quickly by an initial inquiry, or an acceptance that some easily implemented change in practice is required, and appropriate redress offered to the complainant. Many complaints, however, involve serious incidents, complex medical histories and deeply traumatised individuals. A brief consideration of the cases considered in the Independent Case Note Review would confirm that in each of those cases expert external consideration was necessary and in most cases brought new perspective to the concerns of the complainants.

3.144 Such external scrutiny as takes place now will often be overseen by a non-executive director and therefore suffers from not being entirely independent.

3.145 Albeit in the exceptional circumstances of the aftermath of the HCC report, the Independent Case Note Review eventually led by the PCT shows that external and independent scrutiny is possible, even if such an extensive review could not be expected to take place routinely. The involvement of commissioners, as suggested above, may be sufficient in many cases, but there will be others where arm's length independent investigation would enhance the process. The grounds for such a step include:

- A complaint amounting to an allegation of a serious untoward incident;
- Subject matter involving clinically related issues not capable of resolution without an expert clinical opinion;
- Complaints raising substantive issues of professional misconduct or the performance of senior managers;
- Complaints involving issues about the nature and extent of the services commissioned.

Use of the information from complaints

3.146 At the centre of this Inquiry is the question of why the problems of the Trust did not come to light sooner than they did. Much has been said about the absence of signs of serious deficiencies, but such assertions cannot survive a consideration of the hundreds of complaints of appalling standards of care at the Trust as recorded in the report of the first inquiry. The blunt truth is that all the evidence to show that there were serious issues was present in the complaints, if only that information had been accessed and reacted to appropriately.

3.147 The evidence shows that during the period under review, only limited information was collected from complaints and analysed. What information there was failed to reach the Trust Board, which was led by an attitude that an apparently resolved complaint was not one to be concerned about. A similar, if not as extreme attitude, pervaded the system. Thus, information about complaints received by the DH was of a very high level and of little use. Therefore, numbers of complaints would have given little clue as to whether any trust was providing a good or a bad service, as high numbers could be portrayed as indicating an open culture encouraging feedback whereas low numbers could be interpreted as indicating that there was little to complain about. Categorisation of complaints was too broad for example, having one category for all clinically related complaints. The statutory complaints process throughout the period under review paid less attention to "resolved" complaints than it did to ones where the complainant remained dissatisfied.

3.148 AvMA, through Peter Walsh, has suggested that ICAS should take up responsibility for collating information to ensure that the relevant learning takes place. While ICAS and its providers should certainly not be discouraged from such activity, it is not sufficient to replace the role he identified CHCs as performing in a location where all sorts of health data could be collected, including that from complaints.

3.149 Commissioners need to have a view of the standard of service being provided for their patients. They are sufficiently proximate to their commissioned providers to be able to engage with a local level of detail. Part of the information to inform that view should be that coming from complaints in the manner suggested above. Additional scrutiny of the information for this purpose should be performed by Local Healthwatch, OSCs and the local CQC inspectorate.

Transparency

3.150 It was a feature of complaints handling at the Trust that complainants were met with formulaic apologies, assurances that lessons had been learned and action plans which did not prevent repeated deficiencies of a similar nature. None of this would have escaped public attention for so long had the Trust been obliged to publish details of the complaints it received and what it was doing about them. In order to be an effective incentive for good complaints practice it is not sufficient for headline figures and selected examples of apparent good

practice to be published, as appears in some Quality Accounts. AvMA proposed that it be made a requirement for, "every NHS body to declare their status with regard to each PSA (patient safety alerts, safer practice notices and rapid response reports) applicable to them which is past the completion date, in an accessible way on their website, in their Quality Accounts and on a central website such as NHS Choices".[141]

3.151 Subject to anonymisation sufficient to protect patient confidentiality and privacy rights, as well as legitimate staff expectations, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response, should be published on a trust's website. In this way the system can demonstrate its commitment to welcoming complaints and its work to correct deficiencies. It would also give recognition to the accountability of trusts to the public and would provide an additional means of redress for the patient.

3.152 In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the commissioner and the CQC.

Contingency planning for catastrophes

3.153 It is to be hoped that episodes such as that suffered in Stafford do not occur frequently, but it is apparent that events involving concerns about the treatment given to large numbers of patients occur with some regularity. Maidstone and Tunbridge Wells is but one other example.

3.154 The system for dealing with grievances through the complaints system is designed understandably to address individual complaints rather than collective ones. It is not a system which copes well with multiple complaints against the same provider. The need for the Independent Case Note Review indicates the gap that was experienced in the system for meeting the needs of a large group of patients. The vagaries around the setting up of the review did not assist in developing trust in it on the part of those who needed its services. It is no criticism of Dr Laker and his team that it took a considerable amount of time to arrange for the resources and independent oversight necessary for him to be able to conduct it. These problems were due to the absence of any contingency plan, locally or nationally, on how to address such a large group of concerned patients and families. Clearly, what is required in such circumstances will depend on the nature of the issues involved, but large-scale failures of clinical service are likely to have in common a need for:

- Provision of prompt advice, counselling and support to very distressed and anxious members of the public;

141 CL0000000467, *AvMA's closing submissions*, page 113

- Swift identification of persons of independence, authority and expertise to lead investigations and reviews;
- A procedure for the recruitment of clinical and other experts to review cases;
- A communications strategy to inform and reassure the public of the processes being adopted;
- Clear lines of responsibility and accountability for the setting up and oversight of such reviews.

3.155 Such events are of sufficient rarity and importance and require coordination of the activities of multiple organisations for the primary responsibility to reside in the National Quality Board.

Summary of recommendations

Recommendation 109

Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.

Recommendation 110

Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.

Recommendation 111

Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.

Recommendation 112

Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.

Recommendation 113

The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.

Recommendation 114

Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.

Recommendation 115

Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply:

- A complaint amounts to an allegation of a serious untoward incident;
- Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;
- A complaint raises substantive issues of professional misconduct or the performance of senior managers;
- A complaint involves issues about the nature and extent of the services commissioned.

Recommendation 116

Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.

Recommendation 117

A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.

Recommendation 118

Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.

Recommendation 119

Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.

Recommendation 120

Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.

Recommendation 121

The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.

Recommendation 122

Large-scale failures of clinical service are likely to have in common a need for:

- Provision of prompt advice, counselling and support to very distressed and anxious members of the public;
- Swift identification of persons of independence, authority and expertise to lead investigations and reviews;
- A procedure for the recruitment of clinical and other experts to review cases;
- A communications strategy to inform and reassure the public of the processes being adopted;
- Clear lines of responsibility and accountability for the setting up and oversight of such reviews.

Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.

Chapter 4
The foundation trust authorisation process

Key themes

- The foundation trust (FT) policy was based on an assumption that strong finances and governance lead automatically to good quality care and relied on the system of star ratings and health checks rather than direct assessment of the quality of the service.
- Changes in the eligibility criteria for support for an application were implemented without consideration of the potential implications for the assumption that quality followed finance and governance.
- Policy pressure to maintain the flow of applicant trusts may unintentionally have led to less attention being paid to signs of concern.
- The process of public consultation did not expressly explore the quality of service of applicants or whether respondents actually supported the application.
- Ministerial statutory approval for the Trust's application was based on inadequate information which did not adequately draw out concerns that had been identified by officials.
- The significance of Ministerial approval was not clearly understood.
- Monitor's process of assessment for the Trust did not explore in any depth issues relating to quality and safety and did not include any express request to the Healthcare Commission (HCC) for its view of the application.
- Monitor received less than full answers from the Trust Board to the limited questions asked relating to quality.
- The decision to authorise the Trust was made without knowledge of the concurrent consideration by the HCC of whether to launch an investigation into concerns about mortality and complaints, and would not have been made if this had been known.
- The experience of Stafford shows the dangers of separate organisations assessing and monitoring finance and governance, and the quality of the service provided.

Introduction

4.1 It was a finding of the first inquiry, not disputed by any evidence tendered at this one, that the Mid Staffordshire NHS Foundation Trust should not have been authorised as an NHS foundation trust. At the very moment that Monitor's Board was approving the authorisation, its fellow regulator, the HCC, was preparing to announce a formal investigation of the Trust following the serious concerns that had arisen as a result of high mortality rates and complaints about the standard of care being provided. There is a consensus that Monitor's assessment processes were unduly focused on financial governance at the expense of any thorough consideration of clinical governance and the standard of service provided. It was a finding of the first inquiry, not universally accepted at this one, that the Trust Board's drive towards FT status diverted its attention from the issues around the delivery of the service and formed the basis of an ill-judged belief that achievement of this goal would in itself solve many of the problems which had been identified.

4.2 In spite of the consideration already given to this issue, a further detailed analysis is justified at this stage. The concept of FT status remains at the heart of the NHS system and will continue to do so for the foreseeable future. A significant number of NHS trusts have yet to be authorised, although Government policy remains that all should be authorised as soon as possible. Therefore, any lessons to be learned from the failure of the process to detect the ineligibility of a trust continues to have relevance. Further, the process involved many sections of the healthcare system and it is important to consider why, collectively and individually, they failed to perform effectively the task set for them. Whatever may be said about the Trust Board having prime responsibility for the delivery of care, the FT process was one in which many organisations and individuals had responsibilities that, had they been fulfilled, would have avoided this erroneous authorisation. The gravity of such a universal governance failure can hardly be overstated.

4.3 This chapter will first consider the FT process in general terms, including its policy origins, statutory foundations, the framework through which a trust might be granted FT status and the political pressures brought to bear on both the process itself and participants within it. The authorisation process will then be viewed in practice as it applied to the Trust, firstly in its own application and consideration of this by the Strategic Health Authority (SHA), the Department of Health (DH) and the Secretary of State for Health, and then in the assessment and eventual authorisation of the Trust by the FT regulator, Monitor. Finally, overall conclusions will be drawn and recommendations for the better operation of the FT process set out.

Overview of the foundation trust process

The policy origins of foundation trusts

4.4 The legal entity of an NHS foundation trust was created with effect from 1 April 2004.[1] The policy intention behind the creation of NHS foundation trusts was to improve performance through:[2]

- Devolving decision-making from the centre to local organisations and communities;
- Improving local accountability in the NHS;
- Increasing involvement of local communities through boards of governors and membership;
- Increasing autonomy by broadening financial freedom to borrow and invest.

4.5 There is no doubt that the intention was, in the first instance, for FTs to be centres of excellence, and to lead the improvement in standards in the NHS. In his foreword to *A Guide to NHS Foundation Trusts* the then Secretary of State, the Rt Hon Alan Milburn MP, said:

> *NHS Foundation Trusts will be at the cutting edge of the Government's wider reform programme for the public services, with the freedom to improve services for NHS patients without interference from Whitehall. The first generation of NHS Foundation Trusts will be led by the best performers – existing 3-star Trusts. This is not about elitism. It is about starting with the hospitals currently most able to benefit from NHS Foundation Trust status. Forty percent of these 3-star Trusts serve some of the poorest communities in the country. As more hospitals improve, more will become NHS Foundation Trusts. There will be no arbitrary cap on numbers. The freedoms that NHS Foundation Trusts will enjoy will provide an incentive for others to improve. There will, of course, be more help, support and where necessary intervention to raise standards across NHS Trusts where performance is poor.*
>
> *Within the national framework of standards NHS Foundation Trusts will be able to gear their services more closely to the communities they serve.*
>
> *For the first time since 1948 the NHS will begin to move away from a monolithic centralised system towards greater local accountability and greater local control. Reform cannot be achieved by holding on to the monolithic centralised structures of the 1940s. We cannot reform by looking backwards. We need to look forwards. Reform means investing not just extra resources in frontline services, but power and trust in those frontline services.*

1 Health and Social Care (Community Health and Standards) Act 2003
2 WS0000062956, *Review of NHS Foundation Trusts,* Healthcare Commission (July 2005)

I believe the reform programme outlined here is every bit as radical and progressive as that which created the NHS over fifty years ago. It draws on the traditions of social and community ownership that inspired the founders of the NHS. It sticks firmly to the principles on which the NHS was founded. And it places a premium on local accountability for local services.

We are moving to an NHS where standards are national but control is local. NHS Foundation Trusts are a means to that end.[3]

4.6 The principles, which were said to govern the reforms, were to be the:

- *establishment of explicit national standards and clear accountability for NHS care – so that patients know that the care they get will meet national standards wherever they get treatment, and clinicians and managers know what standards they will be judged against;*
- *greater devolution of power and responsibility from the Department of Health to the clinicians and managers who are responsible for care at the front line – so that the people who know best what needs to be done can take action without going through a complex bureaucratic process;*
- *more flexibility for NHS staff – so that care is provided in the way that best fits the needs of patients and the skills of individual members of staff rather than being designed around old-fashioned demarcation between the professions;*
- *greater diversity of provision and choice for patients – so that care can properly be designed around individual needs.*[4]

4.7 It was emphasised that the new framework would operate within a system which "protects high standards for NHS services".[5]

4.8 The intention was that the greater freedom from central control would be balanced by a system of accountability involving:

- The local community via a management board and a board of governors;
- The issue and monitoring of a licence by the independent regulator, Monitor;
- Agreements with commissioners;
- Inspections by the healthcare regulator, the Commission for Healthcare Audit and Inspection (known as the Healthcare Commission), and annual performance assessments.[6]

3 *A Guide to NHS Foundation Trusts,* Department of Health (12 December 2002), pages 3–4
4 *A Guide to NHS Foundation Trusts,* Department of Health (12 December 2002), page 6, para 1.9
5 *A Guide to NHS Foundation Trusts,* Department of Health (12 December 2002), page 8 para 1.16
6 *A Guide to NHS Foundation Trusts,* Department of Health (12 December 2002), page 9,para 1.21

4.9 There is no doubt that the granting of FT status was a very serious step. At the time, there were no provisions for the removal of the status and no "failure regime" was provided for. Indeed, in spite of a late legislative effort by the last Government, no effective provision for the dissolution of an FT was created until the recent enactment of the Health and Social Care Act 2012. Monitor had powers of intervention, but these only included powers to remove the board and to issue directions to the FT.[7]

4.10 The legal effect of a change to FT status was to remove a trust from the ambit of direct responsibility of the Secretary of State. The Secretary of State's powers to make directions did not apply to FTs. This extended to the exclusion of FTs from the reach of the emergency powers accorded to the Secretary of State for Health.[8] On 25 March 2004, the then Secretary of State, the Rt Hon John Reid MP, wrote to the Speaker of the House of Commons making this new relationship clear:

> *NHS Foundation Trusts (NHSFTs) are independent of the Department of Health, and are directly accountable to their local populations and to Parliament. As a consequence of this independent status, and of this separate and local route of accountability, I and my Ministerial team will no longer be in a position to comment on the detail of operational management within NHSFTs ...*
>
> *... Questions about the services commissioned by the NHS locally, which remain the responsibility of Primary Care Trusts, and whether and to what extent they meet the needs and expectations of patients, will of course continue to be the responsibility of DH Ministers.*[9]

4.11 The practical reality turned out to be different when serious failures occurred, such as those at the Trust. As will be considered elsewhere in this report, it has proved to be quite impossible for Ministers to avoid addressing, accounting for, and, in some cases, intervening in the affairs of FTs; a position that persists to the present. Thus the DH has had in recent times to provide substantial cash support to the Trust; £21 million in 2011–2012. There was an inherent conflict between the theory of FT autonomy and the position of the Secretary of State as responsible for securing the provision of the NHS.[10] In political terms, it was always going to be the case that, in instances of serious failure, the Secretary of State would have to account to Parliament for what was being done to address the issues, while legally he had no powers of intervention. This conflict has potentially been reduced by the new legislation that now allows the Secretary of State to apply emergency powers to NHS FTs.[11] Sir Hugh Taylor, the former Permanent Secretary of the DH, admitted that it was arguable that the interrelationship

7 Section 23 Health and Social Care Act 2003; and section 52, National Health Service Act 2006
8 National Health Service Act 2006, section 253(4)
9 MON0000000232–233, Letter from John Reid to Speaker of House of Commons (25 March 2004)
10 National Health Service Act 2006, section 1(2), now replaced by virtue of section 1 of the Health and Social Care Act 2012
11 Health and Social Care Act 2012, section 47(6)

between the different parts of the system in addressing problems or failings in the quality of services provided by FTs had received insufficient attention.[12]

4.12 A second reason for a tension between the concept of FT autonomy and the duties of the Secretary of State was caused by his being the principal source of finance for FTs. As David Flory (the DH Director General of NHS Finance, Performance and Operations and Deputy Chief Executive of the NHS at the time of giving evidence) pointed out, the finances of FTs remained on the DH balance sheet and the DH was accountable for those finances.[13]

The statutory authorisation process

4.13 In order for an NHS trust to become an FT it is required to apply to Monitor for authorisation.[14] The legislation provides for a number of threshold requirements to be fulfilled:

- Secretary of State support: The application has to be "supported" by the Secretary of State.[15] What such "support" entails is not defined in the Act and was the subject of much evidence and will be considered below.
- Public consultation: Applicants have to consult:
  - The relevant patients' forum;
  - Members of the public resident in the area proposed as its public constituency;
  - Potential members of any patient constituency;
  - Any local authority proposed to be empowered to nominate a governor;
  - Any persons prescribed by regulations.[16]

4.14 A number of other criteria had to be satisfied before Monitor was empowered to grant authorisation. It had to be satisfied with the proposed constitutional arrangements as prescribed by the Act and, among other matters, that:

- The steps necessary to prepare for NHS FT status have been taken;
- The applicant will be able to provide the goods and services which the authorisation will require it to provide;
- Any other requirements which the regulator considers appropriate are met.[17]

12 Taylor WS0000061929, para 15
13 Flory T121.83–84
14 National Health Service Act 2006, section 33
[In the National Health Service Act 2006 which consolidated the Health and Social Care (Community Health and Standards) Act 2003 with other statutes, the regulator is referred to as the Independent Regulator of NHS Foundation Trusts, but for convenience is referred to in this report throughout as Monitor, the regulator's operating name.]
15 Health and Social Care (Community Health and Standards) Act 2003, section 4; National Health Service Act 2006, section 33(1)
16 Health and Social Care (Community Health and Standards) Act 2003, section 6(5); and National Health Service Act 2006, section 35(5)
(NB: the patients' forums requirement has since been removed under Local government and Public Involvement in Health Act 2007 c. 28 Sch.18(18) para 1)
17 Health and Social Care (Community Health and Standards) Act 2003, sections 6(2)(d)–(f), National Health Service Act 2006, sections 35(2)(d)–(f)

4.15 Monitor was also required in making its decision to consider the financial position of the application and any report or recommendation in respect of the applicant made by the healthcare regulator.[18]

4.16 Monitor interpreted these requirements as requiring it to adopt a risk management approach and to be "confident" and "able to provide assurance to Parliament" that the applicant was or would be if authorised:

- Legally constituted;
- Financially viable;
- Well governed.[19]

4.17 It will be noted that this approach makes no special reference to the need for applicants to be delivering a service to a minimum standard. The requirement in this regard was merely to take account of any view expressed by the HCC. There was no requirement to request a report from the healthcare regulator, and, at the relevant time, it was not the practice of Monitor to do so. Instead, it relied on the routine output of the HCC as described below. A form of quality threshold was imposed by the DH which applicants had to meet in order to obtain the necessary departmental approval. However, this was lowered over the course of time.

4.18 In his written closing submissions, Counsel to the Inquiry contended that the level of quality of care that applicants had to demonstrate was "decided by the Secretary of State."[20] While this is correct with regard to the requirements for gaining Ministerial support, Monitor was free under the legislation to set its own standards or means of measurement.

Statutory content and effect of authorisation

4.19 Monitor may grant an authorisation on any terms it thinks are appropriate.[21] It can and does have a number of standard terms. These included requirements that the FT:

- Exercise its functions "effectively, efficiently and economically";
- Have regard to the NHS Constitution;
- Govern themselves in accordance with best practice, maintaining the organisation's capacity to deliver mandatory services;
- Put and keep in place and comply with arrangements for the purpose of monitoring and improving the quality of healthcare;

18 2003 Act, section 6(3), 2006 Act, section 35(3)
19 CURE0007000040, *Applying for NHS Foundation Trust Status: Guide to Wave 3 Applicants* (November 2005), Department of Health, para 2.4; Moyes WS(2) WS0000039625, para 10
20 Closing Submissions, Chapter 14, p955, para 21
21 Health and Social Care (Community Health and Standards) Act 2003, section 6(4); National Health Service Act 2006, section 35(4)

- Deliver services to specified standards under agreed contracts with their commissioners; and comply with healthcare targets and indicators;
- Cooperate with a range of NHS bodies and local authorities, and with Monitor and the Care Quality Commission (CQC).[22]

4.20 It can also include conditions and requirements specific to particular FTs. The terms of authorisation may be varied by Monitor but regard must be had to any report from the local Health Scrutiny Committee and, while it existed, any recommendation of the Commission of Patient and Public Involvement in Health (CPPIH).[23]

4.21 Once the authorisation is granted, the trust ceases to be an NHS trust and becomes a statutory "public benefit corporation". The effect is that it ceases to be an agent of the Crown, and its property must not be regarded as held on behalf of the Crown.[24]

4.22 Once authorised, an FT becomes subject to the regulatory supervision of Monitor and its powers of intervention on being satisfied that the organisation is in significant breach of its terms of authorisation. A significant failure in the provision of care could amount to such a breach. The powers of intervention include the power to direct a change of leadership.

The political and organisational expectations

Initial intentions

4.23 The proposal to introduce FTs was politically controversial and the legislation enjoyed a contentious passage through Parliament. During the debates the then Secretary of State, Rt Hon John Reid MP (now Lord Reid), informed the House of Commons that the first wave of FTs would be authorised in 2004, after which the opportunity would be taken between the autumn of 2004 and the autumn of 2005 to review the experience in conjunction with the HCC.[25] The first "wave" was to be divided into two parts, a group of 25–29 hospitals, already announced, and a further group of 30 or fewer.[26] The effect of this, according to Dr Moyes (Monitor's Executive Chairman from November 2003 to January 2010), was that the first group was expected to be authorised by April 2004, and the second by July of that year.[27] In the absence of any established process, Monitor felt there was "considerable time pressure" to get a working process in place. This is described below.[28]

22 AM/3 WS00030000276
23 National Health Service Act 2006, section 38(2)(b)
24 National Health Service Act 2006, section 36
25 Moyes WS0000039624, para 6; BM/1 Hansard, WS0000039712–713 (19 November 2003) col 825–826
26 *House Of Commons Debate,* Hansard (19 November 2003), col 827
27 Moyes WS0000039628, para 15
28 Moyes WS0000039625, para 8

4.24 The initial DH policy was that only trusts awarded a Commission for Health Improvement (CHI) three-star rating would be eligible to apply for FT status.[29] The requirement was that they had to have been awarded three stars for two consecutive years and retain it during 2002/03.[30] As was made clear in the 2002 *Guide to NHS Foundation Trusts*, the intention was that an increasing number of trusts would achieve this rating and thereby evidence their improved performance and be rewarded for this with FT status:

> *The first NHS Foundation Trusts will be drawn from existing 3-star acute and specialist NHS Trusts. But as more NHS Trusts improve more will be eligible to apply for NHS Foundation Trust status and in later waves eligibility will be opened up to other types of NHS Trust. A range of measures is already in place to improve performance across the whole NHS. These include extra resources, external help from the NHS Modernisation Agency and, in extremis, imposition of new management teams through the franchising process. Gaining 3-star status will continue to be a pre-condition for granting NHS Foundation Trust status. This is in order to reward good performance and to act as an incentive for others to improve their performance. No limit has been set on the number of NHS Foundation Trusts that could be established.*[31]

4.25 This carried with it the implication that FT status was an exclusive club.[32]

4.26 Mr Warren Brown, a senior civil servant working on FT policy from 2003, thought that this requirement was "consistent with a sense of 'earned autonomy'", and the fact that "any new policy tended to be focused on those organisations regarded as being the most capable at managing their finances and service performance".[33]

4.27 He recalled that while the legislation was proceeding through Parliament there had been some ambiguity about whether FT status was intended for all trusts or only high performers. This was settled when the then Secretary of State announced that he expected all trusts to be in a position to apply for FT status within four or five years.[34]

4.28 Even at this early stage, it is clear that Monitor, for all the determination of its Executive Chairman, Dr Moyes, to preserve its independence, was cast in the role of providing support for Government policy. This was inherently in conflict with the required role of an independent regulator. The former required achievement of an aim within a specified time, whereas the latter required the taking of such time as was reasonably needed to reach an independent and proportionately thorough assessment of the merits of applicants. That said, Dr Moyes emphasised to the Inquiry that he never felt placed under any pressure to authorise particular

29 Gill T56.11–12
30 Brown T118.6–7
31 *A Guide to NHS Foundation Trusts,* Department of Health (December 2002), p13, para 1.41
32 Gill WS0000008095, para 20
33 Brown WS0000062915, para 6
34 Brown WS0000062916, para 7

applicants or applicants generally. Indeed, during the period under review, a number were in fact rejected.[35]

2004

4.29 In July 2004, the Government commissioned a review from the HCC into the impact of the first 20 FTs on the wider NHS and, among other issues, on the improvement of quality of care. The Secretary of State made a commitment not to approve any new applications between autumn 2004 and autumn 2005 pending the outcome of this review.[36] No change was then made explicitly to the previously announced policy that all trusts would become FTs within four or five years.[37]

2005

4.30 The HCC review was published in July 2005. Its helpfulness was somewhat limited by the fact that FTs had only been in operation for a year at the time of the review. No significant difference between FTs and NHS trusts on the available indicators of quality was found.[38] The indicators included various waiting time and admissions statistics, and some patient survey responses. There was no consideration of mortality or treatment outcomes.[39] However the review did identify a need "to ensure that the respective roles and responsibilities of Monitor and the HCC are clear, building on the existing work of the two organisations".[40]

4.31 No recommendation was made in the review to change the eligibility criteria to be applied by Monitor.

4.32 In November 2005, the Secretary of State, the Rt Hon Patricia Hewitt MP, announced a significant policy shift. She re-committed the Government to "offering all NHS trusts the opportunity" to become FTs by 2008.[41] She announced a programme of diagnostic checks in response to concerns expressed about financial management in some parts of the NHS to help trusts prepare for FT status. She also announced the "opportunity" for those trusts awarded a two-star rating by the HCC to apply to the DH for support in making an application to Monitor for FT status.

35 Moyes WS0000039628, para 15
36 Brown WS0000062916, para 10
37 Brown T118.9
38 Brown WS0000062917, para 11; WB/1 WS0000062957
39 WB/1 WS0000062976–977
40 Brown T118.12; WB/11 WS0000062961, para 5
41 Brown WS0000062917–918, paras 13.3 and 14; WB/2 WS0000063044; CURE0007000036, p1

4.33 Ms Hewitt said that the purpose of the diagnostic exercise was to:

> *... drive a culture of improved financial management across the NHS and give acute trusts a clear indication of any areas for improvement before they embark upon the NHS foundation trust application process.*

4.34 She was quite explicit that extending eligibility for the DH support to two-star trusts was not intended to lower standards:

> *To be authorised as an NHS Foundation trust by Monitor, applicants have to be able to demonstrate their clinical and financial viability and sustainability as well as their overall capacity and capability to take on the additional freedoms and flexibilities ... Monitor's authorisation process ... ensures that NHS Foundation trusts are clinically and financially sustainable, effectively governed, locally representative, legally constituted and well managed ... There is no question of lowering standards for authorisation as an NHS Foundation Trust. Monitor will continue to be as rigorous as before in determining whether applicants can be authorised ...*

4.35 Sir Andrew Cash, Director-General of Provider Development at the DH between July 2006 and June 2007, denied that this change represented a lowering of standards, rather it was to widen the pool from which applicants could be chosen. The need to do this was "because there was a policy direction that every NHS trust should ... be in a position if possible to have the opportunity to apply for an FT status by 2008".[42]

4.36 In his view:

> *... in two star organisations, as they were then, there are some extremely good, very, very good, very good organisations that are perfectly capable of making excellent foundation trusts ...*[43]

4.37 One reason for these changes was explained by Warren Brown as being the realisation that there was no direct connection between star rating status and the level of performance of trusts: two-star status did not necessarily mean that a trust was a poor performer. Monitor, in any event, took into account some other quality information and felt that there was little difference between three and two-star trusts.[44] It was felt that the proposed diagnostic exercise would provide a more thorough analysis of performance.[45] However, by this time

42 Cash T119.34
43 Cash T119.35–36
44 Gill T56.12–13; Gill WS0000008095, para 20
45 Brown T118.16

most three-star trusts had been authorised as FTs, with the exception of those where there were external reasons obstructing authorisation.[46]

4.38 Another reason was suggested by Mr Mike Gill, who worked for Monitor at the time. He suggested that the initial experience was that fewer trusts than had been expected had succeeded in being ready for FT status:

> *There was some concerns that I think various deadlines had been put – or set out nationally, in terms of the timetable of authorisation of foundation trusts. From the word go there was a fairly high attrition rate. I think both the department and Monitor were concerned about the kind of future flows through to foundation trust and the applicants, and wanted to get a better steer in terms of the national picture of when organisations may be ready to to apply to become a foundation trust.* [sic][47]

4.39 The "attrition rate" to which he referred was due to a failure to comply with the expectations of financial governance and sustainability rather than concerns over clinical quality, as all the trusts eligible for consideration at this time had a three-star rating, which was the only quality consideration. The problem was that some trusts might have achieved a three-star rating at the expense of keeping their finances under control.[48] Therefore, there was no necessary association between the assessment of quality and Monitor's focus on financial issues. This was explained by Mr Gill:

> *I think we were trying to set out that we were assessing them on a very different set of indicators than the star rating system and, therefore, there's a disconnect between saying that a three-star trust is a good trust, in quotes, in all aspects and, therefore, should be able to achieve the FT status. So I think we were trying to indicate that ... a three-star status is telling us ... something around the clinical aspects and service delivery aspects of an organisation, whereas we were very focused around the financial and corporate governance aspects, and there was a disconnect between the two.*[49]

4.40 Similarly, Mr Brown told the Inquiry that one reason for the introduction of the diagnostic had been the concerns expressed by Monitor to the DH about the quality of applicants coming through for assessment and the resulting perception of a need to prepare trusts better for the process.[50]

4.41 The limitations in actual practice of the assessment of clinical quality during the diagnostic exercise are explored below, but there was a policy assumption at the DH that during

46 Brown T118.16
47 Gill T56.10; Gill WS0000008093–094, para 13
48 Gill T56.12; Gill WS0000008905, para 20
49 Gill T56.14–15
50 Brown T118.14

Monitor's authorisation process "clinical quality would be part of the rounded picture that Monitor took, looked at".[51]

4.42 However, it was also known that Monitor did not have the resources or skills to undertake its own thorough assessment of clinical quality, and would have to rely on the judgement of others. As Warren Brown put it:

> *I don't think Monitor themselves were in a position to assess clinical quality, in the sense that they didn't have a high level of expertise. They did have some expertise. There were people clinically qualified on Monitor's board, but Monitor was well positioned to take advice from others, as it did on financial matters.*[52]

4.43 This was the true meaning of the expectation expressed by the Secretary of State that the process would "ensure" that FTs were "clinically sustainable".[53]

2006

4.44 In 2006, the star rating system was abandoned in favour of the Annual Health Check (AHC) as the means for the HCC to regulate the compliance of healthcare providers with clinical standards. This gave rise to a discussion between the DH and Monitor about the need for, and nature of, any clinically relevant criteria for FT status. A suggestion was made in a series of revealing emails shown to the Inquiry that there was no need for such criteria at all. In March 2006, in response to an enquiry from Stephen Humphreys, Monitor's Director of Communications, about the "entry criteria" for consideration of DH support for an application, Warren Brown said:

> *Off the record we do need to go to Ministers in the next month or two and will use the* [HCC]*'s change of system and the diagnostic as an argument to remove the entry criteria but I expect it will be a tough argument. Ministers will be very sensitive to any public criticism that entry standards have lowered even if they understand the arguments (which they do).*[54]

4.45 Dr Moyes did not agree:

> *I'm not sure we should support no entry criteria. There's a danger that the department will send everyone to us and leave it to us to sort them out.*[55]

51 Brown T118.19
52 Brown T118.19. Mr Brown assumed responsibility for this policy area in 2006 but there is no reason to believe the position had changed since the previous year.
53 Brown T118.21–22
54 WB/1 MON0000000205
55 WB/1 MON0000000205

4.46 Mr Brown explained to the Inquiry that he had not meant there should be no eligibility criteria at all, merely that the diagnostic was a more effective means of assessing eligibility than reliance on an HCC rating. He did not think the AHC was a reliable indicator of whether a trust would be stable for the next three to five years.[56]

4.47 In July 2006, the DH published a policy document, *Health Reform in England,* in which it expressed the intention for there to be 70 FTs by spring 2007 and "potentially" 100 by the end of that year.[57] SHAs were tasked with working closely with NHS trusts "to get them into a good position and give them the opportunity to apply for FT status in 2008".[58]

4.48 The programme was to be led by Sir Andrew Cash, the newly appointed Director-General of Provider Support, and his directorate team. Sir Andrew was seconded to this post from his post as Chief Executive of an FT. He was also Chair of the Foundation Trust Network. He was a strong advocate of the merits of FT status. Sir Andrew set out the work programme of his Directorate to the NHS Management Board on 17 July 2006. This included "ensuring as many NHS organisations as possible have the opportunity to apply for NHS Foundation Trust (FT) status".[59]

4.49 Sir Andrew also wrote to the Chief Executives of all SHAs.[60] In the letter to Cynthia Bower, then Chief Executive of West Midlands SHA (WMSHA), he said, "We are keen to press ahead [with] the NHS Foundation trust roll out programme".[61]

4.50 He expressed the hope that "a more challenging timescale might be set out for achieving [FT] status for some NHS trusts once you are aware of the issues that need to be addressed".

4.51 The DH would be sending out a team, including Mike Gill, on secondments from Monitor, to assess progress on plans arising out of the diagnostic programme and to support trusts in their work towards an FT application.[62] He wanted "to invest some energy into ensuring the flow of NHS Trusts coming through".[63]

4.52 He was expecting SHAs to nominate trusts "they think could be authorised as [FTs] in summer 2007".[64]

56 Brown T118.24–25
57 *Health Reform in England: update and commissioning framework,* Department of Health (13 July 2006), gateway ref 6865, p26, para 4.4
58 *Health Reform in England: update and commissioning framework,* Department of Health (13 July 2006), gateway ref 6865, p26, para 4.3
59 AC/1 WS0000061536
60 Sir Andrew Cash WS0000061516, para 18
61 AC/2 WS0000061540
62 Sir Andrew Cash T119.11–12
63 AC/3 WS0000061543
64 AC/3 WS0000061543

4.53 The timetable set out for the next wave of applicants was over a shorter period than previous timetables.[65]

4.54 On 2 August 2006, Sir Andrew wrote to the SHAs asking for their list of applicants by 15 September.[66] By 8 September, few applications had been received at the DH. Warren Brown observed in an email to Mike Gill that this meant the timetable was "very tight" for "challenging assumptions". He suggested that it might be assumed that the trusts who had concluded the diagnostic exercise should be put forward:

> *Don't need much consideration (i.e. we take the SHA's assurance that they're on track at face value) but we'll need to challenge those where the diagnostic suggested* [a] *later* [application] *... my temptation would be to let them come in on the SHA's advice unless we know of any good reason why not.*[67]

4.55 Mr Shanahan, then newly appointed as Director of Finance and Capacity at the WMSHA, told the Inquiry that he understood the stage referred to in this email was that of obtaining the DH's approval for a potential applicant to commence public consultation.[68]

4.56 On 18 September, Mr Brown proposed modifications to the DH processes.[69] These included a "light touch" assessment by the DH when considering Ministerial approval for a potential applicant to commence consultation. This was to consist of a "negative" test, ie disapproval only if the trust was not thought to be at least "on track" for fulfilling the requirements of the diagnostic test or if something negative outside the diagnostic process was known. The final advice to the Secretary of State when his approval was asked for was to be prepared by a committee, jokingly referred to as the "Star Chamber", informed by the advice of Sir Andrew's directorate.

4.57 Mike Gill and a colleague from Monitor were concerned at an attempt to make a clear division between the preparation and processing of an application and responded:

> *Overall we do not feel that there is a black and white cut off between preparation for application and the application process, things are never that clean and therefore we have reworded parts to try to reflect this. Ultimately we need the Star Chamber* [Applications Committee] *brief to be comprehensive, rounded and contain the full facts (Apps and FUT) in order that an informed decision can be taken even if it is taken with one eye on the politics!*[70]

65 Sir Andrew Cash T119.29
66 DH00000002251
67 DH00000002251–2252
68 Shanahan T72.106–107
69 WB/4 WS0000063082–3
70 WB/4 WS0000063081

4.58 Mr Brown replied, generally agreeing, but adding a comment he might now regret:

> *Star chamber – hmm you assume these people might read what we put to them? Our task is to demolish prejudices/knowledge they have from their own sources.*

4.59 When asked for his understanding of Mr Gill's reference to "one eye on the politics", Mr Brown said:

> *I'm not entirely sure I understood what it means now or even at the time. I think Mike Gill and David Meek had both been seconded to the Department from Monitor, having previously worked at Monitor, and I think there was a view in Monitor that the Department was nodding through trusts, and I was clear that we weren't. And trying – there was – and there was a – I think it was Mike saying, "We may have supported trusts for the political – for political reasons rather than reasons because of the – other than the quality of the application", which certainly was not the case. And I think he was just trying to work out some of the bases on which we assessed applicants.*
>
> *Q. Isn't that quite a serious allegation to make?*
>
> *A. It would be if it were true.*[71]

4.60 While this email exchange probably expresses a degree of light-hearted scepticism, which might be found in many bureaucracies, it is also evidence that in some quarters there was concern that unsuitable trusts were being put forward, possibly as a result of the pressure of the policy.

4.61 In the same month, a further paper to the NHS Management Board by Sir Andrew proposed a change to the application process.[72] He noted that the diagnostic programme had identified the state of readiness of each NHS trust and included a consideration of service quality. Ministers had agreed that this should replace the HCC rating as an entry point. He stated:

> *To retain public confidence in the quality threshold we shall need to be satisfied that NHS Trusts whose NHSFT applications are supported by* [the Secretary of State] *are performing at the higher end of the scale.*[73]

4.62 The recommendation was that "only NHS Trusts that are compliant with core standards should receive SoS's [the Secretary of State's] support for their NHSFT application regardless of where they are in the application process".[74]

71 Brown T118.65–66
72 Sir Andrew Cash WS0000061520–521, paras 32–40; AC/4 WS0000061547
73 AC/4 WS0000061547, para 5
74 AC/4 WS0000061548, para 11(ii)

4.63 The requirement that trusts should be "compliant" with core standards was not quite what it seemed. To be eligible for consideration for the DH's support, a trust had to have a "fair" AHC rating from the HCC. This meant that trusts who had not complied with up to four of the 24 core standards, but had plans to achieve compliance, became eligible.[75] The expectation of the DH was that if the required level of compliance was not achieved the application would be withdrawn and that Monitor's assessment process would inevitably pick up any issues of concern about quality.[76]

4.64 Sir David Nicholson considered that this scheme addressed issues of quality through the diagnostic process by measuring compliance with targets. These were intended to be a proxy measurement for measurement of quality more generally, as targets were informed by the aspirations of patients with regard to healthcare.[77]

4.65 Also in September 2006, Monitor published a revised compliance framework.[78] While this was focused on the requirements for existing FTs to demonstrate compliance with the licence standards, as Mr Brown pointed out, this was relevant to applicants as Monitor would not want to authorise trusts who were likely to default on licence requirements.[79] This laid out conditions for the reporting requirements in relation to clinical quality, core standards and targets. In each case, trusts were required to annually self-certify compliance and, during the year, report only by exception any significant non-compliance.[80] Monitor intended to rely entirely on FT Boards fulfilling their responsibilities in this regard and did not intend to validate for itself the reports submitted:

> *This self-certification process is distinct from declarations to the Healthcare Commission. The Healthcare Commission uses a declaration as a basis for its assessment of the quality of healthcare, which is subsequently supported by screening data and, if necessary, inspections. Monitor uses the self-certification submitted to it as a basis for determining risk and hence the intensity of in-year monitoring of the NHS foundation trust. Monitor does not propose to scrutinise the validity of self-certifications submitted to Monitor as this is the principal responsibility of the board.*[81]

4.66 It is noteworthy that matters requiring in-year reporting included any initial considerations for investigation or actual investigations by the HCC, the Health and Safety Executive (HSE) and Royal Colleges in relation to a matter which might cause a breach of the authorisation.[82]

75 Warren Brown T118.30–31
76 Sir Andrew Cash T119.44–48
77 Nicholson WS0000067669, para 126
78 AC/7 WS0000061565
79 Brown T118.441
80 AC/7 WS0000061573, para 2.1
81 AC/7 WS0000061574, para 2.3.1
82 AC/7 WS0000061575, para 2.3.3

4.67 In November 2006, the DH was required to produce a briefing for the Prime Minister on, among other matters, the progress of the FT "pipeline". The questions posed, as relayed by Una O'Brien, then a Director of Provider Reform Policy at the DH, included:

> *What is our level of confidence that we will deliver waves 3 to 7 as indicated?*
>
> *... [C]an we produce, in summary form* [for trusts designated to be in waves 8, 9 10 the] *key issue or issues causing delay in readiness to apply, or put another way, if resolved, could enable applications to proceed ... sooner ...*
>
> *... The thinking behind this is to what extent could/might the 8, 9, 10 waves as they stand be re-profiled earlier.*[83]

4.68 The briefing reported that 52 FTs had been authorised, representing 27% of the acute trust turnover in England. To achieve the authorisation of a further 100 FTs by 2008 it was reported that "Direct action will need to be taken to address financial, service, capacity etc issues".[84]

4.69 The "barriers" to authorisation included "service performance", which was said to be in use for nearly 50% of trusts diagnosed as being more than two years away from making an application. Intractable issues had been identified in 54 trusts requiring action such as merger.

4.70 The action being taken by the DH was summarised and included:

> *FT rollout is being driven under the leadership of ... Andrew Cash ... DH will performance manage SHA on trajectories.*
>
> *2 senior assessors, previously working for Monitor, have been seconded to DH to support the FT rollout agenda ...*
>
> *New SHAs have FT rollout as a top priority.*[85]

4.71 On 20 November 2006, Sir Andrew Cash wrote to SHA Chief Executives asking for nominations of trusts for Wave 5 of the process by 4 December. Namely, trusts that they thought could be authorised from the autumn of 2007, including those that could be ready after progress on issues highlighted in the diagnostic exercise.[86]

4.72 On 7 December 2006, a DH submission prepared by Warren Brown was sent to Lord Warner, at the time Minister of State for Reform.[87] This sought his consent for a list of trusts, including Mid Staffordshire, to go out to public consultation in Wave 5. Mr Brown reported that:

83 AC/5 WS0000061551
84 DN/20 WS0000068206
85 AC/6 WS0000061560–1562
86 AC/13 WS0000061720
87 Brown T118.28; DH00000002076–7

The list is shorter than we were previously led to believe and we shall take up with each SHA why specific Trusts were thought no longer to be ready. Our intention is to have a much more substantive list for wave 6.[88]

4.73 This briefing was not met with contentment in Number 10. On 13 December 2006, Warren Brown reported to Mike Gill, among others:

Paul Corrigan is not happy about the size of wave 5 – i.e. half what we told him SHAs had promised. Have we any sense that we can retrieve ground in wave 6? i.e. that we get the lost 8 or so trusts back without any other losses? Can we think up any clever tactics?[89]

4.74 Paul Corrigan was the Prime Minister's Special Adviser on health matters.[90] Mr Brown denied that by referring to "clever tactics" he was implying that the criteria could be watered down, but rather to whether there were any easy explanations for the unfulfilled expectations.[91]

4.75 Mr Gill reported back with the specific reasons for various trusts having been removed from the list.[92] Mr Brown suggested there was a need to review how they could get SHAs to "up their game".[93]

2007

4.76 Concerns about the rate of throughput increased in 2007. In January 2007, Warren Brown observed that "we might need to be a little softer on those Trusts such as [name given] that are out there because we didn't support them in an earlier wave".[94]

4.77 Mr Brown was referring to whether it should be insisted that a trust remain in the wave currently planned, and his explanation of his wording was that he had been suggesting an exception because this was a trust which had understood the process and it was important to avoid the possibility of it pulling out later.[95] The clear implication of what was written was that the DH would insist, to the extent it was possible, that trusts adhere to the planned timetable.

4.78 In February 2007, Monitor and the DH published a new guide for applicants. This did not even completely rule out applications from trusts whose HCC rating was "poor":

88 DH00000002076–7, para 5
89 DH00000002250
90 Brown T118.34
91 Brown T118/37–38
92 DH00000002249
93 DH00000002248
94 WB/12 WS0000063178
95 Brown WS0000062926, para 39

> [E]*ligibility is now considered in a more holistic context as opposed to a historical snapshot in time. A rating of "fair" in the annual health check will not in itself debar a trust from applying to be a NHS Foundation Trust, although the Department of Health would expect all trusts to be in a position to achieve core standards in terms of service quality. A rating of "poor" in either finance or quality would call the application into question.*[96]

4.79 In March 2007, the Prime Minister's Delivery Unit (PMDU) pressed the DH for a credible range of worst and best case timings for the FT "rollout". The concern was that PMDU felt obliged to report to the Prime Minister that outcomes had fallen behind previous predictions. The DH took the position that a certain amount of speculation was inevitable.[97] However, Number 10 was insistent. Greg Beales, then the Prime Minister's Special Adviser on Health, wrote to Mr Brown:

> *I think a revised trajectory is pretty important to ensuring we avoid a discussion with PM and* [the Secretary of State] *which focuses heavily on FT numbers and progress rather than on quality and approach ...*
>
> *... Just quickly on the history of this, both Patricia* [Hewitt, then Secretary of State] *(at a stocktake) and Andrew* [Cash] *(in a submission and policy review panel) have previously presented trajectories as well as targets to the Prime Minister. So its important we are able to replace these old trajectories with a new one ...* [sic][98]

4.80 This made it quite clear that the DH, its Ministers and officials were being held to account for the divergence from previous plans it was now accepting would occur. Mr Brown considered it was "not unreasonable" for Number 10 to be asking questions about what was going to happen and when the political objective of converting all trusts into FTs was going to be fulfilled.[99]

4.81 Of the eight trusts approved for public consultation as part of Wave 5, only two, including Mid Staffordshire, were forwarded by the DH Applications Committee to the Rt Hon Andy Burnham MP, then Minister of State for Delivery and Reform at the DH, for statutory approval.[100] The reasons given to him in a submission in June 2007, were the low numbers proposed by SHAs, and tougher financial rules having been introduced. The Minister was assured that "Our processes are now much more focused on feeding [Monitor's] pipeline and maximising the authorisation rate".[101]

96 WB/10 WS0000063131. It should be noted however that the Inquiry received no evidence that any trust rated "poor" was either put forward to or authorised by Monitor.
97 WB/13 WS0000063182
98 WB/13 WS0000063181
99 Brown T118.115–116
100 Burnham WS0000063400, para 2
101 CURE0033000141, para 12

2008

4.82 Quality was still not a focus in 2008. The policy intention was primarily focused on ensuring robust financial and corporate governance systems. John Holden, a senior civil servant who led the DH team responsible for the FT programme and for DH's relations with Monitor from March 2008 to August 2009, told the Inquiry:

> *When I took up my post in March 2008, NHS Foundation Trust applicants were required to be compliant with core standards or judged by their SHA to have a robust action plan in place in order to be compliant within 12 months ...*
>
> *... However, the emphasis was on the longer-term viability of the organisation and its readiness to operate in a more autonomous way. It did not occur to me to propose changes to this approach, to emphasise the clinical dimension, since I did not perceive the attainment of NHS Foundation Trust status to be primarily a kite-mark of clinical quality.*[102]

4.83 When asked about the Trust's self-congratulatory description of its having entered the "premier league", Mr Holden said:

> *I think one of the learning points for me since the events of Mid Staffordshire and in the light of the commission's investigation and the first inquiry by Mr Francis has been that even though I may perceive the attainment of foundation trust status to be about greater freedom and a recognition of the trust's readiness to use those freedoms in appropriate ways, I think I would have to concede that the rest of the world may see it – or some of the rest of the world may see it in different terms, and there may be people who conceive of it as being something akin to "We're in the premier league now."*
>
> *... If somebody in my team had said to me they wanted to describe attainment of Foundation Trust status in those terms, I think I would have counselled them against it, because I think it ... suggests things which aren't consistent with the object of the exercise.*[103]

Conclusions

4.84 Although it was not the policy intention, there is no doubt that the effect of widening the scope of trusts that could apply for FT status led to a potential lowering of the standard of those put forward for consideration by Monitor. This was inevitable in changing a policy originally designed to provide a form of earned autonomy for the consistently best performing organisations into a near universal means of governance for the provision of hospital services. Under the scheme as originally created, by which any trusts achieving a three-star rating in 2001/02 and 2002/03 were invited to apply for FT status, a relatively crude reference point by

102 Holden WS0000057774, paras 15–16
103 Holden T120.33–34

which to assess the standard of service provided was acceptable. It was entirely understandable that the focus should have been almost exclusively on financial and corporate governance issues, given the consensus that such trusts were in fact the best performing trusts in the system.

4.85 However, as the field of candidates was widened, that eligibility test was effectively replaced by the diagnostic exercise. This again focused on financial viability and governance systems. A lower threshold with regard to the available – and not very comprehensive – measures of quality was accepted, without any adequate consideration of the risks attached to this for patients. Indeed, there were even proposals to remove all eligibility criteria for consideration by the Secretary of State for the statutorily required support, although this was not adopted. A loosening of the eligibility criteria in this way might not have mattered greatly had Monitor's assessment processes been reviewed to take proper account of the changes. As will be seen, this did not occur. Assumptions continued to be made about candidates' ability to provide services to an acceptable standard that proved to be unwarranted. A serious and unheralded gap opened up in a superficially elaborate system of safeguards.

Was there undue pressure on the system to enable trusts to become foundation trusts?

4.86 As it was Government policy throughout the period under review for trusts to become FTs, it was the duty of the NHS structure to seek to fulfil that policy. As Antony Sumara put it:

> *It's a policy of the Government isn't it? … we … effectively as the NHS are a political body aren't we? … we're accountable to the electorate in that sense, that we implement national policies because they are elected on that basis.*
>
> *I think the pressure was coming right down from that sort of Government policy to get foundation trusts implemented. I'm not sure how … hard or soft that was actually … Nobody ever told me to … try for foundation trust status but then maybe they wouldn't.*[104]

4.87 The Rt Hon Andy Burnham MP, at the time Minister of State at the Department of Health, gave the Ministerial support for the Trust's application.[105] He demurred from the suggestion that there was pressure exerted on trusts to make an FT application, preferring to use the word "encouragement".[106] He thought that the process encouraged trusts to become self-questioning and to aspire towards improvement.[107] He pointed out that it would be futile to pressurise unsuitable trusts to apply because they would have had to face Monitor's processes in any event.[108] He illustrated this through the example of Mr Michael O'Brien, Minister of State for Health at the relevant time, refusing to support a trust that had been recommended

104 Sumara T58.13–14
105 Burham T115.3.5–8 and T115.4.8–13
106 Burnham T115.134.13
107 Burnham T115.134.15–24
108 Burnham T115.135

for support by the DH's Applications Committee because of his own local knowledge. He also referred to a further occasion when he personally had demanded action because of information he received on a visit to a trust:[109]

> *The "Thick of It" caricature is that we're all ... being run rings round by these sort of* [things] *– and it's all just being nodded through. Well, it's not like that, and, you know, we can't go out delving down into every – the NHS is too vast and too large for that, but where we do know of a problem we should intervene, and I think those two are relevant examples of where Ministers take initiative on their own to challenge the Department.*[110]

4.88 However, Mr Burnham accepted that perceptions might differ at lower levels in the system:

> *Q. To what extent do you perceive that what you call encouragement from your office in Whitehall becomes either a career enhancing or a career limiting matter down at the front line?*
>
> [Answer] *... I think that is the NHS culture to some degree, that, you know, things said – that people then think, "Oh, that's what the Department want, so therefore let's go for that because then that will put our organisation and us in a good light". I think you're right, that is a reality of how the NHS has operated in its first 50 years or more, 60 years.*[111]

4.89 Sir Andrew Cash agreed that his plan sent out in 2006 (see above) placed pressure on SHAs to come up with a quicker timetable for trusts to be fed into the pipeline. He acknowledged that he had proposed a "tight timetable".[112]

4.90 Warren Brown also said:

> *There was always a focus in the DH on what needed to be done to ensure Trusts met the trajectory; however, the decision to authorise rested with Monitor who maintained the bar be set at a high entry standard. Most Trusts wanted to be NHS Foundation trusts, and if they were not proceeding as quickly as they should have towards authorisation because they had unresolved issues, the DH did not put pressure on them, instead, we focused on identifying what was stopping them.*[sic][113]

4.91 Although he had felt obliged to pre-empt the need for an apology in his phrasing of the briefing for the Prime Minister in December 2006, he asserted there was "Never any sense of

109 Burnham T115.137–139
110 Burnham T115.139
111 Burnham T115.135
112 Sir Andrew Cash T119.29–30
113 Brown WS0000062925–6, para 37

... pressure [to] just get the numbers up, or just bump a few more through. It was trying to work out what it was that was preventing trusts from applying".[114]

4.92 Nonetheless, he accepted that as head of the relevant branch he would have been regarded as responsible within the DH for the low rate of throughput in the "pipeline".[115] He also accepted that the FT policy was of particular significance in Government ambitions:

> *Foundation trusts were a fundamental part of health reform and the Prime Minister's office had an interest in progress.*[116]

4.93 In the course of preparation by officials of answers required by Rt Hon Ben Bradshaw MP, Minister of State for Health in May 2009, in the aftermath of the HCC report on the Trust, Mr Brown recalled that at the relevant time: "We were under a strong expectation from both Number 10 and Ministers to get all trusts to Monitor as soon as possible".[117]

4.94 When asked in his oral evidence about the relevance of this to the concerns later exposed at the Trust, Mr Brown stated with commendable candour:

> *I suppose what I was probably driving at is, there wasn't a sense of caution required. There was caution required in the sense that if you spotted anything, you know, knock it back, but if it did not – it did not have to be a high flying trust provided you didn't identify anything wrong with it.*[118]

4.95 Sir David Nicholson, from his experience as Chief Executive of the WMSHA, denied he ever felt under any pressure to put forward trusts which were not ready to apply for FT status: "Others may have done, but I did not".[119]

4.96 He would not have wanted to have trusts in his region turned down by Monitor.[120]

4.97 He amplified this in his oral evidence:

114 Brown T118.33
115 Brown T118.33
116 Brown T118.40
117 WB/15 WS0000063202
118 Brown T118.87
119 Nicholson WS0000067670, para 130
120 Nicholson WS0000067671, para130

There's no doubt that if I couldn't identify hospitals that were potentially sustainable financially and clinically someone would say to me, "Why are you different to everybody else?" But worse than that for me would be putting forward a set of organisations to become foundation trusts which Monitor then turned down later. So I didn't personally feel that, in the way perhaps – I don't know whether others did but I certainly didn't feel that.[121]

4.98 He described his experience as NHS Chief Executive:

... my job in all of this is that interface between the Ministers and the NHS, and my job in a sense is to make those connections. What we're talking here about is what the Department was – the Department was doing. And it was the policy of the Government that all organisations should be given the ability to apply to become Foundation Trusts by 2008, and what you're seeing here is a playing out of the Department's response to trying to deliver Government policy.

Can I say, I personally felt no pressure in order to deliver more foundation trusts during this period. I met – we had monthly meetings with Number 10 Downing Street, in which Paul Corrigan was the lead in relation to all of this, and we had quarterly meetings with the Prime Minister at the time, where we went through a whole series of issues around reform to the NHS, and I can genuinely say during those periods no pressure was put on me to do anything other than the right thing, which was when we thought organisations were ready we should put them forward.[122]

4.99 Mr Gill, when asked about the email of December 2006 which referred to "clever tactics" (see above), read it in retrospect as suggesting pressure to be placed on SHAs by the DH.[123]

4.100 Speaking about her former role as the WMSHA Chief Executive, Cynthia Bower said there was pressure but not undue pressure; it was a key Government policy, an aspirational standard and a "gold star": "[E]veryone wanted to become a foundation trust".[124]

4.101 In contrast, Professor Ian Cumming, Chief Executive of the WMSHA at the time of giving his evidence, agreed that at the time (2007) it would not have been an option in the area in which he then worked for a trust to say it was not ready for FT status.[125]

4.102 Mr John Newsham, the Trust's Director of Finance at the time, did not believe any pressure was applied to it to make an application for FT status. However, given what is known about the diagnostic process, his justification for the Trust being in a position to make an application

121 Nicholson T127.150
122 Nicholson T127.149
123 Gill T56.47
124 Bower T73.137
125 Cumming T67.142

is hardly reassuring: "The Trust came out of the Diagnostics process better than most other organisations, and therefore the Trust seemed to be ready for the application."[126]

4.103 Given the extremely unflattering conclusions of the SHA following the diagnostic process in 2005, as evidenced in the letter from David Nicholson of 6 January 2006, this does not provide a credible explanation.[127] Something must have happened between that letter and the subsequent support expressed by the SHA in April 2006 to change their view.

Conclusion

4.104 The evidence shows that there was no intention at any time that standards be lowered to accelerate the implementation of the FT policy. The intention was to improve and accelerate the processes to bring as many trusts as possible up to the level at which Monitor would authorise them.

4.105 However, although this was not accepted by a number of witnesses, it is clear that there was very considerable pressure from the very top of the Government down to trust level for NHS trusts to apply and be authorised for FT status. This was due to the cumulative effect of a number of circumstances and actions:

- The commitment that all trusts should become FTs by a particular date was regarded as a fundamental part of the Government's health reforms. The policy was politically controversial as shown by the heated debate at the time of the original legislation.
- There was an inherent political danger in a failure to succeed in achieving the goal of converting all trusts to FT status pointed out astutely by the Rt Hon Ben Bradshaw MP, who was Minister for Health, albeit not at the time under review. It might suggest that all hospitals were not performing to the standard that the public had a right to expect:

  The ... desire for FTs was because FTs were ... seen as ... a standard that all hospitals ... should aspire to, and if there ... was a recognition that there were some hospitals that were never going to be able to manage themselves properly, reach a level of competence and quality that would enable them to be successful FTs, that, if you think about it, is a recognition of failure. It's a recognition that there are some institutions that, for whatever reason, are never going to be able to get up to that standard.

  So I think ... there's a natural tension there between wanting more FTs to come through, because that is a sign of improvement in the system, and those hospitals not being ready for it.[128]

126 Newsham WS0000011957, para 148
127 CURE0003000109
128 Bradshaw T116.38–39

- Pressure on the policy was increased by the "pause" necessitated by the review of the first wave ordered by the Rt Hon John Reid MP, the then Secretary of State, to be undertaken by the HCC.
- The need for review of the policy at regular face-to-face discussions between the Prime Minister and the NHS Chief Executive would not have suggested to anyone in the DH that a relaxed attitude was being adopted about the difficulties in progressing the policy.
- The importance accorded to delivering this policy was further demonstrated by the searching enquiries from the Prime Minister's office and the increasing levels of "support" provided from the DH to SHAs and trusts to prepare them for an FT application.
- There was a diagnostic exercise designed to identify and correct obstacles to possible success at trust level.
- A Director General post was created to assist with FT development.
- A special team was created from experts at Monitor to provide advice and assessment of particular problems.
- Timetables and procedures were constantly reviewed and revised in order to increase the prospects of feeding the "pipeline" with applicants. Searching questions were asked from top to bottom of the system to account for any failure to live up to the expectations created.
- Another form of pressure at trust level was the self-imposed pressure caused by the enthusiasm of boards and chief executives to attain what many saw as recognition of being among the best of NHS organisations, described infamously by Mr Yeates in his press release announcing the attainment of FT status by the Trust as "the premier league".

4.106 No one involved in this process could have been in any doubt about the potentially career-limiting consequences of failure to pursue FT status or to achieve it. While this was not made explicit, it did not have to be.

4.107 Inevitably, this must have presented a temptation at many levels to cut corners, to rely on the complacent assumption that Monitor's processes were sufficiently rigorous to weed out bad apples. The pressure certainly had the effect of the various safeguards, whether those required by Parliament, such as Ministerial support, or those put in place by the DH, such as the diagnostic, being watered down. It also meant that to the extent that Monitor relied on the processes leading up to its assessment as providing reassurance, that reliance was misplaced.

4.108 The existence of pressure to implement a Government policy is not, of itself, improper or a matter for criticism. The policy intention was undoubtedly to improve the performance of the NHS in terms of both finance and quality, without compromise in relation to the latter. It must be accepted that there was no intention to pressurise the system into allowing unqualified trusts to be authorised. Indeed, the evidence shows that trusts were turned down both at the Ministerial approval stage and as a result of the Monitor assessment. The danger of such pressure is, however, that the achievement of the goal or target set, in this case, a conversion

of all trusts to FT status, becomes an end in itself without due regard to the consequences for the section of the public the policy was designed to assist.

4.109 Whether or not it was intended, the entry criteria were weakened to enable trusts that were not performing at the highest levels to have applications for FT status considered for DH support. The inconsistency between this change and the policy intent that FT status required demonstration of clinical sustainability and no lowering of standards seems to have been overlooked. Similarly overlooked was the effect of allowing trusts, which were known not to be currently fulfilling the required conditions, DH support either for consultation or for the applications themselves. The pressure resulted, as Mr Brown candidly explained, in a lack of caution being applied in the processes leading up to Secretary of State approval:

> *... there wasn't a sense of caution required. There was caution required in the sense that if you spotted anything, you knock it back, but if it did not it did not have to be a high flying trust provided you didn't identify anything wrong with it, so more in that sort of area.*[129]

4.110 The process ran the risk of giving what might appear to the public a Ministerial seal of approval to underperforming trusts and offering a false level of reassurance both to them, and because of the reliance it placed, in practice, on this step, to Monitor. It can be concluded that this came about as a result of not constantly reviewing the potential effects of the manner in which a policy of change was pursued on patient safety and well-being. There was, thus, a failure to put the patient first.

Approach to quality issues

Stages in authorisation process in 2006–2007

4.111 The stages a trust had to go through at the time of the Trust's application were as follows:

Pre-submission

4.112 The diagnostic assessment conducted earlier was intended to have assessed financial position, compliance with core standards and national targets, and future plans. At the pre-submission stage, a review by the SHA would consider whether a trust had addressed any issues raised by the diagnostic exercise. The SHA would agree with the trust an indicative application date based on the diagnostic outcome, and current financial position and delivery of targets. A "trajectory" or target date would then be agreed between the SHA and the DH.

Permission to consult

4.113 The Secretary of State's consent was required (in practice but not by statute) before a trust was permitted to engage in the consultation exercise required by statute. It was intended that the DH should be satisfied at this stage that a trust was on course to become an FT, even if

129 Brown T118.87

there was "still work to do". SHAs provided quarterly lists of trusts it supported for this stage. The DH would indicate which ones were supported after a "light touch" assessment to confirm that actions required by the diagnostic were being implemented.

Consultation

4.114 During the statutory 12-week consultation period, the trust's business plan and financial models were to be reviewed with support from the SHA and the DH.

Support of the Secretary of State

4.115 Applications would be submitted to the DH, which then assessed them on the basis of the support from the relevant SHA, a "due diligence" process, and consistency with policy and finance considerations.

4.116 The application was to be considered by the DH FT Applications Committee, which offered advice to the Secretary of State. The questions considered were:

- Is it safe for Ministers to support?
- Has the SHA confirmed its confidence in the business model and management team?
- Does the application stand a good chance of authorisation by Monitor?

4.117 What this actually entailed will be considered in detail below. If the application was supported, it was sent to Monitor. If not, the trust and SHA would discuss the way forward.[130]

Application made to Monitor and Monitor assessment

Diagnostic exercise

4.118 As noted above, the diagnostic exercise was introduced in part as a replacement of the three-star rating threshold. The Secretary of State had laid emphasis on it embracing clinical quality and sustainability, as well as financial and governance capabilities. The reality may have been different.

4.119 The diagnostic did include a consideration of a trust's AHC, but no part of the assessment looked at the ongoing clinical quality of the organisation, including its current performance against core standards. Mr Brown thought that aspect would have been dealt with when the SHA and the DH assessments considered whether the Secretary of State's support was to be given.[131] Even within the limitations of the self-declaration which informed the AHC, its use in this way left a gap in the assessment of the clinical quality delivered by a trust. The AHC was retrospective, providing a declaration of performance in the previous year.

130 Sir Andrew Cash WS0000061524–1525, paras 43–46; DF/8 WS0000066911–66912, para 10
131 Brown T118.17–18

Consent for consultation

4.120 The process for obtaining consent for public consultation was explained by Warren Brown:

> *There was no statutory requirement for Ministers to approve trusts going out to consultation; the note* [to Ministers] *was more of a confirmation that those proposed for the Wave had completed the necessary assurance processes.*[132]
>
> *... it was an important hurdle, in the sense that you don't want to be consulting with people and then decide later: well, it was a bad idea. So it was a serious decision, if you like.*
>
> *And the ... questions being asked of trusts at that stage was: are you serious about your foundation trust application? And there was a light-touch view from the Department and SHA that at face value they were meeting everything that they had* [to] *... it was just making sure that there was nobody in there that, on the face of it, shouldn't have been.*[133]

4.121 As detailed above, there was no absolute requirement that trusts were fully compliant with standards at the time of Ministerial consent; it would suffice that there were action plans in place which were intended to achieve compliance by the time of authorisation. The reality of the process was that it continued to rely on the assurances of the trust boards that they were achieving that goal. Further consideration would only be given where specific and substantial negative information came to the attention of the SHA or the DH. In other words, the obtaining of Ministerial consent to go to public consultation was little more than a formality. No active consideration was given to whether the interests of the patients served by potential applicants were compromised. Nothing was done at this stage to fill the gap in the assessment process left by the diagnostic exercise. As this part of the process was designed to obtain information from and involve the public and other local stakeholders, this omission would in itself not be critical, assuming the later steps were, as they were intended to be, rigorous.

4.122 The process to this stage, however, contained the weakness that clinically based risks had not been thoroughly assessed. Shortly after the HCC announced its investigation into the Trust, Dr Howard Shaw, FT Project Director at the WMSHA, offered to Peter Shanahan his retrospective analysis of what the SHA did:

> *I think the issue here is about clinical risk not about "performance", which in practice means achievement of "targets".*
>
> *In the diagnostic through self assessment process, we would test their self-assessment at a site visit or a board to board.*

132 Brown WS0000062934, para 47
133 Brown T118.29–30

In the substantive application process, we would test at the site visit their governance systems.

We do ask them repeatedly about risk and examine the IBP [Integrated Business Plan] *for their risk assessment and their risk systems.*

But this is mainly about financial risk which we can triangulate by looking at the IBP and LTFM [Long Term Financial Model] *plus the HDD* [Historic Due Diligence] *and soon to be pre-HDD.*

We do not probe clinical risk and do not triangulate i.e. we take what they say at face value and do not have the information systems or other resources to do any different.

I think we do somewhat superficially test their governance proposals which provide a representative and complete governance strategy.[sic][134]

Secretary of State statutory support

4.123 The process leading to the Secretary of State considering giving his statutory support to an application was set out in the guide for applicants. Support for a trust's application would be dependent on:

- Satisfactorily completing the DH pre-submission phase;
- The findings of an independent accounting firm's historic due diligence (HDD) exercise, taking into account the findings of the diagnostic programme.[135]

4.124 The HDD report would highlight the underlying financial position of the trust and:

Indicate the risks associated with achieving sustainable surplus in the future to meet Monitor's assessment criteria.[136]

4.125 The guidance stated that:

The Secretary of State may not support an application ... if it is evident that significant issues pertaining to the applicant will jeopardise the likelihood of them becoming a viable or sustainable NHS foundation trust.[137]

4.126 Examples of such issues were given, all of which appeared to relate to a trust's business plan and corporate governance matters, rather than clinical or quality matters, which were effectively assumed to follow from robust financial management.

134 SHA0018000070
135 WB/10 WS0000063134, para 3.5
136 WB/10 WS0000063134, para 3.5
137 WB/10 WS0000063144, para 4.4

4.127 As Mr Brown put it:

> *The process was about being assured that the trust's business model was strong enough to ensure the provision of quality healthcare within the available resources.*[138]

4.128 When, after the publication of the HCC report, Mr Brown looked back on what had occurred while assisting in the preparation of answers to a Minister's questions and made it clear that little, if any, assessment was made by the DH on quality issues. Mr Brown explained:

> *Monitor apply the tests and decide who becomes an FT, all DH can do is work with SHAs to weed out prima facie non-starters.*
>
> *We were under a strong expectation from both Number 10 and Ministers to get all trusts to Monitor as soon as possible.*
>
> *We were in no position to judge clinical outcomes – we took advice from the SHA on performance issues – our advice in the* [submission] *on all 6 Trusts* [the Trust and those considered at the same time] *was driven by issues around their financial models. SHAs were required to withhold support from trusts where there were concerns about performance issues.*
>
> *Did any of our assessments refer to concerns over clinical quality? My recollection was that it was the financial model that needed a debate.*[139]

4.129 The DH, therefore, took the SHA assessment at face value and then relied on the perceived rigour of Monitor's assessment. David Flory put it this way:

> *I distinguish between the criteria to be able to apply and the tests that you have to have passed to become one. And my own view is the tests that you have to pass by Monitor to become a foundation trust is as tough now as it's ever been. There has been no lowering of the bar. What there has been ... is a different definition of what criteria you need to meet ... to start the process that leads to an application to Monitor.*[140]

4.130 Mr Shanahan, of the WMSHA, suggested the contrary in an email in 2009 reviewing what had happened:

> *... it was largely DH driven and our input was minimal.*[141]

138 Brown WS0000062946, para 88
139 WB/15 WS0000063202
140 Flory T121.70
141 SHA0019000008

4.131 Sir Andrew Cash, on being asked about this comment, disagreed with it as being a true reflection of the process at the time.[142]

4.132 A change in approach occurred late in 2007, too late to affect the processing of the Trust's application. This was the result of continuing anxiety at the rate of progress of the FT "pipeline". On 2 October, David Flory, then the NHS Deputy Chief Executive, wrote to SHA Chief Executives requiring them to provide "more meaningful assurance" of their confidence in the calibre of the leadership of aspirant FTs and their credibility as applicants. The assurance required included compliance with core standards and "robust" plans for recovery where necessary.[143] A paper was submitted by David Flory's team to the NHS Management Board. In October 2007, it was forecast that at the present rate of progress it could take another seven years to complete the project.[144] It observed that:

> *Significant challenges remain with those NHS Trusts in the latter waves of the programme (Waves 8, 9 and 10). Of these 122 Trusts, a significant number have financial challenges (these include the 17 financially challenged Trusts) with the rest needed to do more and be faster in developing credible FT applications.*[145]

4.133 It was planned to "condense" the programme into three years by improving the quality of trust leadership, clarifying financial rules, ensuring SHAs were "much more focused" on what was required to deliver successful applications, and placing more emphasis on performance in relation to Healthcare Acquired Infection (HCAI) rate targets:

> *National interest in H[C]AIs, particularly MRSA and C-diff, is currently impacting on FTs, and the DH is being asked to consider the implications of raising the bar in relation to this specific quality area for aspirant FT applications.*[146]

4.134 The paper concluded that:

> *FT roll-out has been strong to date and there is a full FT pipeline ... However there are significant challenges in those NHS trusts in the latter waves ... and a firmer approach is needed to ensure they can function as successful FTs.*[147]

4.135 This appeared to acknowledge that the obstacles to readying trusts for the application process were becoming more difficult as the less well-performing ones were allowed into the system through the changes in the eligibility criteria. Like other DH witnesses, David Flory refused to

142 Sir Andrew Cash T119.55–56
143 DF/8 WS0000066911
144 DF/8 WS0000066907
145 DF/8 WS0000066907–9
146 DF/8 WS0000066907
147 DF/8 WS0000066915, para 15

accept that these changes amounted to a lowering of the standards; he explained that the purpose of the changes was to make it clear to all trusts that they could not excuse themselves from the process by pleading that they had too much to do to achieve success in it.[148]

4.136 There was a limited acknowledgement that quality delivery could be of concern, in the reference to the "interest" in HCAI rates. What continued to be absent was any express concern that the system as operated to date may have let through trusts which should have been subjected to the "firmer approach". Consideration of a trust's delivery of acceptable standards did not change substantially, with reliance still being largely placed on the self-assessment of core standards compliance.

Monitor's process

4.137 As already noted above, Monitor's general approach to the assessment of applications was one of risk management. It focused on governance processes rather than the standard of service actually delivered or other outcome-based considerations. It did not look at issues of quality of service other than superficially, relying in large part on an assumption that the HCC would address such issues. This was because the concept of FT status as envisaged by the DH was principally directed at the way provider organisations were governed rather than at *what* they did. John Holden, Head of the DH's FT branch from March 2008 to August 2009 told the Inquiry:

> *When I took up my post in March 2008, NHS Foundation Trust applicants were required to be compliant with "core standards", or judged by their SHA to have a robust action plan in place in order to be compliant within 12 months ...*
>
> *... However, the emphasis was on the longer-term viability of the organisation and its readiness to operate in a more autonomous way. It did not occur to me to propose changes to this approach, to emphasise the clinical dimension, since I did not perceive the attainment of NHS Foundation Trust status to be primarily a kite-mark of clinical quality.*[149]

4.138 He accepted that this might not have been how the public understood the significance of FT status. He would not have thought the self-description by the Trust on attaining FT status as being in the "premier league" appropriate, if he had been aware of it at the time, but he now understood how people might view it in that light.[150]

4.139 Miranda Carter, an Assessment Director at Monitor from February 2007, although describing Monitor's approach as "rigorous", admitted that it relied on the HCC as the quality

148 Flory T121.75
149 Holden WS0000057774, paras 15–16
150 Holden T120.33–34

inspectorate.[151] It was assumed that an applicant would not be referred for assessment if the HCC had quality concerns. She stated further that Monitor had not in retrospect reflected as it should have done on the implications of the reduction of the threshold requirement from a three to a two-star rating.[152] The quality measures looked at were very limited:

> *Monitor looks to issues relating to quality but only because they are telling in relation to governance.*[153]
>
> *I feel the problem starts with the fact that we designed our process around the assumption that the Healthcare Commission was looking after quality and it – we didn't have a framework to test quality governance in the same way as there was a well-established framework for testing financial governance through the financial reporting procedures opinion from the independent accountants.*[154]

4.140 She also admitted that there had been no reassessment of methodology in response to the changes made by the DH in the eligibility criteria:

> *I feel very strongly that Monitor did not and should not lower its own assessment bar, but equally Monitor did not reflect on the impact of the DoH's decision to lower the quality threshold for applicants, and specifically on whether the declining eligibility threshold meant that particular issues were more likely to fall between the cracks in the application process. Perhaps if Monitor had conducted a review at that point it might have wanted to implement a quality bar in its assessment process.*[155]

4.141 Stephen Hay, Monitor's Chief Operating Officer, accepted that there should have been a review:

> *I think the working assumption in 2004 was that because they were three-star hospitals, the aspects of quality of care and probably quality of clinical governance should be taken as a given ... to this day I don't know why, when effectively the threshold moved from three stars to two stars, and then down to fair under the annual health check, we didn't step back and say, "What are the implications of this? Do we need to have a conversation with the Department of Health, with the Healthcare Commission?" With hindsight we clearly should have done, but we didn't.*[156]

151 Miranda Carter WS0000030582, para 8; WS0000030588, para 23
152 Miranda Carter WS0000030588, paras 24–25
153 Miranda Carter WS0000030587, para 22
154 Miranda Carter T88.121
155 Miranda Carter WS0000030588, para 24
156 Hay T92.12

4.142 Dr Moyes explained:

> *I certainly didn't want Monitor to be forming an independent judgement on clinical quality, when the Healthcare Commission existed to make assessments of clinical quality and clinical performance. That would seem to me to be entirely contrary to Parliament's intentions and not at all efficient. So de facto what we did was we relied on the use of the Healthcare Commission's ratings system by the Department as the gateway, to give us an indication that the first assessment, the first pair of eyes had concluded that this hospital had quality good enough to be referred to Monitor to be assessed as a foundation trust.*[157]

4.143 While there were regular contacts between the DH and Monitor, in particular between Sir Andrew Cash and Dr Bill Moyes, it appears there were no discussions about the impact of DH policy changes on Monitor's approach to assessing applications.[158]

4.144 Mr Gill, who worked for Monitor before moving to the Trust to become its Director of Finance, also accepted that there were gaps in the assessment process and that the focus was on the risks presented by the financial autonomy granted to FTs:

> *... I think at that time there was a focus on the financial aspects and also perhaps on the board itself, and the board's capabilities and fitness for purpose ... with the benefit of hindsight perhaps we did ...* [not] *drill down into the organisation to understand the kind of information flows at that level really.*[159]
>
> [M]*y understanding was the remit was very much around if these are the new found freedoms of foundation trust, how do we ensure that an organisation can take these on in an appropriate way and be assured that it will be well managed going forward?*[160]

4.145 He stated that self-declaration was an important aspect of the process because:

> *... the whole purpose of Foundation Trust status was to assure that the trust was self-aware and equipped to be independent, so we needed to test their ability to do that.*[161]

4.146 It was intended that a trust's self-declaration would be checked against other sources of information, such as those from commissioners.

157 Moyes T92.129
158 Sir Andrew Cash T119.52–53
159 Gill T56.10; Gill WS0000008093, para 12
160 Gill T56.19
161 Gill WS0000008096, para 23

4.147 Mr Gill did claim that while Monitor relied to some extent on the star rating, it did also ask the HCC if it had any concerns about an applicant.[162] No evidence, however, was presented to the Inquiry that the HCC was approached by Monitor in this way in respect of the Trust's application. Mr Gill accepted that at the time there was no source of positive evidence of a trust's compliance with standards other than the star rating (and subsequently AHC). A trust might be the subject of negative information from another source which Monitor would look at to some extent, but this depended on such information being made available to it.[163]

Conclusion

4.148 As noted by Dr Moyes in his evidence, the statutory requirements described above left considerable latitude to the DH and Monitor in how the authorisation process would be organised, the substance of the matters to be taken into account and the time within which the process was expected to be completed.[164]

4.149 Between 2003 and when the Trust made its final application for FT status in 2007, a number of changes were made in the process, in part due to the increasing pressures being placed on the system to fulfil the policy that all NHS trusts become FTs. While Monitor defended its independence fiercely and always sought to exercise an independent judgement on how to undertake the assessment of applications, the process was inevitably influenced by the DH.

The lack of focus on quality

4.150 At its inception the concept of FT status was to allow trusts which had demonstrated a consistent ability to govern themselves effectively and provide a high quality service the independence to continue to deliver excellence: a form of "earned autonomy". The independence from the NHS's central command structure included the ability to manage their own finances, constrained only by the regulatory oversight of Monitor, and to invest any surpluses in projects of their own making. It was, therefore, entirely understandable and necessary that public funds were safeguarded by stringent checks on the standards of financial governance before a trust was authorised. There was an assumption that trusts which demonstrated good standards of governance and were financially stable would be delivering a good quality of service. This led to considerably less emphasis being placed on reviewing quality measures during the authorisation process and to a reliance on the existing, sketchy ratings assessments of the healthcare regulator.

4.151 There was an understandably strong political desire to see this reform succeed. Inevitably, the first waves of trusts seeking authorisation were strong candidates, the least likely to throw up problems. These were, in the main, organisations where strong financial management and high quality service did indeed walk hand in hand.

162 Gill T56.20–21; Gill WS0000008097, para 29
163 Gill T56.17
164 Moyes WS0000039623, para 5

4.152 Sadly the, in retrospect, somewhat complacent assumptions underlying the initial process became challenged by the commitment that all trusts should become FTs within a relatively short timescale – a commitment which was made without adequate consideration being given to the consequences of widening the eligibility criteria for DH support. Reliance on an admittedly unsatisfactory star rating system was replaced by reliance on evidence of past (and not necessarily continuing) substantial (but not necessarily complete) compliance with a set of core standards. That evidence was in itself in large part based on self-assessment by trusts. A diagnostic exercise was undertaken to detect financial and corporate governance weaknesses. However, this was not used to detect trusts which should not be put forward for FT status, but as the starting point of an exercise to get them ready for it. Indeed, the whole system became engaged in doing everything possible to maximise trusts' prospects for successful applications. There seems to have been little pause for consideration whether deficiencies found in corporate management were indicative of deeper systemic issues. The drive was to cure the symptoms, not diagnose the disease.

4.153 In any event, the diagnostic had no more focus on safety and quality issues than what had gone before. Such assurance as had previously been given by a three-star rating, in itself the only available, but blunt, tool for this purpose, was weakened first to acceptance of two-star trusts and then those with a "fair" compliance rating and plans to be compliant in the near future. No further investigation of quality issues was undertaken before Ministerial approval was given unless specific serious concerns were raised. Therefore, the pre-existing potential gap between the assumption of an acceptable level of safety and quality and the reality became wider. The net which should have been designed to catch and detect an unsafe trust became less effective.

4.154 This is not to say that all applicant trusts were successful; far from it. The majority of trusts considered in the same wave as the Trust were in fact rejected at that time. However, this merely increased the pressure imposed by the commitment to complete the programme by 2008.

Monitor's role as a quality regulator

4.155 Following his appointment as Executive Chairman of Monitor in November 2003, Dr Moyes found that while Monitor had been given extensive powers under the Health and Social Care (Community Health and Standards) Act 2003, little had been done to formulate a plan as to how it would actually operate.[165] However, as he told the Inquiry, it was made clear to him at an early stage in meetings with senior DH officials, including the Permanent Secretary, Sir Hugh Taylor, that the DH did not expect Monitor to duplicate the work of the HCC.[166] Dr Moyes endorsed that view and felt that Parliament could not be supposed to have intended a duplication of roles given that both Monitor and the HCC were created in the same

165 Moyes WS0000039624, para 7
166 Moyes WS0000039625, para 7

Act.[167] However, it was recognised that Monitor's powers of intervention did enable it to intervene in clinical issues, and the terms of authorisation were drafted to enable this to occur.

4.156 Dr Moyes candidly accepted that although Monitor always had the ability to approach the HCC for its expertise, it did not always do so:

> *I freely acknowledge that in the early days, Monitor's discussions with the HCC were infrequent and limited in scope and that this was a mistake.*[168]

4.157 Monitor under Dr Moyes's leadership concluded that the model to follow was one analogous to a "due diligence" process adopted in the assessment of a company applying for a stock exchange listing. It was felt this would demonstrate whether applicants were well run and financially viable. It was feared that if an FT's finances were not under control then care would suffer, for example, by cutting staff:

> *... In my experience, if an acute hospital loses even 2% of its income without having planned for this, its finances will be in serious difficulties, and it will often respond to that by removing staff throughout the organisation, rather than focusing on particular services which may not be clinically or financially sustainable.*[169]

4.158 This was to be achieved not by direct inspection and audit, which it was felt would be disproportionate in terms of cost, but by obtaining information from the applicant's board "with some external validation". It was never intended by Monitor that it should verify every piece of information submitted to it, as it was felt that the reputational and other consequences to directors for misleading the regulator would be a sufficient deterrent.[170]

4.159 Monitor thus focused its attention in the assessment of FT applications on financial and corporate governance issues and looked only superficially at quality and safety performance. It relied on the work of the healthcare regulator for its monitoring of those aspects. This approach derived from the understandable view that regulators should not duplicate the work of others. It was a view expressed by Adrian Masters, Monitor's Director of Strategy:

> *There is a strong argument to say that one independent body should make judgements on the quality of care of all providers and that other regulatory bodies should be wary of attempting to duplicate that role and should instead made use of such judgements where possible in exercising their own regulatory functions.*[171]

167 Moyes WS0000039629–630, paras 18–20
168 Moyes WS0000039630, para 22
169 Moyes WS0000039626, para 12
170 Moyes WS0000039630, para 21
171 Masters WS0000035313, para 8

4.160 He pointed to a survey of stakeholders, in which 49% thought that Monitor should have a role in relation to quality but not duplicate the work of the CQC.[172] He also noted that Monitor has functions which touch on quality issues; for example in its role of judging how well governed an applicant for FT status is. It is now represented on the National Quality Board.

4.161 Mr Masters correctly identified the need to avoid duplication. However, as the sad story of the Trust shows, gaps between the functions of regulators must also be avoided. Gaps are likely to appear where one regulator's area of focus brings to light matters relevant to another's functions, but in a manner only that regulator understands. While two separate regulators are examining the operation of one organisation in relation to functions impacting on the area of focus of both, there is a serious danger of issues affecting patient safety being missed until they have become serious and obvious, however good communication between them may be. There is a strong argument in favour of a single regulator dealing with corporate governance, financial competence and compliance with patient safety and quality standards.

The authorisation process in practice: From the Trust's application to its authorisation by the Secretary of State

Application in 2003/04

4.162 A process of application for authorisation was commenced by the Trust in 2003, under the leadership of Mrs Brisby's and Mr Yeates's predecessors. This had had to be withdrawn following the loss of the Trust's three-star rating. As this occurred outside the focal period reviewed by the Inquiry, little evidence was obtained about this. While the reason the application could not proceed is obvious, no subsequent analysis seems to have been attempted of what happened in case it was of relevance to the later application. The reason for the replacement of the leadership of the executive and non-executive Board was its perceived weakness. No explicit consideration was given to whether any inherent deficiencies caused by the lack of effective leadership had been fully resolved.

4.163 Mr Gill told the Inquiry that he did not recall any information about this first application having been received by Monitor while he worked for it (as an Assessment Director from October 2004 until November 2006). He felt that if such information had been available to Monitor during its assessment of the Trust's application in 2007:

> [it] *would have been treated with greater scrutiny, as we would have focused on the reason for deferral of the application to check that there were no longer any issues.*[173]

172 AM/2 WS00000335492, page 41
173 Gill WS0000008098, para35

4.164 It may well be that this application did not get to the stage of being submitted to Monitor, in which case it would have required either the Trust or the SHA to disclose that history. In any case, that disclosure does not seem to have happened.

Diagnostic exercise 2005/06

Overview

4.165 The background leading to the national diagnostic exercise has been described above. In practice it consisted of a desk top review carried out by an SHA diagnostic team, assisted, in the case of the Trust, by Mike Gill, who, as already noted, had been seconded from Monitor for this purpose.[174] This would look at the Trust's five-year business plan, its position in the local health economy, its future and its self-assessment of risk areas. Following the desktop assessment, there was an SHA/Trust board-to-board meeting at which the Trust was challenged on its governance and other matters considered to be relevant. The Monitor secondee would sit in on the meeting and advise the SHA officials on the key questions to be asked.

4.166 The result of the exercise in the case of the Trust was unfavourable. It was concluded that it would not be ready for authorisation for at least two years and a number of deficiencies were identified.[175] The conclusions of the exercise were not shared with the DH or Monitor at any stage of the processing of the Trust's later successful application. The exercise did not look in any depth at the Trust's delivery, or compliance with, minimum safety or quality standards.

4.167 Mr Gill's only direct contact with the Trust in the course of the diagnostic was his attendance at a Trust Board meeting on 1 December 2005 with other members of the Shropshire and Staffordshire SHA (SaSSHA) diagnostic team.[176] At that time the Trust leadership was in a state of transition. Mr Yeates was in post as Acting Chief Executive, but it was confirmed at this meeting that Mr O'Neill would not be returning. The minutes show that the Board was confronting a number of problems. These included:

- An overspend over the year to date of £914,000 was reported, but Mr Yeates expressed confidence that the Trust would break even by the end of the year;
- Jan Harry's clinical floors project which was reported to be in progress. Describing the first phase of the project, and particularly the new short-stay surgical unit, Ms Harry, the Trust's Director of Nursing, reassured the Board that this phase would be revenue neutral and was recorded as saying "the qualitative issues would also be considered"; and that "surgical

174 Gill WS0000008094, para 14
175 DN/22 WS0000068258
176 Gill WS0000008098–099, paras 35–36; CURE00330000457, Minutes of the Trust Board Meeting (1 December 2005)

teams and senior nurse colleagues had been involved during the planning process, and the support of all concerned during the implementation process was important".[177]

The Board was asked to support the project's continued implementation. In view of what is now known about this project, it might have struck an outside observer as odd that the Board was prepared at this meeting to resolve to support the continued implementation of the project when there was no actual evidence that the professional staff supported it and quality issues were yet to be considered. In fact, the evidence of Dr Nakash (the Clincial Director for Emergency Care and Clinical Lead for Acute Medicine at the Trust) to the Inquiry suggested that concerns had been raised but were ignored: according to him the issue was discussed in an Emergency Care Meeting on 9 March 2007, and he also provided guidance from the Society of Acute Medicine in relation to emergency care staffing numbers (which must have been effectively ignored). He asserted that the issues about qualified staff numbers were 'escalated' to Jan Harry and then to the Senior Medical Management Team.[178] Sir Stephen Moss (Chair of the Trust at the time of giving evidence to the Inquiry) told the Inquiry that the Trust had been unable to find any evidence of a risk assessment in relation to this project.

- The 2004/05 audit had identified issues said to include slowness of response to concerns about theatre management. However, assurances had now been received that these matters would be addressed. It might have been a matter for concern that they had not been addressed at the half-way point through the following financial year. The minutes recorded that 2004/05 had been a difficult year for the Trust in a number of ways, including the incurring of a deficit for a second consecutive year, and that:

  The trust's financial standing remained an area of concern, and it was noted that the Trust's Finance Team should not be held solely accountable for the successful delivery of the Financial Recovery Plan. The financial position of the Trust would be closely monitored.[179]

  Mr Yeates reported on steps taken to remedy the position, which included an immediate ban on the use of agency staff, and the fact that a paper outlining the future strategic vision of the Trust would be submitted in January 2006.

- An increase in staff vacancies, reduction in the use of agency staff and an increase in sickness absence rates. There appears to have been no discussion of the impact of these developments on the quality of service.

4.168 The Trust's position may not have been much more impressive at the board-to-board challenge meeting which took place on 22 December. It was attended by David Nicholson,

177 MG/1 CURE00330000459, Minutes of the Trust Board Meeting (1 December 2005)
178 Nakash WS10 WS0000005209
179 CURE00330000460 *Minutes of the Trust Board Meeting* (1 December 2005)

then interim Chief Executive of SaSSHA and of the WMSHA, as well as Chief Executive of Birmingham and Black Country SHA, all in the process of being merged into the WMSHA. He was accompanied by Antony Sumara, then Managing Director of SaSSHA, and SaSSHA's Director of Nursing and Workforce, Neil McKellar. A representative of Monitor was present. The meeting took place in somewhat inauspicious circumstances. The previous day the SHA team had met the board of the University Hospital of North Staffordshire (UHNS) in a similar exercise. That board had performed so unimpressively that David Nicholson had immediately initiated processes which led to the resignation of the Chair. Therefore, the meeting with the Trust took place at a time when Antony Sumara and he were somewhat preoccupied with the aftermath from the day before. It is also fair to note, as does Sir David Nicholson, that the episode showed he was prepared to act forcefully and urgently when he perceived the need to do so.[180]

4.169 David Nicholson was not impressed by the Trust Board. In particular:

- Not one member had thought what to do with Cannock Hospital, a major potential strategic issue;
- They had no clear strategy about their clinical direction;
- There seemed to be few connections with local organisations.[181]

4.170 The Board expressed confidence that they would break even by the end of the year. At the time David Nicholson did not see their financial recovery plan, but when he did so for the purpose of the Inquiry he did not consider it disclosed cause for concern about the impact on the quality of service through the proposed staff reductions.[182] That was not discussed at the board-to-board meeting but Sir David would have expected Mr McKellar to have done so if he had thought it necessary.

4.171 Sir David said that he had not been aware that in 2002 the CHI had been concerned at staffing levels; and that had he been aware of this, he would have queried the effect of any further reductions.[183]

4.172 He would not have been over-concerned by the Trust's loss of a three-star rating, first to zero stars and then one star. He contended that this would "not necessarily" have indicated problems with quality or safety, as the Trust had scored in the top band of trusts for "clinical focus" and "capacity and capability".[184] In fact the Trust was graded in the "middle" band for clinical and patient focus and in the lowest band for capacity and capability.[185]

180 Nicholson WS0000067671–672, para 133–5
181 Nicholson WS0000067672–673, paras 136–9
182 Nicholson WS0000067675, para 145
183 Nicholson WS0000067676, para 146
184 Nicholson WS147 WS0000067676.
185 DN/21 TRU0005000011

4.173 Mr Nicholson's conclusion after the meeting was one of concern that there were so few clinicians present and, "I was very clear that they could not deliver their ambitious strategy without genuine clinical engagement and buy in".[186]

4.174 Mrs Brisby was no more satisfied with the Trust's performance at this meeting. She recalled that the Board's performance had been:

> *Dismal. Our presentation was vague, aspirational and did not show a proper understanding of financial risk assessment.*[187]

4.175 She did not dissent from Antony Sumara's recollection that the Board's performance had been:

> *Flamboyant, although it did not appear to have much substance behind it.*[188]

4.176 On 6 January 2006, David Nicholson wrote to Toni Brisby to share the provisional view of the diagnostic team, which he endorsed.[189] The overall conclusion was that the Trust was:

> *At least two years away from being in a realistic position to meet the criteria for application. The main factors affecting this are:*
>
> - *One star status;*
> - *Lack of a robust strategy that includes a convincing plan for Cannock Hospital;*
> - *Confidence in the ability of the Trust to deliver the large recurrent cost improvements (c 5% of turnover) year on year.*[190]

4.177 The strategy presented by the Board was described as "aspirational" and "not sufficiently robust", and required clarity about fundamental issues. Development of clinical engagement and leadership was required.[191] The Trust had identified many gaps in control and accountability, including the absence of an executive lead for governance, an appropriate assurance framework, inadequate risk and performance management systems.[192] Service performance had to be improved:

> *The current one star status means there is much to do here.*[193]

186 Nicholson WS0000067678, para 152
187 Brisby WS0008000035, para 132
188 Brisby WS0008000035, para 136; Sumara WS0000005911, para 6
189 DN/22 WS0000068258
190 DN/22 WS0000068259–60
191 DN/22 WS0000068260
192 DN/22 WS0000068261–2
193 DN/22 WS0000068262

4.178 The full analysis of the diagnostic included a number of concerns perceived by the Trust about clinical risks including:

- Clinical staffing – ensuring appropriate skill mix and change, which was recognised as having implications for the quality of service.
- Systematic clinical risk analysis included training, staffing, complaints, litigation and risk appraisal with implications for clinical and financial risk.[194]

4.179 However, the only "gap" detected in compliance with national and other targets related to MRSA but no recent infections had been reported.

Strategic Health Authority assessment and support

4.180 A dramatic change in attitude occurred soon after the critical and pessimistic outcome of the diagnostic process.

4.181 On 23 January 2006, Mrs Brisby replied to David Nicholson's letter offering assurances that the concerns raised would be addressed. She told him:

> *We were clearly disappointed with our performance, both individually and corporately, but will learn from that experience as we move towards Foundation status. We note your provisional view that the Trust is at least two years away from being in a position to meet the criteria for application. We acknowledge the main factors affecting the timescale and look forward to discussing this with you in February.*[195]

4.182 She said the Trust was "a little disappointed" at the criticisms of their strategy and expressed the view that a document sent to the SHA in December might have given confidence that most of the issues raised by David Nicholson had been addressed. In short, she made it clear that the Trust did not accept this part of the criticisms made. She apologised for the "confusion" over the financial presentation and anticipated that this was being resolved following subsequent meetings. She was unclear why there had been a "lack of clarity" in the presentation. She expressed confidence in the Trust's financial position.

4.183 Sir David told the Inquiry that he had been reassured by this letter as showing that the new Trust Board understood the challenges facing it and was setting about addressing them. He described it as containing a "frank acceptance" of those challenges.[196] However, another interpretation could have been that the Board did not really agree with much of the criticism made, and was seeking to offer assurances that most of the necessary remedial action had

194 TRU00050000215, *Foundation Trust Internal Diagnostic,* p21
195 SHA0027000051, Letter from Toni Brisby to David Nicholson (Jan 2006); DN/23 WS0000068265
196 Nicholson WS0000067678, para 154; Nicholson T127.119–122

already been in hand. The letter certainly evinced an intention to proceed with an application for FT status, in spite of the reservations arising out of the diagnostic exercise.

4.184 The Trust's determination in this regard was demonstrated by its holding the first meeting of its Foundation Trust Committee the following week on 2 February. Mr Yeates is recorded as telling the meeting about the view expressed by the diagnostic team as to the Trust's state of readiness, and made it clear that he did not accept this:

> *However, several of the areas that had been commented upon in the feedback were already within the Strategic Direction document and would be implemented early in 2006. It is therefore possible that the Trust will be in a position to apply for Foundation trust status earlier than 2008.*[197]

4.185 It is difficult to see how this view was consistent with the outcome of the diagnostic, confirmed a matter of weeks before this meeting. The strategic document referred to had been sent to the SHA before the board-to-board challenge meeting. Therefore, either the document and the Trust Board's presentation of it had failed to impress, or the diagnostic team had failed properly to take it into account. It does not appear there was any explicit resolution to this difference of view.

4.186 A month later, on 2 March, the Trust was sent a copy of the final report of the diagnostic exercise. This appears to have been the first occasion on which the Trust received any more detail of their conclusions than had been contained in David Nicholson's summary letter of January. It is, therefore, difficult to understand how the Trust leadership could have expressed such confidence in its ability to tackle the issues the exercise had raised.

4.187 The enclosing letter, from Andrea Green, the SaSSHA FT Diagnostic Project Director, made it clear that the SHA required an action plan with a view to deciding whether the Trust could be put forward to the DH as part of the next wave of applicants at the end of the month.[198] The wave which was under consideration involved an application being submitted by February or May 2007. No explanation was offered for the apparent discrepancy between the diagnostic team's view and this apparently accelerated timetable. Mrs Brisby admitted to being slightly "unnerved" by this.[199] But also:

> *I read it as encouragement. I read it as a fairly – I mean, genuinely encouragement, an optimistic letter, suggesting that they were confident that we could go for foundation trust status or sufficiently confident.*[200]

197 TRUST00030011887; VS/1 WS0000012534
198 TRU00010008076–077; TB/34 WS0008000488–489
199 Brisby WS0008000037, para 142
200 Brisby T129.87

4.188 It was not long before the SHA was giving the Trust its full backing to proceed with an FT application on a timetable quicker than that envisaged in the diagnostic.

4.189 A further board-to-board challenge took place on 29 March 2006. On 27 April 2006, a mere four months after the view was expressed that the Trust was at least two years away from being able to be an FT, the Managing Director of SaSSHA, Moira Dumma, wrote to Mrs Brisby indicating that it was accepted that "significant progress" had been made, and that the SHA was keen to support the Trust in its "ambition to achieve fitness for purpose for foundation trust status to be ready to enter the twelve month process later this year".[201]

4.190 The timescale was described as "quite challenging" but the list of actions the Trust was asked to take to enable SaSSHA to receive the assurance necessary to support an application in the next wave were limited to three matters: to finalise the strategy for Cannock Chase Hospital; consideration of the risks presenting in the local health economy; and a revision to the long-term financial model following on from the agreement of the business plan for the year. This list was very much shorter than that of the concerns raised in the diagnostic exercise.

4.191 Mr Yeates's reaction to this was to advise the Foundation Trust Committee at its next meeting on 11 May that for an application to be authorised they were required to make improvements in these areas.[202] It clearly did not occur to him that there ought to be other areas for attention as well or that, in any event, it might be necessary to do other than that which the Trust was undertaking.

4.192 Karen Morrey, Chief Operating Officer at the Trust, thought that this apparent turnaround of view was explained by the fact that the SHA had effectively completed the merger process and there was a perception that the West Midlands had fallen behind in fulfilling the national targets, and therefore it needed to accelerate some applications.[203]

4.193 David Nicholson had no further personal involvement in the Trust's application after his January letter, but on reviewing Ms Dumma's letter he suggested it was not inconsistent with the view he had expressed earlier.[204] In oral evidence he said:

201 TRU00010008121, Letter to Tony Brisby from Moira Dumma (April 2006)
202 CURE0038000143, Minutes of Foundation Trust Committee (July 2006)
203 Morrey WS0000011202–203, para 21; Morrey T61,49–50
204 Nicholson WS0000067679, para 156

If you're saying to me, you know when I left that meeting did I think I'll be writing within four months to them to tell them that they're on the way to be a Foundation Trust? Probably not, as I left that room. But as you're no doubt aware the team did a lot of work with the organisation, they put a lot of time and effort into making it happen and the team concluded at that stage that we should give them some encouragement and support them through the process, which is what the letter responds to.[205]

4.194 At this time the leadership at the Trust was still relatively new, and in effect was being allowed time to put right what was perceived to have gone wrong before. David Nicholson and his colleagues were unaware from the concerns raised that there were any serious concerns about the quality of care being delivered. Had they become aware of such issues, it is highly probable they would have taken action to see they were addressed.

4.195 It is clear that the SHA was persuaded to encourage the Trust to "beat" the expectations of the diagnostic team and that the Trust was keen to try to oblige. It appears that less focus was placed on the totality of the concerns that had been raised, and their implications for patient safety, and no further consideration was given to the impact on services to patients.

4.196 On 11 May 2006, Michael Brereton, the outgoing Chair of SaSSHA, undertook his routine appraisal of Mrs Brisby's performance as Chair of the Trust. In the appraisal document she identified as one of her personal objectives taking the lead on Board development "to ensure that the Board is fit for purpose for Foundation Trust status".[206]

4.197 Mr Brereton's assessment, recorded in his own handwriting, was:

I concur that Toni's chairmanship has seen a significant strengthening of governance process and behaviours at [the Trust]. *She needs now to focus her Board on the goal of achieving FT status in 2007.*

4.198 He told the Inquiry that this objective would have been a trust-led decision and that he would have advised her informally "not to set a date that was too ambitious, because that would be planning for a fall".[207]

4.199 In his oral evidence, he explained that this was a first appraisal for Mrs Brisby and that his role would have been to offer encouragement. While he may have thought the target date for achieving FT status was ambitious, he also regarded the process of application as a useful driving force for improvement:

205 Nicholson T127.120–121
206 Brereton WS62 WS0000037211–212, para 62; MB/2 WS0000037261–264; Annual Review Summary Form (May 2006)
207 Brereton WS62 WS0000037211–212; Brereton T97.100–101

... in essence the FT timescale, though I thought was very ambitious, was a little piece of driving. It was a little piece of pressure. It was to see if you can get yourself in a fit state ... bluntly, I thought the two-year comment about how long it would take them was at least true and might take them longer than that, but I was very concerned that they had an early date to work at because that would encourage them to address these issues and get them right.[208]

4.200 He had regarded the letter from Andrea Green in a similar light.[209] The exercise of going through the FT assessment process was a "tool" to get the Trust to "up their game":

To be blunt, in the first diagnostic exercise we did with them, and there were two, our informal conclusion was that they ... hadn't understood what the work streams necessarily were to start the process. And so using this process as a context and as a model and as a series of examples for what good looked like, was an opportunistic tool and we seized it.[210]

4.201 The position adopted by Mr Brereton was, therefore, very close to that which the first inquiry report identified as having been taken by the Trust Board, and was echoed at the present Inquiry, by Peter Bell, a Non-Executive Director:

We wanted to achieve it because we felt that it would put us in a position where we were one of the better trusts, and we could move the trust forward. And, I mean, it seems odd with hindsight, knowing everything else that's happened, but at the time we saw it as a really positive move, giving us lots of independence, the ability to act, and the ability to actually improve local healthcare standards, by tailoring our services towards the local needs. That was a big, big plus for us.[211]

4.202 Their purpose had been to use the process of obtaining FT status to improve the structure and governance of the Trust, rather than seeking to get it up to the relevant standard before making an application.

4.203 Such an approach had dangers. It encouraged a focus on processes at the expense of a hard look at the standard of service being provided to patients. Entering a regulatory process apparently voluntarily, but in reality under a considerable degree of pressure, both external and self imposed, made it inevitable that the Trust would concentrate on the issues likely to be thought important by Monitor. The Board was new and relatively inexperienced and likely to adopt this as the task to undertake in a too literal sense. The approach gave insufficient weight to the problems the Trust faced because of the chronic weakness in leadership from

208 Brereton T97.103–104
209 Brereton T97.104–105
210 Brereton T97.106
211 Bell T53.113

which it had suffered for too long. It heightened the need for the new management to value "success" in the project of becoming an FT over and above the need to identify and correct any fundamental service deficiencies. It placed the Trust under increased financial pressure, because of the financial requirements of FT status, when it was already under severe financial strain. All these dangers were increased by encouraging it to accelerate the timetable towards making an application.

4.204 A further board-to-board challenge meeting took place on 5 June 2006.[212] It obviously went well. In July 2006, Mr Yeates reported to his Foundation Trust Committee that he was still awaiting a formal letter from the SHA confirming that the Trust would be in the fourth wave. He had little doubt they would be and said that:

> *The Trust would be supported by West Midlands SHA. We were one of the few Trusts the SHA saw in a positive light.*[213]

4.205 His confidence was justified. In August 2006, the WMSHA confirmed that it supported the inclusion of the Trust in the next wave of applications.[214] The Trust was congratulated on the progress it had made since March and it was recognised that there was a need to focus on the long-term financial model, the business case for Cannock Chase and the risks faced due to high access rates.

4.206 Support was offered to assist in the process. The following week the WMSHA confirmed a revised timetable of the following: a September start for the formal process; a public consultation stage between November and January 2007; DH support being signified in March; and finally the Monitor assessment process ending in authorisation in July 2007.[215] Such a timetable, had it been adhered to, would have resulted in the Trust being authorised within 18 months of the diagnostic team's view that it would not be ready for at least two years. As will be seen there was a degree of slippage, unassociated with any consideration of the merit of the application.

4.207 In October 2006, the Trust achieved only a fair rating in the HCC AHC. This did not appear to be of concern to the Trust's Executive. The Consultant Staff Committee was assured by Dr Suarez, the Medical Director, that this was "acceptable" as it had been due to a failure to submit certain documentation in time. She stated that: "The Trust remains on course for becoming a Foundation Trust".[216]

212 PCT00280011054, Minutes of Diagnostic Action Plan Follow up Meeting (June 2006)
213 CURE0038000153, Minutes of Foundation Trust Committee (July 2006)
214 PCT00280012751, Letter to Toni Brisby from Deborah Shaw (August 2006)
215 HCC0016000647, Letter to Martin Yeates from Deborah Shaw (August 2006)
216 CURE0041000128, Minutes from Consultant Staff Committee Meeting (October 2006)

4.208 At the same meeting there was more than a hint of concern about the difficulties in providing an A&E service. It was reported that there was an unacceptably low level of middle-grade cover in A&E, and that consultant cover was only possible for 12 hours a day. As a result considerable costs had been incurred on locums. Also serious matters indicating a failure of clinical governance were raised. A significant increase in *C. difficile* infections was reported, as was the fact that many consultants were unaware of the prescribing policy issued by the Infection Control Committee. A concern with regard to clinical safety was raised over a change which had been made to the supply of intravenous fluids without consultation with clinicians.

4.209 If such matters caused any significant concern among the executive team it was muted. At the Executive Directors' Foundation Trust Committee meeting on 9 November 2006, it was merely noted that:

> *The Trust needs to achieve the core standards. Where this is not the case we need to convince the SHA that we have robust action plans to do so.*[217]

4.210 It is clear that the WMSHA agreed with this approach. On 28 November 2006, Deborah Shaw, WMSHA FT Programme Lead, wrote to the Trust encouraging it to send a first draft of its Integrated Business Plan, a document required for the FT process.[218] This would enable the WMSHA to consider it before the formal public consultation and offer the Trust its draft comments on it in advance of the consultation.

4.211 While formal WMSHA support for the Trust to be authorised by the Secretary of State to go to public consultation had yet to be given, Ms Shaw made it clear that her view was positive:

> *You have made significant progress since the diagnostic process and therefore are ready to move into Wave 5 application. The formal support, therefore, now only requires sign off of your Healthcare Commission action plans to satisfy us that you will be fully compliant with core standards in 2006/07 ... We will then work with performance management to satisfy ourselves that there is sufficient evidence that you will be compliant.*[219]

4.212 Mr Shanahan accepted that this appeared to be saying that the WMSHA's approval was conditional on seeing an acceptable plan, rather than its implementation.[220] Clearly the WMSHA were under significant pressure at the time to propose trusts for the pipeline as considered above. In this letter, Ms Shaw made it clear she needed the evidence to enable formal approval to be given very rapidly as the DH required a list by 4 December 2006.

217 ES100026357, Minutes from Foundation Trust Committee Meeting (November 2006)
218 TRUST00030037057, Letter to Martin Yeates from Deborah Shaw (November 2006)
219 TRUST00030037057, Letter to Martin Yeates from Deborah Shaw (November 2006)
220 Shanahan T72.114–115

4.213 At the Trust's Executive Directors' Foundation Trust Committee meeting on 14 December 2006, the Trust's draft progress report for December 2006 was reviewed. The Committee understood that this document would form the basis of the DH's decision on whether to approve the Trust to go forward for FT status. The team reviewed areas highlighted as "red", and Helen Moss expressed concern that two clinical governance areas had been marked "green" instead of "amber". These were changed accordingly and it was agreed that more detail on progress should be added to the document as a whole. The document was then approved for submission to the WMSHA, highlighting several areas as "red" and "amber".[221]

Secretary of State authorisation for public consultation

4.214 The WMSHA submitted a list of two trusts to the DH which supported the granting of permission for them to go to public consultation: the Trust and one other, Walsall Hospitals NHS Trust.

4.215 In a submission to the Minister of State (Reform) dated 7 December 2006, Warren Brown sought the Minister's agreement to this.[222] The Minister was assured that all the trusts were complying with core standards or had action plans to do so. Mr Brown remarked that:

> *The list is shorter than we were previously led to believe and we shall take up with each SHA why specific Trusts were thought no longer ready. Our intention is to have a much more substantive list for Wave 6.*

4.216 The Minister gave his consent on the basis of this very sparse material, and it might be thought he had little option but to do so. No matter of concern was drawn to his attention, apart from the scarcity of trusts ready at this stage.

4.217 Sir Andrew Cash wrote to the Trust on 22 December 2006, immediately after the Minister's consent was given setting out the expected timetable which would lead to formal application for the Secretary of State's statutory support in April 2007 and authorisation by Monitor from October 2007.[223] Sir Andrew set out four "underlying principles" he said that the Trust had to be sighted on. These included:

> *All Trusts need to demonstrate that they are meeting core standards. Organisations that failed to meet some of the core standards in the annual health check will need to demonstrate that they have already dealt with any problems or have credible plans in place to meet standards. We shall seek SHA confirmation of this when Trusts submit an application in April 2007.*

221 CURE0038000171, Minutes of Executive Directors Foundation Trust Committee of Mid Staffordshire General Hospitals NHS Trust, 14 December 2006
222 Brown WS0000062933–934, para 46; WB/17 WS0000063209–211
223 WB/18 WS0000063214–215

All Trusts need to be making sufficient progress with their post-Diagnostic action plans so that there is no doubt that they are a strong candidate when they submit an application in April 2007.

Consultation

Patient/public comment in trust committees

4.218 The 12-week public consultation exercise, required as part of the process, ran between January and April 2007. However, before then there was a degree of public involvement in the working out of the project at the Trust. The Patient and Public Involvement Forum (PPIF) were given representation on the Trust's Foundation Trust Committee, which was attended on its behalf by Rod Hammerton, Chair of the PPIF, and Carl Bennett. At the Foundation Trust Committee's meeting on 13 April 2006, Carl Bennett, the PPIF representative, voiced concerns about the possible impact of redundancies on standards of cleanliness in the hospital:

> *He expressed concern that the view of the public was that the trust was proceeding to Foundation Trust status at their expense ...*[224]

4.219 The Committee then discussed how the Trust could "work on altering the perception of the public", and it was agreed that open days presented an opportunity to do this. There does not seem to have been any consideration of whether Mr Bennett or the public were right about their perception; and the fear expressed that staff reductions might affect cleanliness does not seem to have been addressed at all either. The truth is probably that, along with Mr Bell, the Non-Executive Director, the directors present did not believe there was a problem with cleanliness.[225]

4.220 At the next meeting, Mr Rod Hammerton, the PPIF Chair, reported that on three recent visits by the PPIF there had been a "dramatic improvement" with regard to cleanliness and that the open days had been a tremendous success.[226] Mr Hammerton did not give evidence about this observation, but he did describe inspection visits by the PPIF in which he had participated. He told the Inquiry that on occasions cleanliness had been "pretty poor" and that it could be hard to get anything done about it.[227]

4.221 At the July meeting of the Committee, Mr Bennett appears to have been satisfied with what had occurred in the meantime. He reported that the open days had been a success in restoring confidence and suggested that it be stressed in future that the redundancies had not affected front-line services. Mr Yeates noted that the consultation process was now closed.[228]

224 CURE0038000137, Minutes of the Foundation Trust Committee (April 2006); Bell T53.114–115; PB/4 WS0000007778
225 Bell T53.115
226 CURE0038000141, Minutes of the Foundation Trust Committee (May 2006)
227 Hammerton T22.108–109
228 CURE0038000153, Minutes of the Foundation Trust Committee (July 2006)

4.222 A perusal of the minutes of this Committee suggests this was the only occasion on which the possible impact of the FT process on patient safety was raised. It may be significant that it was raised by a member of the public, but neither the PPIF or any other consulted external body appears to have raised this issue in the statutory consultation.

Process of consultation

4.223 The public consultation exercise included the publication of a consultation document and leaflets, four public events, four staff events, stakeholder meetings and a weekly column in a local newsletter. A form was included on the Trust's internet site for responses.[229] The consultation document was sent to over 150 local groups, as well as stakeholders, Members of Parliament, staff and public members. A presentation was made to the Health Scrutiny Committees of the various local authorities.

4.224 Mr Hammerton was recorded as being satisfied that every effort had been made to communicate.[230]

4.225 The consultation document posed 12 questions, all but one of which related to the specifics of the proposed priorities of the FT, and its constitutional arrangements. The final question asked whether there was, "Anything else about becoming a Foundation Trust that you would like us to consider further?"

Response of Staffordshire Health Scrutiny Committee

4.226 The Staffordshire Health Scrutiny Committee received a presentation from Mrs Brisby and Mr Yeates on the FT proposal on 14 February 2007.[231] They told the Committee that the primary motive for the application was that it would enable the Trust to improve services to patients and make it easier to work with partner organisations. A member welcomed the objective of making the Trust "the cleanest [place] in town". Later in the proceedings Mr Yeates read from an email received from Helen Jenkinson of the HCC, stating that she was "so far" reassured at the Trust's efforts to improve cleanliness. The Committee set up a sub-group to consider its responses to the consultation questions.

4.227 The Committee sent an effusively positive response to the consultation; it congratulated the Trust and expressed its support for the proposal.[232] The only hint of a possible concern was an expression of pleasure that the Trust at its presentation to the Committee had announced one of its objectives to be to become "the cleanest place in town".

229 CURE0038000176, Minutes of the Foundation Trust Committee (January 2007); CURE0038000179 Minutes of the Foundation Trust Committee (February 2007); CURE0038000189, Minutes of the Foundation Trust Committee (April 2007); TRUST00030000030, Consultation Report
230 CURE0038000190, Minutes of the Foundation Trust Committee (April 2007)
231 ESI00015324, Minutes of the HSC Meeting (February 2007), p2–5
232 TRU0005000277–278

4.228 A member of the Committee, Janet Eagland, had a limited recollection of this response, perhaps because she had not been at the meeting when the Trust gave its presentation and was not on the sub-group which prepared the responses.[233] She had a limited understanding of the powers of the Committee, even though she subsequently became its Chair; for instance she was unaware that they could have sought expert advice. With regard to the consultation itself, she did recall it, and had felt that this was a matter on which the lay members of a committee like this had to trust the professionals and accept what they were told by the Trust leaders.

Response of Stafford Borough Council Health Scrutiny Committee

4.229 The Borough Council Health Scrutiny Committee received a presentation from Mr Yeates and Mrs Brisby on 20 February 2007. The Committee felt able to make a decision to give its support immediately, subject to a reservation about the proposed name.[234] The Trust's slides for the presentation were attached to the minutes. They give an impression of an unrelentingly positive picture being portrayed, with the focus being on issues such as the precise make up of the FT governors and membership, as opposed to a consideration of any performance issues.

4.230 The Inquiry heard evidence from a member of the Committee, Mrs Ann Edgeller, who was later to become its Chair. She had previously had concerns about the Trust, arising out of an observation of a lack of cleanliness when a relative was a patient at the hospital, and some knowledge of its past financial difficulties and the staff cuts. She explained the support given to the Trust's proposal in these terms:

> *We come down to the fact that when it's a chief exec that's giving you the – we've got no reason to query it or no reason to say that we couldn't give them our support.*[235]

4.231 She agreed that, on reflection, support given in the circumstances of this meeting was meaningless.[236] She also pointed out that consultation about whether an organisation should be an FT was of little value where it appeared to be mandatory that all such organisations should achieve that status. What she had learned from the experience with the Trust's application was the importance of insisting that the Committee was told of the negatives as well as the positives.

Response of Members of Parliament

4.232 The Trust's consultation document was sent to three local MPs. None could recollect this, but by the time of the Inquiry each had read it in detail.

233 Eagland T41.60–63
234 Edgeller WS31 WS0000003050; AE/9 WS0000003104–105, Minutes of the HSC Meeting (February 2007)
235 Edgeller T37.37
236 Edgeller T37.39

4.233 Dr Tony Wright, the then MP for Cannock, was extremely helpful in assisting the first inquiry by sharing information about complaints he had received about the Trust over a number of years, with the consent of his informants. However, he had no memory of making any response to the FT consultation although, inaccurately, he would have expected to send any consultation response to the DH rather than to the Trust itself. He told the Inquiry:

> *I suspect what I was being asked to do locally by the trust, in terms of people like the SHA and the Department of Health, was to write supporting foundation trust status. "Will you, please, give foundation trust* [status] *to mid-Stafford?" Now, I'm as sure as I can be that I never did anything of that kind.*[237]

4.234 In the Trust's report of the consultation, it recorded that Dr Wright was sent the consultation document and that his response was that he was "broadly in favour of the application" and he was also said to be "Extremely supportive of the application".[238]

4.235 Dr Wright was, somewhat unfairly to him, taken by surprise by being shown the report for the first time as he was giving evidence and he could only speculate on how this response came to be recorded. He suggested it might have been as a result of one of the meetings he often held with Trust representatives, as opposed to anything he had written. Certainly no letter or other directly written statement by Dr Wright has been disclosed to the Inquiry by the Trust. He doubted he would have said he was "extremely" supportive, but he would have felt at the time that he had no reason to object.[239] Summing up his feelings about the application at the time he told the Inquiry:

> *I probably felt* [that] *insofar as this trust was going to be exposed to an evaluation process because it wanted something, namely foundation trust status, that that evaluation process would be a good thing for it, and if it came through the evaluation process, well, it would probably mean that it's on the right course. So, in that sense, I thought the process would have good consequences.*[240]

4.236 The unfortunate situation in which Dr Wright was placed in the course of this Inquiry highlights the difficulties that can arise if proper records are not kept of what consultees have actually said in response to a consultation. It would clearly not be appropriate for any weight to be placed on reported views that could not be confirmed by some reliable record, such as a signed letter. As Dr Wright pointed out, the view ascribed to him was someone else's view or understanding of his position, rather than a direct quotation, and as such is not a reliable record for this purpose.

237 Wright T38.104
238 TRU0003000021, Consultation document for Mid Staffordshire General Hospital (May 2007)
239 Wright T38.142–143
240 Wright T38.146–147

4.237 Dr Wright might, had he been asked to address his mind at the time to the issue of the quality of service being provided, have been able to produce a file of complaints from constituents. After the HCC report was published, he told the House of Commons:

> *We all knew from cases that we were dealing with that something was going seriously wrong.*[241]

4.238 However, a degree of hyperbole must be allowed for. Dr Wright explained that his file of cases arose sporadically over a number of years, and that it was not possible for him to know whether the issues raised had been tackled effectively, as he was being assured by Mr Yeates that they had. He told the Inquiry that there had been nothing about the volume of complaints he had received which led him to believe that there was anything exceptional about this hospital.[242]

4.239 Mr William Cash, MP for Stone, also could not recall being consulted regarding the Trust's FT application. In his oral evidence, he confirmed that he did not in fact respond, stating that he did not consider that he had any particular expertise to offer.[243] It transpired in the course of Mr Cash's oral evidence, that he had been unaware of the fact that the Trust's FT application had to be approved by the Secretary of State before proceeding to the Monitor stage.[244] He was not prepared to speculate on what his response would have been, had he made one.

4.240 Like Dr Wright, Mr Cash had a file of complaints, but in his case he had invariably forwarded them to the DH rather than to the Trust. Like others, however, he had discerned no concerning pattern in the complaints which might have led him to raise that as an issue had he responded to the consultation.

4.241 Mr David Kidney was MP for Stafford from May 1997 to May 2010. He was recorded in the Trust's report as being "broadly supportive" of the application, and his response was reported as being "Very positive and supportive of application".[245]

4.242 Like others, Mr Kidney had not seen this document before giving evidence to the Inquiry, and, while he accepted that he had indeed been "broadly" supportive, he felt the Trust were "gilding the lily" in describing him as "very positive and supportive".[246] Indeed, he said he would have told the Trust he disagreed with that as a description of his views, if they had asked him. His position as he described it to the Inquiry might be termed one of supportive neutrality:

241 Wright T38.110
242 Wright T38.147
243 William Cash T40.123, 127
244 William Cash T40.126
245 TRU0003000021
246 Kidney T39.91

They made it as a decision of board, but when they felt that they could justify the people they applied to in the NHS and Monitor, that they were good enough, they made the decision to apply for foundation trust status. Personally I thought with the history we'd just been through, I couldn't see how they were going to be granted their application ... I did not give my support to their application but neither did I oppose it.

Q. Did you ever give any indication to Martin Yeates that you might support it?

A. Well, I met him several times when he was describing to me the process they were going through. So certainly I heard the reports and they sounded positive you know, I said to him "Well done for what you're going through". Obviously if they got the status, and it meant that after a rigorous assessment they were good managers, that's good for our hospital.[247]

4.243 As the MP of the constituency containing the principal hospital of the Trust, Mr Kidney was in a difficult position. He told the Inquiry he was not enthusiastic about the concept of FT status, but he was faced with a Trust management "bubbling" with enthusiasm, and he clearly felt he had to support them in this endeavour. When they obtained the support of the Secretary of State, he wrote to congratulate them:

I've been honest with you about my political view about foundation trust, torn though I was, and I wasn't a big fan. But if they could prove to what I thought was a rigorous testing system that they were good at what they did, then I thought that was worthy of congratulations.[248]

4.244 However, he had been aware of certain aspects of the Trust's troubled history, and had not expected its application to succeed:

I didn't think it was going to succeed with the application because of this history. If it did succeed and if the system tested them rigorously, then it was a pleasant surprise to me that they were better than I thought they were at leadership, management and controlling their finances and that would be a good, pleasant surprise.[249]

Outcome of consultation

4.245 The Trust prepared a report of the consultation which formed part of the material supporting its FT application.[250] Seventy-one responses had been received. The report summarised these in a positive way. For example, the responses to a question about the priorities set for the FT were said to be "Very supportive, with extremely strong support for our future plans."[251]

247 Kidney T39.87–88
248 Kidney T39.93
249 Kidney T39.94
250 TRU0003000002, *Consultation Report* (May 2007)
251 TRU0003000015, *Consultation Report* (May 2007)

4.246 Clearly, however, some concerns were expressed:

> *Some members of the public felt more nurses would be required for those plans (and the financial plan allows for staffing level rises to accommodate this). Other suggestions included ensuring continuous improvement and effectiveness and the provision of more counselling services for admitted patients.*[252]

4.247 Some answers which were reported to the final question indicated specific concerns linked to the feelings of the staff and clinical standards:

> *Listen to what the staff have to say.*
>
> *To improve children's ward and services and have surgeons that are children's trained.*
>
> *Assurance that there will be sound governance linked to clinical need, patient involvement and excellent patient care.*
>
> *Consider increasing your nursing staff. I stayed in your hospital not so long ago and there was one night when we only had a ward sister to look after a very busy and demanding mixed surgical ward. There were people who needed a high degree of care and that was not given; it was only luck that prevented something disastrous happening!*[253]

4.248 In spite of this, the report drew only encouragement from the tenor of the responses. It observed that there had been no objections to the application to become an FT. However, no question had specifically asked that, and those that were posed were phrased in a way which assumed the Trust would become an FT. No comment was made on the concerns raised about clinical standards.

Conclusions

4.249 The general law imposes on any public authority holding a public consultation exercise, whether or not in fulfilment of a statutory obligation, an obligation of fairness. This means the process must:

- Be conducted properly;
- Be undertaken at a time when the proposals are at a formative stage;
- Present the issues in a way which facilitates an effective response;
- Must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response;
- Give sufficient time for responses;
- Ensure the product of the consultation is conscientiously taken into account;

252 TRU0003000015, *Consultation Report* (May 2007)
253 TRU0003000017, *Consultation Report* (May 2007)

- Fulfil the statutory obligation of engaging users in the development and consideration of proposals in the way services are provided;
- Present the available information fairly.[254]

4.250 The Rt Hon Andy Burnham MP told the Inquiry that the consultation process was intended to give the public an opportunity to say whether or not they approved the applicant organisation. He was surprised that the process had not picked up concerns or complaints.[255]

4.251 The process of consultation was unsatisfactory. Its focus was on matters of detail such as membership, appointment of governors and the name of the Trust. No question was posed expressly asking whether the Trust should apply for FT status or was fit to be authorised. It was effectively a matter of chance whether respondents offered a view on that issue. No express question was asked about the quality of the service provided. Again it was a matter of chance whether respondents felt able to raise such concerns. Clearly at least one respondent did so, as described above. The evidence does not suggest that there was any reaction to what appeared to be a serious complaint.

4.252 The Inquiry has not reviewed or audited all the responses made in the consultation, but the summary prepared by the Trust not surprisingly focused on the potentially positive implications to be drawn. In the case of the MPs whose "strong" support for the application was prayed in aid, no written record of the terms in which such support was expressed has been forthcoming, and the evidence casts doubt on whether they were as strongly supportive as was suggested.

4.253 Consultation with the public, and stakeholders, should be an important safeguard when important changes are being proposed to an NHS healthcare provider. It is notable that this consultation raised few signs of serious concerns about the Trust. That is in part explicable by the nature of the issues identified for consultation. They were focused on governance issues and not on the standard of service. The process was entrusted to the applicant, who would inevitably find objectivity a challenge. Little, if any, attention or analysis of the replies appears to have been conducted by any other body. The consultation "box" was "ticked" and the process moved on. In short, the process was treated as a formality, albeit a complicated one to organise, and once it was completed the process was able to continue.

4.254 Local accountability is intrinsic to the FT concept. Therefore, it is absolutely necessary that the local stakeholders and the public contribute to the process. A provider's ability to deliver a service which the public finds satisfactory should be an important factor in deciding whether it is fit to be granted the autonomy afforded to an FT. The public are probably better equipped

254 *R (Royal Brompton and Harefield NHS Foundation Trust) v Joint Committee of Primary Care Trusts & another* (2012) EWCA Civ 472, paras 6–11; *R v North and East Devon Health Authority ex parte Coghlan* (2001) QB 213, para 108; National Health Service Act 2006, section 242(2)(b)
255 Burnham WS0000063413, paras 44–46

to offer views on this, based on the experience of themselves and their friends and families, than on technical governance issues, although they must be consulted on those as well. It is not entirely satisfactory or fair on an aspiring applicant trust to expect it to undertake an entirely objective consultation process, but objectivity is required, both in the preparation of the consultation and in its analysis.

4.255 What is required is a greater degree of oversight of the process, although it should still be handled locally. The new NHS Trust Development Authority should oversee the process by setting, in consultation with Monitor, standard requirements for questions which applicants should be required to include in the consultation. These should include questions designed to elicit stakeholder and public opinion on whether the applicant is fit to be considered for FT status, and whether it is delivering a sustainable service compliant with minimum standards. A proper record should be maintained of responses. While the applicant should undertake its own analysis of the responses, and take them into account in refining proposals, the original responses should be available for review by the DH on behalf of the Secretary of State and in due course, should the application be supported, by Monitor.

Strategic Health Authority support for application

4.256 In April 2007, Cynthia Bower, the WMSHA Chief Executive, and Peter Shanahan, the WMSHA Director of Finance and Capacity, held a meeting with the Trust and South Staffordshire PCT (SSPCT). The purpose of the meeting was to establish whether the PCT supported the Trust's application. A difficulty had been caused by the Trust's reluctance to share its draft business plan with the PCT on grounds of commercial confidentiality.[256] This was thought to be "strange" behaviour, and the SHA put effective pressure on the Trust to share the information that the PCT reasonably required. Mr Shanahan told the Inquiry that there had been concerns up until around this time about the Trust's willingness to be "open", but after that the Trust became more willing to share information.

4.257 Following that meeting, and a separate one with the Trust, Peter Shanahan wrote to Mr Yeates and Stuart Poynor, SSPCT Chief Executive, indicating that the application now had the SHA's "unqualified" support.[257] However, the SHA still needed to see the Trust's final Long-Term Financial Model (LTFM).

4.258 This support was given in spite of Mr Shanahan considering at the time that elements of the Trust's Integrated Business Plan (IBP) were "very aspirational",[258] and that the LTFM, which had been agreed with the PCT, indicated that there was a "disconnect" between the Trust's plans and the PCT's expectations.[259] While he was concerned to try to "bottom out" which of the

256 Shanahan T72.122–123
257 PWS/8 WS0000020750, Letter to Martin Yeates from Peter Shanahan (April 2007)
258 Shanahan WS58
259 Shanahan T72.119

Trust's plans were and were not supported, he felt that the viability of the Trust's case for FT status did not depend on such issues.[260]

Strategic Health Authority report to Department of Health

4.259 As described above, the DH assessment of whether the Trust should receive the Secretary of State's statutory support depended, to a large extent, on the SHA's views and work, and the HDD Report. Changes were made to the proposed arrangements for governors and to the proposed name of the FT as a result of the consultation.

4.260 The support of the SHA came in the form of a feedback form sent to the DH by Dr Howard Shaw, the SHA Foundation Trust Project Lead on 16 May 2007.[261] On the feedback form, the SHA indicated its support for the application. It stated that there were no outstanding issues from the diagnostic.[262]

4.261 Only one question was asked on the form about the SHA's view of the Trust's performance against core standards and key targets. In its answer the SHA reported that the Trust scored "amber" against Monitor's assessment criteria, on the basis of non-compliance with three HCC core standards (training, consent, emergency planning) and one missed MRSA target.[263] The SHA pointed out that whilst the MRSA target had been missed, it had improved in the past year and the Trust had also received very positive feedback from an HCC inspection against the Hygiene Code in January 2007.

4.262 In answer to the question on the form, "Is the SHA aware of any additional information about the trust that may have a bearing on the Secretary of State's decision about whether or not to support this application?", the SHA's response was "None".[264]

4.263 The form was submitted a month after the publication of the Dr Foster Hospital Standardised Mortality Ratio (HSMR) ratings in which the Trust had fared so poorly. No mention was made in the feedback form of this or of the work being undertaken in relation to the implications of this HSMR rating (see *Chapter 5: Mortality statistics*). Equally, there was no mention of the history of the loss of a three-star rating, the adverse peer reviews or of previous poor management. Warren Brown stated that:

> [I]*f those issues had been highlighted and not dealt with and raised concerns about the capability of the Trust, they should have been brought to our attention.*[265]

260 Shanahan T72.117–118; Shanahan WS0000020511, para 538
261 WB/20, WS0000063219
262 WB/20, WS0000063228
263 WB/20, WS0000063219, para 2
264 WB/20 WS0000063231
265 Brown T118.93–94

4.264 Sir Andrew Cash agreed:

> *I would have expected it to have appeared on this form if there were any worries that the SHA or the Trust had. So that would be my position.*[266]

4.265 Mr Shanahan, who was party to this feedback, agreed that with hindsight the WMSHA had placed more credence than it should have done on the AHC score in deciding to support the application, and that there were "issues with the way the Trust was delivering clinical services".[267]

4.266 He explained the absence of any reference in the feedback to Dr Foster's HSMR ratings on the grounds that:

> *I don't think it was flagged at the time because it was an issue we were still trying to understand. And as you know, there was a work stream initiated to actually try and understand the Dr Foster outputs.*[268]

4.267 In his written evidence Mr Shanahan went further, stating that at the time of the publication of the Dr Foster report, in April 2007, he would "not have been unduly concerned" in part because he was aware of no other indicator giving cause for concern.[269]

4.268 However, he accepted, clearly correctly, that this did not justify failing to draw a matter of potential concern to the attention of the DH.[270]

Conclusion

4.269 There can be no doubt that the Trust should never have been authorised as an FT. The SHA was aware of issues about quality but these were never considered as a possible reason for withdrawing support for the Trust. Dr Shaw, the WMSHA Project Director, put it succinctly in his retrospective email already quoted above:

> *Did we miss the Mid Staffs issue? Yes.*
>
> *Was the SHA aware of the issue? It seems like it was.*
>
> *Was the issue clear? Not at all. It is a complex matter, hospital SMR, to unravel.*
>
> *Would we spot a similar matter at* [trusts named]*? No.*[271]

266 Sir Andrew Cash T119.62–64
267 Shanahan T72.128
268 Shanahan T72.131–132
269 Shanahan WS0000020517–518, para 80; T72.135
270 Shanahan T72.132–134
271 SHA0018000070, *Email chain between Dr Shaw, Peter Shanahan and Steve Coneys* (March 2008)

4.270 The issue of mortality rates is considered elsewhere in this report, but the truth was that the SHA's FT processes did not address quality issues, other than in the most superficial way (although this may not have been understood at the DH).[272]

4.271 The SHA did not offer information to the DH about a series of concerns arising in relation to the quality of service at the Trust, of which it was, or should have been, aware. Its approach, doubtless driven by the focus of the process as a whole on financial and corporate governance and not clinical standards, was to be supportive and focus on a goal of advancing the Trust as a successful applicant as an end in itself. This meant the SHA's focus was on financial and governance issues, as the key criteria valued by the DH and Monitor. However, the SHA should not have allowed itself to forget that the purpose of any development in the NHS should be to improve the ability of the system to care for its patients. There were board-to-board "challenge" meetings, but these gave insufficient consideration to whether the deficiencies found in the planning process raised concerns about the general competence of the management of the Trust. The support of the SHA offered false reassurance to the DH as to the soundness of the Trust as a potential applicant. No attempt appears to have been made to consult the HCC as the healthcare regulator or to inform it that the Trust was entering the FT "pipeline". No consideration was given to whether the demands of the process of applying for FT status gave rise to any unacceptable risks for patients.

4.272 Following the abolition of SHAs, it is intended that the support previously given by them to aspiring applicant trusts should be provided by the newly created NHS Trust Development Authority. This provides an opportunity to inject a degree of transparency and consistency into the process of helping trusts prepare for the transition to FT status. One of the roles of the NHS Trust Development Authority will be the assurance of clinical quality in NHS trusts.[273] Its first intended priority is to "safeguard patients".[274] Allied to its intended role as performance manager of NHS trusts, this should enable it to develop a more intensive picture of the fitness of an NHS trust. It must develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for an FT application.

Department of Health assessment and support

Department of Health encouragement

4.273 The Trust's Foundation Trust Committee received encouragement in January 2007 from a report by Mike Gill, by then seconded from Monitor to work for the DH. He had commented that its Diagnostic Action Plan was one of the best he had seen, and that he wanted to show it to other SHAs.[275]

272 Sir Andrew Cash T119.41–42
273 *Building the NHS Trust Development Authority*, Department of Health (January 2012), p8
274 *Building the NHS Trust Development Authority*, Department of Health (January 2012), p10
275 CURE0038000175, Minutes of Foundation Trust Committee (January 2007)

4.274 In May 2007, Mr Gill told the Trust he was content with its revised LTFM.[276] At the same time, it had become apparent that it was unlikely the timetable would allow authorisation in October 2007.[277] The delay does not appear to have been due to any reservation about the merit of the Trust's application.

Due diligence

4.275 There followed some due diligence work within the DH checking matters such as fulfilment of the requirements of Agenda for Change, NHS Litigation Authority (NHSLA) notified claims, and information management compliance.[278] No concerns were raised on any such issue.

4.276 The principal exercise in due diligence was the Financial Due Diligence Report which was prepared on the Trust by Grant Thornton UK LLP and dated 26 May 2007.[279] While, as the title suggested, this report was focused heavily on financial issues, some issues which were raised might have had an impact on the Trust's ability to comply with quality standards. These were:

- The Cost Improvement Plan for the year 2007/08 was questioned and it was suggested it might need to be higher;
- Governance procedures had only recently been improved by the Board and performance, risk and finance reports needed further development;[280]
- The risk management system needed embedding;[281]
- Risk reports to the Board required development.[282]

4.277 This 57-page report was not presented in full to the DH Applications Committee.[283] There was no consideration by the Committee of the implications of the level of staff reductions made to fulfil cost improvement programmes. The total savings from such reductions had been: £3.5 million in 2004/05, £4.3 million in 2005/06 and £5.3 million in 2006/07.

Department of Health applicant assessment

4.278 In advance of the meeting of the DH Applications Committee, a report was prepared on a template form assessing the merits of the Trust's application.[284] It was prepared by David Stocks, a civil servant in Mr Brown's team, who had lengthy experience of the NHS as an administrator and had been involved in the support provided to aspirant trusts, dealing with non-financial aspects of the application.[285] It did not present a favourable view:

276 CURE0038000197, Minutes of Foundation Trust Committee (May 2007)
277 CURE0038000198, Minutes of Foundation Trust Committee (May 2007)
278 WB/22 WS0000063235–255
279 WB/23 WS0000062358, *Financial Due Diligence Report* (May 2007)
280 WB/23 WS0000063260, *Financial Due Diligence Report* (May 2007)
281 WB/23 WS0000063263, *Financial Due Diligence Report* (May 2007)
282 WB/23 WS0000063265, *Financial Due Diligence Report* (May 2007)
283 Brown WS0000062937, paras 57–58
284 WB/25 WS0000063324
285 Brown T118.103; Gill T56.64; Gill T57.19–20

- It reported the outcome of the diagnostic that the Trust was unlikely to be ready for more than two years on the grounds of having had:

  No agreed and costed service strategy in place although being developed. Lack of robust internal controls in place to manage operations and finances to ensure rapid and effective implementation of the plan.

- The SHA support was reported and summarised.
- It was noted that the Trust's LTFM had been late in arriving and had required extensive reworking based on advice from the DH.
- The Trust had staff sickness levels of 5.43%, a vacancy level of 3.8% and a staff turnover of 15%.
- The assumptions in the LFTM were not reasonable: there was insufficient "implied efficiency" built into the LTFM.
- It was reported that there had been "little improvement" in MRSA rates and *C. difficile* rates were up in the last quarter.
- In answer to the question requiring his "on balance" recommendation to the Applications Committee Mr Stocks did not recommend that the DH support it. He wrote:

  The Trust has produced a good IBP [Integrated Business Plan] *based on reasonably sound agreements with its principal commissioner, and the long term strategy is supportable. Unfortunately, the financial requirements are lacking and the trust had to submit a revised LTFM* [Long Term Financial Model] *after the closing date following extensive reworking based upon advice from the Department's lead adviser. The HDD* [Historical Due Diligence report of Grant Thornton] *also identifies significant improvements that are necessary and taken together it adds up to a less than convincing case that makes the application difficult to support.*[286]

4.279 The form is notable in that only one question directly related to the standards of service provided, namely that concerning infection rates.

4.280 Mr Stocks had not been alone in his concerns about this application. Mr Gill, the person within the DH most closely involved in supporting the Trust, had initially been surprised at the speed with which the Trust had entered the process following the negative outcome of the diagnostic exercise ending in February 2006:

I think it's fair to say we were surprised at the speed with which Mid Staffs came back into the process. But equally they appeared to have addressed the key concerns that were raised on the back of the diagnostic process.[287]

286 WB/25 WS0000063325
287 Gill T57.3

4.281 In an email sent on 9 May 2007, Mr Gill was critical of the Trust's final version of its LTFM.[288] Among many other observations, he noted that:

> *This model as submitted is very borderline ...* [it allows] *very little wriggle room to withstand a set of downside sensitivities being run (inc mitigation) and still demonstrate a surplus.*

4.282 By this he meant that the Trust might not be viable if a realistic set of negative assumptions were to come to fruition.[289]

> *Original draft submission assumed 5.9% CIP cumulative across 5 years. Final submitted model has increased this to 8.4% but still below expectations ... less than the implied CIP requirement.*

4.283 This referred to his perception that the Trust's planned cost improvements would not keep pace with national requirements.[290]

4.284 His conclusion was that:

> *Currently I have Mid Staffs as unsupportable ... I do not propose to feed these comments back to the Trust at this point and not having discussed with Warren* [Brown] *as in reality all trusts have had my earlier feedback and have had the opportunity to reflect these in their final submission.*

4.285 By this he meant that he thought the Trust's case could not at that point be supported at the Applications Committee in its advice to the Secretary of State and as such he clearly disagreed with the support being offered by the WMSHA:

> *It would be the cumulative impact of all of those* [comments on the LTFM] *and just taking one step back and saying "Overall on balance is there too much risk here in terms of Monitor throwing out the application because there's just too much risk there?"* [291]

4.286 The intended implication of Mr Gill's conclusion was that, if a reasonably possible set of negative circumstances occurred, the Trust would not be financially viable.

288 DH00000002080–2082
289 Gill T56.79
290 Gill T56.80
291 Gill T56.77–82

4.287 Again, there was no comment on any clinical aspect because that was not Mr Gill's role. He assumed such matters were being addressed by the SHA and the HCC.[292] It did not occur to Mr Gill to consider the clinical implications of his negative view of the Trust's planning, and he cannot be personally criticised for that because considering such matters had never been part of his responsibility. However, the threat of not meeting Monitor's requirement for financial sustainability, resulting from financial strains that could be reasonably predicted from the Trust's own financial planning, clearly presented a risk of the Trust not being capable of maintaining the required standards of service. Thus, the very purpose of good financial management in the NHS was in danger of being forgotten, as, unhappily, it was in this case.

Department of Health Applications Committee

4.288 The DH's Applications Committee was chaired by Sir Andrew Cash. Its role was to reconcile any conflicting advice and decide on what advice should be given to Ministers.

4.289 The Committee was attended by:

- David Meek, to advise on the merits of trusts in the South;
- Mike Gill, seconded from Monitor to the DH, who advised on trusts from the North and the Midlands, including the Trust;
- Martin Foulds (NHS Financial Controller), who would have been expected to identify financial risks;
- Alastair MacLellan (Group Financial Controller at the DH), to advise on the general financial criteria for the relevant wave;
- Warren Brown, whose duty it was to ensure that the decisions taken enabled coherent advice to be given to Ministers.[293]

4.290 It is to be noted that the Committee membership comprised of officials responsible for ensuring an effective FT application pipeline – some of whom had provided support to potential applicants during earlier stages of the process – and senior NHS financial experts. There was no representation from a healthcare professional or a representative to advise on quality.

4.291 The meeting at which the Trust's application was considered took place on 7 June 2007 and lasted about two hours. It considered the Trust's IBP, the SHA's view on readiness and any other views that had been expressed by other DH officials in attendance.[294]

4.292 Mr Gill, who was speaking only from recollection, told the Inquiry that he thought the view of the Committee had been that:

292 Gill T56.81
293 Brown WS0000062939–940, para 65
294 Brown WSW0000062939, para 64

... it was a borderline application that had risks attached to it but, equally there was levels of confidence in terms of how the organisation had moved in a relatively short space of time and had addressed the key issues that had arisen out of the FT diagnostic some time before. And I think that level of confidence ... helped provide a level of confidence that we would continue to work with the applicant, and support them to Monitor.[295]

4.293 He agreed with the decision which, he said, was "to cautiously support it, with further support".[296]

4.294 The Inquiry heard evidence on the Committee's view of Mr Stocks's report. Warren Brown suggested in evidence that Mr Stocks was raising concerns that members of the Committee were more qualified than he to assess.[297] He thought that Mike Gill would have advised that:

There were some presentation issues which could be dealt with. And there was the sense that there was, given the additional funding going into the local health economy, enough leeway to allow this trust to go forward because the financial model wasn't as pessimistic as being presented.[298]

4.295 In other words, it was thought that the pessimism could be toned down. This is to be contrasted with the view held by Mr Gill before the meeting as described above.

4.296 With regard to the reported issues around standards compliance and HCAI targets, it is apparent that the Committee would not have been concerned about these. Warren Brown said that its view would have been to consider whether the Trust was doing everything it could to maintain hygiene levels, and that the Committee had concluded that it was, evidenced by the apparently reassuring view of the HCC cited.[299]

4.297 Sir Andrew Cash stated that the Committee were "reassured" that the Trust had no performance problems.[300] However, there was no specific discussion about how the Trust had achieved its cost improvement targets, certainly none that Warren Brown could recollect.[301] There had been concerns about the robustness of its long-term financial plan, but it was felt that these could be addressed.[302]

4.298 Warren Brown, whose job it was to sum up the views of the Committee, told the Inquiry that it thought that the Trust's application was marginally supportable:

295 Gill T57.26
296 Gill T57.26
297 Brown T118.104
298 Brown T118.105
299 Brown WS0000062942, para 73
300 Sir Andrew Cash WS0000061530–1, para 60
301 Brown WS0000062937, paras 58–59; WB/23 WS0000063257–95
302 Brown WS0000062937, para 59

The Committee (which included accountants) decided that Mid Staffs was a marginal case, having taken David Stocks' advice as well as the advice of others. The Committee concluded that Mid Staffs' application was just about acceptable, and it could be made to work. In other words, the view of the Committee was not that Mid Staffs was ready to be assessed there and then by Monitor but that with additional support it should be in a position to put up a strong case when assessed by Monitor much later in the year.[303]

4.299 This was hardly a ringing endorsement of the application, and the recommendation that it be supported depended entirely on an assumption that sufficient support could be given to a willing Trust leadership to get the application into a state fit for Monitor's assessment.

4.300 Mr Brown was asked whether the Trust would have received the Committee's approval if there had been a number of stronger trusts in the same wave. He replied:

I suspect if we had ten high quality applicants, we might have wondered more about that particular trust, but we didn't. But, but at the same time, we did not identify reasons not to support it, so ... it's – it's a difficult judgement in retrospect.[304]

4.301 When asked about this answer, Sir Andrew Cash said it was "fair" and that Mr Brown was entitled to his view, but he himself did not think the Committee would have turned down the Trust, even if there had been a number of stronger candidates.[305]

4.302 John Holden, who took over responsibility for the DH's FT team in March 2008, after these events, was party in 2009 to explaining the decision made about the Trust to the Rt Hon Ben Bradshaw MP, then Minister of State for Health. An email summarising what had been said in that conversation contained these words:

I took part in a telecon with Ben today in which David Flory and I did – I believe – a reasonable job of explaining to Ben some of the context for the mid staffs decision (momentum of pipeline in a relatively weak wave of applciants [sic]*, etc) and the process which led to its receiving SOS support.*[306]

4.303 He accepted that he had been in a position to gain an impression of how things had been done before he joined the FT team, and said that he offered the Minister his opinion on that basis.[307]

303 Brown WS0000062943, para 77
304 Brown T118.88
305 Sir Andrew Cash T119.88–89
306 JH/18, WS0000057976–8
307 Holden T120.107–108

Submission to the Minister

4.304 Following the meeting, on 14 June 2007, Warren Brown prepared a submission for the Minister, in this case Rt Hon Andy Burnham MP.[308] This would have been approved by the Applications Committee members. It reported that the Committee recommended that only two out of the six trusts considered should be given Ministerial support to proceed to Monitor.[309]

4.305 The Minister was offered an explanation for the high attrition rate. It was, said Mr Brown, likely to be due to "the low numbers and risk base of those put forward by SHAs and a reality check around what the statutory break-even duty means".[310]

4.306 "Tougher" financial rules had been introduced by the DH in advance of seeking Ministerial support "which has resulted in more Trusts being weeded out but allowing a much greater degree of confidence in those being supported which should mean a higher success rate at Monitor".[311]

4.307 The submission explained that the Applications Committee considered that four trusts were "not yet ready", but would be "supported" to help them address what was needed to enable them to submit an application at the earliest opportunity. The issues which led to this conclusion were:

- A late reduction in available financial support from its SHA which made one trust's business model present too high a risk;
- A marginal financial model, which appeared not to have sufficient cushion to meet capital loan repayments with enough residual surplus to meet future risks. The trust concerned would be asked to revise its model. If that were done that trust might be in a position to re-submit its application in the summer;
- A weak financial model presenting a "borderline" case. Again it was hoped this could be remedied and an application re-presented in the summer;
- Another weak financial model assuming a level of Private Finance Initiative (PFI) support which could not be identified at the time, together with the recent departure of the Finance Director.[312]

4.308 The trust that was recommended for support other than the Trust itself was anticipated to be a "strong applicant", having seen a "significant turnaround in recent years". It would currently have been in breach of Monitor's borrowing limit, but this was going to be remedied in the near future.[313]

308 WB/28 WS0000063359–63
309 WB/28 WS0000063363, para 13
310 WB/28 WS0000063362, para 5
311 WB/28 WS0000063362, para 5
312 WB/28 WS0000063361–2, para 8
313 WB/28 WS0000063361, para 6

4.309 The information provided to the Minister about the Trust consisted of the following two sentences:

> *Mid Staffs' business model is marginal in that it does not appear to generate the level of surplus that would stand up to risk assessment. However, there is a strong 'can-do' attitude at the Trust and we can provide them with additional support ahead of them presenting their model to Monitor.*[314]

4.310 While the submission made it clear that support would be necessary to bring the Trust's model up to the required standard, it is notable that the submission did not inform the Minister that anyone had suggested the application was "difficult to support".[315] Warren Brown's justification for all this was:

> *It was the committee's decision to present the advice that was presented. The committee's view on the clinical issues was that they were being dealt with and, therefore, did not need to be drawn to the attention of the Minister, and that's consistent with previous waves – you tended to bring out issues where you were advising not to support. There wasn't a sense that the clinical issues at that time were of any great magnitude. And in terms of the financial model it is very clear that Mid Staffs' business model is marginal,* [it] *is a message saying that it's only just workable and still needs some more work to be done.*[316]

4.311 He did not agree that more information ought to have been given to the Minister: "The Minister would have understood that that was not a trust going forward with massive surpluses, it was a trust going forward just good enough".[317]

4.312 David Flory, having been shown this advice at the Inquiry agreed that it was dangerous to propose reliance on a "can do" attitude.[318]

4.313 Sir David Nicholson was sympathetic: Sir Andrew Cash was new to the DH at the time and perhaps not familiar with the expectations of the civil service.[319] In fact, the submission was drafted by Warren Brown, a civil servant who would have been aware of the expectations, although the Committee chaired by Sir Andrew would have approved its contents. In any event Sir David thought that it was "unnecessary" to take a risk in putting forward this trust on the basis of a perceived "can do" attitude and he also thought that more balanced advice should have been offered to the Minister:

314 WB/28 WS0000063361, para 7
315 David Stocks report, WB/25 WS0000063325
316 Brown T118.107–108
317 Brown T118.110
318 Flory T121.99–101
319 Nicholson T127.155

I think you would expect, in these circumstances, for a pros and cons to be much more clearly set out in a document like this. And as I say, I don't think there was any real need to take a risk at this time with this organisation ...

... it would be my experience in work that the Civil Service would generally do, that Ministers would expect much more detail. But clearly we'd got into a place where Ministers didn't really expect that much detail, and so they were happy with a relatively short statement, when in other circumstances you would want a much more clearer exposition of it all.[320]

4.314 Although he made it clear that he did not know what the discussion in the Committee had been, he did not consider that the advice reflected the content of the underlying reports "All I've seen is the paperwork and they don't reflect what's in the paperwork".[321]

Conclusions

4.315 The advice tendered to the Minister was deficient and supported by insufficient information to enable him to make an informed decision. Brevity in advice is commendable, unless it serves to mislead. On any reading of the material, the Applications Committee considered this a marginal decision, carrying a degree of risk with it. The submission to the Minister did not reflect that adequately, or at all. Whilst it referred to a marginal business model, it provided assurance that this could be remedied. It did not disclose that the conclusion of the analysis presented to it was that the application was difficult to support, or offer the Minister any reasoning as to why the "can do" attitude referred to could make an application which was difficult to support into one which could be supported. No reference was made to the conclusions of the HDD (Historic Due Diligence) exercise that improvements were required. It has been suggested that less weight could be attached to the work of Mr Stocks because he was not an accountant. An alternative view would be that this might be a reason for giving weight to a more generalist perspective. This report was also consistent with the concerns expressed before the meeting by Mr Gill. The advice to the Minister relied on a perception of a "can do" attitude, which was superficial in the extreme, but could have been assumed by the Minister to be soundly evidence based. The reality was that the Trust's leadership was bent on FT status as a solution to its deficiencies, rather than as evidence that they had been solved. There was no evidence that they were aware of the deficiencies in their model until this was pointed out to them in the course of the "support" offered by the DH. This should have, but did not, call into question their competence. A "can do" attitude is very dangerous if held by people in leadership positions who lack the ability to detect the deficiencies in their organisation. Leadership of autonomous organisations, such as FTs, requires the ability to detect and remedy issues without having to be told from above how to do so.

320 Nicholson T127.155–156
321 Nicholson T127.158

Decision of the Minister

4.316 The Minister of State for Health, the Rt Hon Andy Burnham MP, was unaware that the report on the Trust provided to the Applications Committee had said that it was "difficult to support". He noted that the financial case for its application was marginal, but in the context of the time, when NHS finances were generally a matter of difficulty, it was a positive feature that the Trust was generating a surplus.[322] He told the Inquiry that, having now seen the information about HCAI and hygiene available to the Applications Committee, he noted that there was no report of other existing compliance measures, such as A&E waiting times, and as such there were no major issues being reported.[323]

4.317 He would have assumed, erroneously, that the DH would have obtained the view of the HCC on the application as part of the process.[324]

4.318 In considering Warren Brown's submission to him, Mr Burnham said that he would have treated this somewhat differently from many forms of advice received from civil servants. He was aware that the matter had been discussed by the Applications Committee, and said that:

> *I did not think that a trust could get to that stage of the process if there were issues, given the number of different layers they had to go through.*[325]

4.319 The fact that senior directors had discussed each individual trust gave him a high degree of confidence in their recommendations.[326]

4.320 He felt that he would have derived comfort with regard to the rigour of the process from the fact that he was being advised that four trusts should not be supported. From this he appears to have felt able to deduce, "That any trusts I was being advised to support were considered to be high performers, who could handle financial autonomy and everything that FT status brings".[327]

4.321 He also derived comfort from his knowledge that any trust he supported would be subjected to what he believed would be a rigorous assessment by Monitor:

> *There was no finality about what I was doing; I was simply saying that, on the basis of what had been presented to me, there was no reason for me to stop this trust being put forward for further consideration by Monitor.*[328]

322 Burnham WS0000063418, para 63; Burnham WS0000063420–1, para 71–73;
323 Burnham WS0000063423, para 81; Burnham T115.91
324 Burnham WS0000063418, para 65
325 Burnham WS0000063419, para 67
326 Burnham T115.90–91
327 Burnham WS0000063419, para 66
328 Burnham T115.92–93

4.322 He did not anticipate that Monitor would place reliance on Ministerial support. He considered the meaning of it to be much less significant than that:

> *My support was simply a confirmation that there was no reason that I knew of that Mid Staffordshire should not have had a chance to go forward to Monitor's application process, which would seriously test and inspect them in a rigorous way, and subject them to higher scrutiny to flush out any issues.*[329]

4.323 It is apparent that Mr Burnham gave careful consideration to the submission as a whole. The Inquiry has been furnished with the copy on which he made annotations and recorded his decision. He wrote his agreement with the recommendations, but made an observation about the future prospects of two trusts which were not to receive support and the help they would need from the DH. He required a clear lead to be given to all four rejected trusts about the issues they needed to address.

4.324 He volunteered that in retrospect the reference in the submission to the Trust management's "can do" attitude could have been interpreted as meaning that they had a cavalier attitude to their responsibilities, but that was not a thought which occurred to him at the time, and that was clearly not what was being suggested to him.[330]

4.325 He did not expect Monitor to place much, if any, weight on the Ministerial decision to support the Trust because they had always been so assertive of their own independence and had their own rigorous processes.[331]

4.326 Considering the matter retrospectively, Mr Burnham thought that he had little choice but to accept the recommendation made to him:

> *I think you have to be realistic about what you can do as a Minister. You've got to remember that the NHS is a huge organisation. I was dealing with large number*[s] *of issues to do with finances at the time, also trusts with very high MRSA rates. So you have to be realistic in terms of what you can – what you can ... do do. I've looked back at it. I have to say, looking back at the submission, I mean, I followed the advice that the Department was putting to me. It was advice that had come through a number of layers that began at the local level, that's signed off by the PCT, a period of public consultation, came through the SHA. I mean, you have to say as a Minister, if all of that hasn't flagged up any issues, on what basis am I coming in to overturn the advice of civil servants to say, no, this organisation can't go forward, because no reason was put to me to stop that.*[332]

329 Burnham WS0000063427–428, para 97
330 Burnham T115.96
331 Burnham T115.107–108
332 Burnham T115.107–108

4.327 The Minister's decision was communicated by his Private Office to Warren Brown on 16 June.[333] On 22 June, Sir Andrew Cash wrote to the Trust congratulating it on securing the Secretary of State's support and describing it as a "major achievement". The Trust was warned that the Monitor process would be "rigorous" and they were urged to continue developing and improving the business plan and financial model.[334] The letter enclosed a version of Mr Stocks's report but crucially it excluded his conclusion that the application was difficult to support.[335]

Conclusions

4.328 On the basis of the extremely limited information offered to Mr Burnham, it is impossible to say his decision to support the Trust's application was unreasonable. He was entitled to, and did, rely on the fact that an expert committee made a recommendation to him having considered the issues. He could reasonably have expected the Committee to draw to his attention any issues taking the application out of the ordinary. Some Ministers might have required more detailed supporting documentation as a matter of routine, but all holders of such challenging offices have to balance demands to be told detail with the need to process many decisions expeditiously and not to repeat work which others in the hierarchy have done; there was nothing in this advice to prompt him to ask for more information. He relied, and was entitled to rely, on the judgement of senior and experienced officials to draw to his attention matters that were relevant to his decision. That should have included the fact that some thought the application was difficult to support, and the reasons why that view had not been followed, but Mr Burnham cannot be blamed for not knowing that.

4.329 It is of concern that Mr Burnham's understanding of how the system leading to Ministerial approval operated differed from the reality. His belief that it identified trusts which were "high performing" was at odds with the fact that there was little, if any, focus on an assessment of an applicant's current ability to deliver services compliant with standards. However, this is easier to see in retrospect than it would have been at the time for a Minister. While it is a matter of speculation, it seems likely in any event that had he been made aware that there were unresolved issues about mortality rates at the Trust, that he would have hesitated before giving his support.

4.330 Mr Burnham, like so many others, was caught up in a system driven by an established policy. This policy had turned the achievement of FT status into an end in itself, without sufficiently pausing for thought as to whether an organisation was delivering care to patients which warranted the granting of that status. He may share in a small way his Government's responsibility for the policy but, given its points of reference, his decision to support the Trust, although wrong in retrospect, was not unreasonable on what he knew at the time.

333 WB/29 WS0000063366
334 WB/30 WS0000063369
335 WB/31 WS0000063371–78

Overall conclusions

4.331 On the face of it, a huge amount of effort was put into the process undertaken by SaSSHA, the WMSHA and the DH to drive the Trust into a condition in which it was felt possible to allow its application to be considered by Monitor. A trust which was delivering the standard of care it is now known was being given by the Trust at the time should never have been allowed to make an FT application. The system failed rigorously to examine the effectiveness of the Trust in delivering safe care, where the public might reasonably have expected such a system to do so.

4.332 As has been said all too often, the reason was a focus on financial and corporate governance processes, at the expense of a thorough consideration of whether the Trust was successfully achieving what it was set up to do: deliver safe and effective care and treatment to its patients. It is clear that some NHS trusts were rejected; indeed in the wave which involved the Trust, the majority were. In general, such rejections were on financial or corporate governance grounds, but no doubt if a very serious issue of non-compliance with standards had come to light, that too would have resulted in a trust being rejected at this stage. The problem was that little effort was put into looking for such concerns. Instead, there was a passive reliance on a limited number of indicators, such as compliance with waiting time and HCAI targets, and a general assumption that the healthcare regulator would draw any current concerns to the attention of the rest of the system. The assumptions were so strong that no effort was made to communicate with the HCC to ask for their view.

4.333 Even within the system as it was then constituted, there is serious doubt whether the Trust should have been given support by the WMSHA, the DH Applications Committee and Ministers. Despite the availability of seemingly endless "support" from experts, the Trust leadership was unable to produce a credible business and financial plan for the future. Its achievement, or near achievement, of the financial criteria expected by Monitor was to be achieved by sequential and significant staff cuts, and yet no assessment was made of the impact of this on the Trust's ability to deliver services compliant with acceptable standards. Sufficient consideration was not given as to whether the inability of the Trust's management to produce a credible plan within the time required raised concerns over their leadership generally. Unhappily, the focus was excessively on ensuring that at least some trusts were offered for Monitor's consideration at a time when there was considerable pressure to evidence progress in implementation of the policy, and when few trusts were even marginally close to the criteria. It was imprudent to put forward trusts on the basis that, although not compliant at the time support was given, it was expected they would be by the time of the assessment. Adopting that approach put the Minister in the invidious position of supporting organisations which were not actually ready, in the hope they would be in due time. Further, the Minister was furnished with information which was inadequate for an informed

judgement and concealed from him adverse factors of which he should have been made aware. All this meant that his support, required by law, was a formality not a safeguard, which cannot have been the intention of Parliament.[336]

The authorisation process in practice: Monitor assessment and authorisation

The process in outline

4.334 On 12 July 2007, Monitor informed the Trust of the timetable for the provision of required information.[337]

4.335 On 24 July 2007, the Trust sent its initial submissions to Monitor, which included a version of the IBP. The letter asserted that its IBP and LTFM had received the Secretary of State's support, and that it had the "full support" for its vision, plans and governance arrangements from patients and the general public, as well as the PCT, the SHA and other stakeholders. It referred to FT status as being a "further milestone in [its] ambition to provide Excellent, Accessible and Sustainable services".[338]

4.336 On 31 July 2007, the Trust was informed that it had been allocated to an assessment slot for potential authorisation on 1 February 2008 and that the assessment work would commence approximately three months before then.[339]

4.337 On 1 October 2007, a further submission of documents was made by the Trust which included an updated IBP, a LTFM and direct evidence relating to risk management and performance management.[340]

4.338 In October and November 2007, the Monitor assessment team visited the Trust and met a wide range of people, individually and collectively. In particular they met:

- Trust Board members;
- Executive Directors;
- Finance team;
- Divisional leads;
- Trust internal and external auditors.[341]

336 National Health Service Act 2006, section 33(1)
337 DH/6 WS0000038032–35
338 TRU00010000419, Letter from Martin Yeates to Miranda Carter (4 July 2007)
339 DH/8 WS0000038184
340 DH/17 WS0000038274–76
341 Hill WS0000037886–89, paras 19–20; Hill WS0000037895–96, paras 29–33

4.339 During the same period, the team met officials from the WMSHA and the Primary Care Trust (PCT).[342]

4.340 In addition to assessing the IBP and LTFM, the team reviewed the Trust's performance against healthcare targets, as required by their compliance framework.[343] As a result of breaches in MRSA targets, the Trust was given a score of 1.4 and an "amber" risk rating for governance risk.

4.341 A board-to-board meeting was held on 5 December 2007, in advance of which the team prepared a briefing pack identifying issues they suggested should be pursued. At the meeting a limited number of questions were asked on quality issues, but, in the main, the focus remained on financial and corporate governance issues.[344]

4.342 Following this meeting, the assessment team reviewed the application and further material was provided by the Trust. This included information about HCC reports indicating weaknesses in some services.[345] A report was obtained from Grant Thornton reviewing the Trust's working capital and financial reporting.[346] Among other material considered was the 2006 staff survey, but little weight appears to have been attached to its poor results.[347]

4.343 On 30 January 2008, the Monitor Board considered the Trust's application and accepted the assessment team's recommendation that it be authorised with a side letter referring to concerns about compliance with MRSA targets.[348] At the time Monitor was unaware at any level of the impending decision by the HCC to launch a formal investigation into the Trust. Had they known of that it is highly likely that Monitor's Board would not have agreed to authorisation at that point.[349]

4.344 It is unnecessary to consider actions taken by Monitor in its assessment process in detail, but instead a number of key points will be examined which show the principal weaknesses in the system as it was applied to this trust.

The Trust's business plan

4.345 On 24 July 2007, Martin Yeates wrote to Miranda Carter, the Assessment Director of Monitor, sending her the approved IBP and LTFM. Mr Yeates made the following statements in the letter:

342 Hill WS0000037903, para 38
343 Hill WS0000037908–11, paras 49–51
344 Hill WS0000037922–24, paras 84–89; Moyes W0000039645–48, paras 59–60
345 Action plans DH/23 WS0000038436; DH/24 WS0000038445; Hill T89.127
346 Hill WS0000037927–28, paras 97–101
347 Hill WS0000037900, para 34
348 Hill WS0000037942, para 108
349 Moyes WS0000039644, para 56

We are committed to further improving the services we provide, as is evidenced by the lead role taken by senior clinicians in the development of our service plans ...

It is the considered view of the Trust Board that the work undertaken by the Trust demonstrates that, upon authorisation by Monitor, the Trust will be legally constituted, well governed and financially sustainable.[350]

4.346 This latter statement was described by Helen Moss as "bold" and that:

There were some things that it is fair to say were still a work in progress. Change was certainly happening and we were moving in the right direction, but there was still some way to go. I would not have been uncomfortable hearing this statement at the time because we were making good progress, but, in hindsight, I would query whether change was happening fast enough.[351]

4.347 The finalised IBP (version 4.2) set out a number of statements which, in hindsight, were over ambitious and misleading in effect. As well as repeating the statement Mr Yeates had already made about the Trust being "well governed", a statement signed by the whole Board included the following:

The trust has been transformed over the last two years, the organisation is now focused, lean and hungry, well managed and increasingly well respected for its ambition and its delivery.[352]

We are aware of our weakness as well as our strengths and we have assessed our limitations but we are also exploiting our opportunities.[353]

4.348 The summary claimed:

The culture of the organisation has changed as a result of the change in leadership and through adopting the requirements for applying for FT status. The way things get done is rapidly becoming more business-like with devolved earned autonomy, greater focus on patients and our customers, being responsive and open to criticism. The culture will continue to change as a result of FT status to one of "can do", "with pace" whilst seeking upper quartile performance and maintaining the appropriate level of quality.[354]

350 MON000400007880, Letter from Martin Yeates to Miranda Carter (24 July 2007)
351 Moss WS0000009500, para 127
352 HM/37 WS0000010113
353 HM/37 WS0000010113
354 HM/37 WS0000010116–117

4.349 The IBP did draw Monitor's attention to the fact that the HCC found the Trust to be among the worst performing trusts for:

- Not enough nurses on duty to care for patients;
- Doctors not washing or cleaning their hands between touching patients;
- Not enough information given regarding the patients, their condition or treatment.[355]

4.350 The IBP also made it clear that there had been a reduction in nursing, midwifery and health visitors staff group establishment of 103 whole time equivalent posts (WTEs) from 2004/05 to 2006/07.[356]

4.351 The results of the annual staff survey for 2006 were also reported, including the fact that under 50% of the staff would want to be treated by the Trust.[357]

Lack of communication with the Healthcare Commission

4.352 It will be noted that the above list of actions does not include reference to any contact between Monitor and the HCC in connection with the Trust's application. This is because there was none. The Inquiry examined how this came about.

4.353 In October 2007, the HCC published its rating for the Trust based on the self declarations for 2006–2007. The rating was "Fair" for Quality of Service. As pointed out by Mr Brown, it missed being rated as "Good" only because of a "Weak" rating for achieving new process targets, having achieved "Fully met" for existing targets.[358]

4.354 A Memorandum of Understanding between Monitor and the HCC was signed on 15 September 2006 by Dr Moyes and Anna Walker, the Chief Executive of the HCC, and was in force throughout the period of the assessment of the Trust's application.[359] One of the agreed general principles for cooperation was that:

> *There needs to be ... the proper exchange of information in relation to ... NHS trusts ... that have applied for foundation trust status.*[360]

355 HM/37 WS0000010132
356 HM/37 WS0000010133
357 HM/37 WS0000010205
358 Brown WS0000062936, para 53.2
359 MON00030026931–37, Memorandum of Understanding between the commission for healthcare audit and inspection and the independent regulator of nhs foundation trusts (monitor) (15 September 2006)
360 MON00030026934, Memorandum of Understanding between the Commission for Healthcare Audit and Inspection and the Independent Regulator of NHS Foundation Trusts (Monitor) (15 September 2006)

4.355 Requirements were set out for sharing information and cooperation between the two organisations. These included undertakings that:

> *Each organisation would keep the other informed promptly and fully about developments in which the other party may have an interest ...*
>
> *In reaching decisions within their respective areas of jurisdiction each part will seek advice from the other in good time and with good reason on matters in which the other is or would be interested, explaining how the advice will be used and giving careful consideration to that advice ...*
>
> *Each party will inform the other without delay of any matters that may require action by or a response from the other party. Such matters will include ... information held by one of the parties that may give rise to potential concerns in relation to an NHS Foundation Trust ...*
>
> *Each party will ensure that the other party is given adequate warning of and sufficient information about, any planned announcements to the public that the other may need to know of so as properly to conduct its affairs ...*
>
> *The Healthcare Commission will seek to ensure that Monitor has the opportunity to consider in a timely manner: annual reviews; reviews and/or investigations; reports; and/or recommendations in relation to ... NHS Trusts that have applied for authorisation under the 2003 Act.*[361]

4.356 Monitor witnesses offered retrospective criticism of the Memorandum as being insufficiently specific and systematic.[362] However, it was, or should have been, clear to all concerned from the Memorandum that an exchange of relevant information about applicants for Monitor authorisation was required. In fact, there was no formal process in place requiring an enquiry to be made of the HCC as to whether it had any information over and above the last published rating relevant to the issue of authorisation.[363] Such steps were apparently taken in respect of some applications, including that of a trust considered at the same time as the trust. According to Miranda Carter, Assessment Director at Monitor, it was not "routine" for Monitor to send the HCC a list of applicants, although such a list did exist on Monitor's web-site, but assessment managers were "encouraged" to communicate with local HCC teams.[364]

4.357 There was some contact between Monitor and the HCC in connection with the Trust. Miranda Carter recollected sending an email, which she could not trace, suggesting that the Assessment Team contact the local HCC office.[365] David Hill recollected asking Rupinder Singh,

361 MON00030026934–35, Memorandum of Understanding between the Commission for Healthcare Audit and Inspection and the Independent Regulator of NHS Foundation Trusts (Monitor) (15 September 2006)
362 Masters WS0000035320, para 22; Hay T92.57
363 Hay T92.57; Hill T89.194
364 Miranda Carter WS0000030593, para 37
365 Miranda Carter WS0000030602–603, para 37

a Senior Compliance Manager at Monitor, for contact information at the HCC concerning three trusts, including the Trust.[366] On 23 October, Rupinder Singh emailed this request to HCC officials, including Andrea Gordon, informing them that David Hill had asked for contact in connection with three trusts, including the Trust, in order to "Understand some aspects of their performance in order to assess risk as part of their application for Foundation Trust status".[367]

4.358 Rupinder Singh then collected and distributed contact numbers. Dr Bennett, the HCC area manager for the North West, suggested on the same day that David Hill should speak to the appropriate assessor, not the area manager. Nonetheless, Rupinder Singh confirmed to David Hill, again on 24 October, that Andrea Gordon was willing to speak to him.[368] Andrea Gordon herself replied by email to David Hill on 8 November 2007, inviting him to call her if he wanted to talk about the Trust.[369]

4.359 David Hill understandably had difficulty in recalling to whom he had spoken and what he was told.[370] He confirmed that he remained unaware of the contact made by the HCC with the Trust and the SHA indicating it was considering investigating concerns. He was clear that had he known of the HCC's concerns being communicated in January 2008 he would certainly have reported them to Miranda Carter, Stephen Hay and the Monitor Board:

> *I do not make decisions on whether or not an applicant should be authorised as a Foundation Trust, but based on my experience with similar situations in relation to other applicants, I consider that Monitor's Board would have deferred consideration of the application until the HCC's concerns had been resolved.*[371]

4.360 He accepted that if he had spoken to Andrea Gordon, she would, in his view, have identified to him any mortality alerts of which she was aware, and that they would have discussed these to ensure he understood them and to enable him to feed these into the assessment process.[372] Dr Gordon also thought she would have mentioned them, but likewise she could not recall having such a conversation.[373]

4.361 Mr Hill was unclear as to why he had not spoken to Andrea Gordon after she had offered to receive his call, apart possibly from there having been difficulty in getting through. In hindsight he clearly wished he had made more of an effort.[374]

366 Hill WS0000037916, para 66
367 MC/7 WS0000030773
368 DH/48 WS0000039313
369 MC/7 WS0000030772
370 Hill WS0000037916, para 66
371 Hill WS0000037916–917, paras 67–68
372 Hill T89.195–197
373 Gordon T88.4; Gordon WS0000024118, para 123
374 Hill T89.198

4.362 Clearly this omission had important consequences. Dr Moyes was emphatic:

> *Monitor was completely unaware that HCC was considering launching an investigation the month immediately following the Trust's authorisation as a foundation trust. If the HCC, or the Trust ... had told us, we would have stopped the assessment decision immediately and deferred a decision on the application until the results of the HCC's investigation were known. But that did not happen, I do not know why that was.*[375]

4.363 This was confirmed by Stephen Hay:

> *Neither the trust, nor the SHA nor the HCC told Monitor what was happening, which is disappointing, and which I am confident could not happen now ...*
>
> *Had Monitor been told the HCC was considering launching an investigation into the Trust on 28 January 2008, the Trust would not have been considered by Monitor's Board and would not therefore have been authorised as a foundation trust'.*[376]

4.364 The problem created by a failure of communication was foreseen within Monitor and by Dr Moyes personally in 2005. An investigation officer of the HCC had emailed an assessor at Monitor asking whether Monitor wanted to be notified of concerns about trusts applying for FT status. Dr Moyes was asked for his comment and in a reply, on 2 February 2005, said:

> *We would both look pretty silly if we authorised a Trust and then the Healthcare Commission drew to our attention clinical performance issues of which it had been aware but had not mentioned to us. So yes, I believe they should tell us if it is likely that they would refer to us under section 53 any trust that could be authorised in the foreseeable future.*[377]

4.365 It was this thinking which informed the Memorandum of Understanding, but as already remarked, this was not translated into a system for ensuring such information was obtained.[378] Mr Hay was at pains to disagree with the suggestion that the failure of the assessment team or Board to inquire after the input of the HCC, when considering the application, was born of the focus on finance and corporate governance. However, it is difficult to avoid the conclusion that this was the case. In the absence of a focus on finance, it is likely there would have been more attention paid to quality. Any reasonably thorough consideration of the quality of service being delivered by the Trust would have led inevitably to the question of what was the HCC's current thinking.

375 Moyes WS0000039644, para 56
376 Hay WS0000041208, para 41
377 MON0000000116, Email chain between Brian Courtney, William Moyes and Stephen Hay (02 February 2005); Moyes T92.56
378 Hay T92.58–59

4.366 Dr Moyes was very reluctant to accept that it had been Monitor's responsibility to pursue the HCC for information, or even proactively to inform them that the Trust was applying for authorisation. He contended that it was "inconceivable" that the local HCC office would not have known this, and he expressed doubt that a more formal system of communication would have led to a greater state of knowledge at the HCC.[379] In the end, he was prepared to accept that there should have been a better system and that erroneous assumptions were made:

> *I suspect equally, with the benefit of hindsight, that the assessment team assumed that silence meant there was nothing much to say. And I wish now that they had not done that. I wish now that they had persisted and got, as you say, either a telephone call or an email or a piece of paper of some kind. But they didn't.*[380]

4.367 It is of concern that Monitor was sufficiently aware of the importance of communication with the HCC to sign up to a Memorandum of Understanding emphasising it, and was aware, as shown by Dr Moyes's observation in 2005, of the potential consequences of a failure of communication, and yet had done nothing to systematise enquiries about applicant trusts. Dr Moyes's suggestion that Monitor was entitled to rely on an assumption that the HCC knew the identity of applicants, and therefore could be expected to tell Monitor of any concerns, is untenable.[381] A regulator performing its statutory functions should not rely on the chance that another regulator, performing a different function, would realise that it needed particular information at a particular time. Such a suggestion is also belied by the action David Hill actually took to make contact with the HCC. The primary cause of Monitor being unaware of the HCC's concerns was the failure of Mr Hill, no doubt through overlooking the need to do so in a busy schedule, to follow up Andrea Gordon's invitation to call her. He should not be heavily criticised for this omission in the absence of any system requiring him to have pursued the point, and where Monitor did not accord significance to this sort of information. Had it been a matter of priority, the oversight of the work of the assessment team would have included a check on whether the HCC had been asked for information and, if so, their response. No such check existed, and no question was asked by the Board about the absence of such information.

4.368 Turning to the HCC, it is clear that there was knowledge within the organisation that the Trust was applying for FT status. In addition to the email referred to above, Celine Wilkinson and Sara Reeve, HCC officials who were not part of the team normally dealing with the Trust, were told of its FT application at a meeting on 10 October 2007. They were also told of the expected authorisation date of February 2008.[382] Dr Gordon said she regularly received lists of applicants and that the HCC had been informed the Trust was applying for FT status.[383] On the

379 Moyes T92.135
380 Moyes T92.138–139
381 Moyes T92.133
382 AG/38 WS0000024447
383 Gordon T78.50–51

evidence before the Inquiry, it is highly unlikely that Andrea Gordon or anyone else at the HCC actually gave information to Monitor about their growing concerns about the Trust. Dr Gordon accepted that in retrospect more could, and should, have been done to bring these matters to Monitor's attention.[384] Clearly that is correct, but, as with Monitor, it would be unfair to criticise individuals given the absence of any system ensuring that active consideration was given to what information needed to be shared with Monitor.

Monitor's assessment of the Trust

Meetings with Trust management and stakeholders

4.369 Between 8 October and 14 November, Monitor's assessment team (David Hill and Craig Watson) met various groups from the Trust's leadership and management.

4.370 On 8 October 2007, they met Mrs Brisby, the Trust Chair, on her own. She profiled her fellow non-executive directors in complimentary terms.[385] Mr Hill told the Inquiry that he would have sought to confirm this view when the team met the directors as a whole and from other information gathered.[386] A reservation was expressed about the Director of Finance; that he lacked strategic vision. The record of the meeting listed three other concerns:

> *FD* [Finance director] *appointment.*
>
> *Governance devolved down the organisation.*
>
> *Standards of nursing care.*[387]

4.371 There was no elaboration on this observation.

4.372 On the same day, Mr Hill and Mr Watson met three non-executive directors with the Chair. They were asked to give examples of challenging the executive, and their assessment of the Chair.[388]

4.373 There was also a meeting with the Board as a whole, executive and non-executive, to discuss the Trust's strategy and key relationships.[389] Of a list of 17 questions included in a preparatory briefing note for the team, two appeared to focus on quality issues: one on the outcome of Dr Foster's benchmarking exercise and one on the AHC score and plans for improving it.[390]

384 Gordon T78.53
385 DH/13 WS0000038219
386 Hill T89.100–103
387 DH/13 WS0000038219
388 MON00030002661, Notes of Meeting with Mid Staffordshire Trust – Chair and NEDs (8 October 2007); Two non-executives were also seen separately on 16 October; No concerns were recorded then: MON00030002682, Notes of Meeting with Mid Staffordshire Trust – Remaining NEDs (16 October 2007)
389 DH/11 WS0000033196; MON00030002685, Notes of Meeting with Mid Staffordshire Trust – Trust Strategy and Key Relationships (8 October 2007)
390 DH/11 WS0000038195

4.374 At the meeting, the issue of the negative outcome of the diagnostic exercise was addressed. A brief note of the meeting recorded somewhat laconically:

> *There were inadequate processes in place particularly around the management of risk …*
>
> *The management team was not fit for purpose.*

4.375 It was noted that the Trust was not going to meet the MRSA target as the maximum number of cases had been nearly reached by September. Various action plans were described.

4.376 Concerns about mortality rates were effectively completely discounted:

> *There was an issue with mortality rates due to data capture and initial diagnosis. Data capture/initial diagnosis has been improved and this is no longer an issue.*[391]

4.377 On 15 October, the team met Peter Shanahan of the WMSHA. The note of the meeting was optimistic in tone and such quality-related issues as were mentioned were discounted:

> *There are some issues with targets* [and the Trust did not comply with the Hygiene code], *however the Trust is not high on the SHA's agenda in this regard.*
>
> *No concerns regarding quality …*
>
> [Peter Shanahan] *has met the Chair and executive team and they seem to have a good understanding of the issues historically and the vision going forward …*
>
> *The SHA believes the Trust is ready for FT status …*
>
> *Risks/concerns:*
>
> - [the Trust] *must deliver the basics;*
> - *Healthcare acquired infections – small* [district general hospital] *therefore reputation at risk.*[392]

4.378 On 16 October, Monitor met the Trust's Audit Committee at which its activities were reviewed. The following clinically related issues were noted:

> *There was an issue with Standards for Better Health last year and as a result a special* [Audit Committee] *meeting was called (7 last year). Executives were asked to attend and provide evidence …*
>
> *The clinical audit plan is relatively new and has been aligned with the Trust's objectives …*

391 DH/11 WS0000038196 MON00030002685–86, Notes of Meeting with Mid Staffordshire Trust – Trust Strategy and Key Relationships (8 October 2007)
392 MON00030002683–84, Notes of Meeting with NHS West Midlands (15 October 2007)

There has been tension in the past around A&E scores.[393]

4.379 On the same date, the team met Mr Yeates and Anne Gynane, the Trust's Head of Human Resources, to discuss staff issues. A number of matters were drawn to Monitor's attention, including:

> *Staff survey … the main concern coming out of the staff survey was that under 50% of staff stated that they would not want to be cared for/treated in* [the Trust]. *Management is following this up …*
>
> *Vacancies: the Board is concerned about nursing staff vacancies and the impact on the quality of care.*
>
> *Staff appraisals: less than 50% of staff has had an appraisal in the last 12 months. This needs to be improved and plans are currently being developed.*[394]

4.380 Mr Hill told the Inquiry that he would not have asked to see the staff survey report:

> *I think it wasn't part of our standing process at that time. So it wasn't something we routinely followed up on, although with the benefit of hindsight, it's clearly something we should have followed up on and now do.*[395]

4.381 A further meeting was held on clinical governance issues with Dr Helen Moss, Dr Val Suarez, Trudi Williams and Mike Court. It was noted that the Trust had received a "Fair" rating for quality of services at the HCC AHC and that the areas "failed" had been MRSA, stroke care, cancelled operations, diagnostic waiting times and staff mandatory training attendance.[396]

4.382 Mortality was referred to again:

> *Per Dr Fosters the trust had a high mortality rate. This was due to the quality and depth of coding.*

4.383 Among the "key issues" noted from patient surveys were:

> *The number of staff on duty.*
>
> *Talking over patients.*
>
> *Cleanliness.*[397]

393 MON00030002659–60, Notes of Meeting with Mid Staffordshire Trust – Audit Committee (16 October 2010)
394 MON00030002687–88, Notes of Meeting with Mid Staffordshire Trust – Workforce & HR (16 October 2010)
395 Hill T89.158
396 MON00030002664–65, Notes of Meeting with Mid Staffordshire Trust – Clinical Governance (16 October 2007)
397 MON00030002664–65, Notes of Meeting with Mid Staffordshire Trust – Clinical Governance (16 October 2007)

4.384 On 17 October, a series of meetings were held with representatives of the clinical divisions.

4.385 In the meeting with the Surgical Division, concerns were expressed about staff sickness and numbers:

> *Sickness levels are high and there is a new sickness policy.*
>
> *75% of sickness is long term ...*
>
> *Staff turnover is 16% and there are 30 vacancies (mainly nurses).*[398]

4.386 The "key risks" noted included the achievement of the cost improvement plans.[399]

4.387 No mention was made at this meeting of the invited review by the Royal College of Surgeons (RCS), or the problems which had led to it, even though this meeting occurred a matter of 12 days after the RCS's report was produced on 5 October. The knowledge of the report possessed by those attending this meeting is not known; it had been commissioned by the Medical Director and its contents given limited circulation. In any event, none of those attending had the responsibility of ensuring that all material information was offered to Monitor.

4.388 It is clear, however, that this report would have been material to Monitor's consideration of the Trust's application. Having been shown the report at the Inquiry, Mr Hill said he would have expected to have been told about it and was surprised he had not been.[400] Mr Hill said the report, if known to Monitor, would have given "pause for thought" in the assessment of the Trust.[401] If it had been discovered that such a report existed, but had not been disclosed, that would have been taken very seriously by Monitor. Deliberate non-disclosure would have raised major concerns about the governance of the Trust.[402]

4.389 In the meeting with the Division of Medicine, staff sickness levels were again described as high, as was staff turnover. Achievement of cost improvement plans was noted as a "key risk".[403]

4.390 The team met a representative of the internal auditor, RSM Bentley Jennison, on 16 October. A more detailed description of this appears in *Chapter 1: Warning signs*. The qualified assurance opinions provided in 2005/06 and areas of limited assurance reported in 2006/07 (which included clinical coding) were referred to. The key risks included the achievement of

398 DH/28 WS0000038626–27; MON00030002668, Notes of Meeting with Mid Staffordshire Trust – Clinical Division: Surgery (17 October 2007)
399 MON00030002669, Notes of Meeting with Mid Staffordshire Trust – Clinical Division: Surgery (17 October 2007)
400 Hill T89.169–170
401 Hill T89.178–179
402 Hill T89.177
403 MON00030002670–71, Notes of Meeting with Mid Staffordshire Trust – Clinical Division: Medicine (17 October 2007)

cost improvement plans. The auditor was complimentary of the Chief Executive and the non-executive directors. No concerns about clinical governance were recorded.[404]

4.391 A meeting with the external auditor, KPMG, was generally positive. It was noted that:

> *The Trust has made significant progress since Martin Yeates became Chief Executive. Internal control and governance has improved and he has strengthened the management team.*[405]

4.392 The recent appointment of non-executive directors had strengthened the Audit Committee and the degree of challenge. The view was expressed that

> *The trust is ready for FT status and Martin Yeates has done an excellent job. The* [non-executive directors] *are good and proactive.*
>
> *The Trust is a good DGH although it lacks a unique Selling Point.*[406]

4.393 Finally, on 14 November, the team met Stuart Poynor, Chief Executive of the SSPCT. A generally positive feedback was noted; in particular Mr Yeates was described as a "firm leader" who had the respect of his staff. There were some concerns about the capability of the Director of Finance and Mr Poynor was "not overly impressed" with the non-executive directors. The SSPCT was "supportive" of the FT application.[407] Mr Hill's recollection is that there was a great deal of talk at the meeting about problems concerning clinical letters.[408]

4.394 In hindsight, although with very few exceptions those interviewed gave positive information with regard to the Trust, there were occasional hints of things which should have been sufficient to cause concern about the Trust's ability to deliver quality care, and which required more detailed consideration. For this to have come to light would have required Mr Hill and his colleagues to put together the existence of key risks in the fulfilment of cost improvement plans, apparent staff shortages, low morale and high sickness rates, along with non-compliance with some healthcare related targets and standards, as potentially indicating a long-term problem. Mr Hill was an accountant by training, not a clinician, and was not operating in a system which gave much attention to clinically related issues. It is, therefore, not surprising that he took assurances at face value, particularly if stakeholders raised no issues about them:

404 MON00030002676–77, Notes of Meeting with Mid Staffordshire Trust – Internal Audit (RSM Bentley Jennison) (16 October 2010)
405 MON00030002674–75, Notes of Meeting with Mid Staffordshire Trust – External Audit (KPMG) (17 October 2010)
406 MON00030002674–75, Notes of Meeting with Mid Staffordshire Trust – External Audit (KPMG) (17 October 2010)
407 DH/31 WS0000038638–39; MON00030002679–80, Notes of Meeting with South Staffordshire PCT (14 November 2007)
408 Hill T89.186

Q. Is the reality that you wouldn't have been in a position in any sensible way to assess what the trust could afford to lose in terms of staff and what it couldn't afford to lose?

A. I think at that time it would have been difficult for us to assess that. I think now we have the ability to also look at – or we also choose to look at – the acuity reviews or reviews of ward staffing that we frequently ask if acute trusts have done – as to how they gain assurance that they both have the requisite nursing on their wards under the current system and how they will have appropriate nursing under the new situation after the CIPs have been achieved.[409]

4.395 Even though Mr Hill claimed it is now easier to take a view on such matters, there is an impression that the assessment is hampered by the absence of much, if any, clinical input.

4.396 Mr Hill also accepted that, although the negative staff survey return had been raised, he did not look at the results because it was not a required part of the process at the time. He accepted that they could have focused more on this information.[410]

Issues raised in the briefing pack for board-to-board challenge

4.397 In advance of the board-to-board meeting between the Trust and Monitor, the assessment team prepared a briefing pack which drew attention to a number of issues for consideration including:

- Clinical coding;
- Dr Foster's HSMR ranking;
- Future cost improvement plans and the quality of service;
- Missed MRSA and thrombolysis targets;
- Financial concerns.[411]

4.398 Although mortality is considered in *Chapter 5: Mortality statistics*, it is necessary to look here at the information available to Monitor and its approach to the issue.

Clinical coding and mortality

4.399 The briefing note stated that the Trust started to have concerns about clinical coding towards the end of 2006 and had commissioned CHKS (an independent provider of healthcare information) to undertake a review. Monitor understood that CHKS had reported that there was a lack of quality and depth in coding, which if resolved could result in additional annual income of £2.9 million. The Trust had responded by recruiting a data quality manager and additional coders; and it had included the projected additional income in its cost improvement

409 Hill T89.160–161
410 Hill T89.128; Hill WS0000037900–01, para 34
411 MC/8 WS0000030775–831

plan.[412] It was noted that the Trust's Audit Committee Chair should be asked if he was satisfied with the action plans.[413] Monitor also understood that it was being said that poor clinical coding impacted on the HSMR result.[414]

4.400 The HSMR ratings of 127 for 2005/06 and 120.9 for 2006/07 were also noted. The briefing note included summaries of the Trust's reaction to this figure:

- It was reported that a CHKS review commissioned by the Trust "highlighted quality and depth of coding as issues, especially poor coding of co-morbidities".[415]
- The Trust had reported that "their Dr Fosters mortality rates have reduced to c 101 between May and August 07/08 as a result of the actions they have taken".[416]
- An analysis performed by CHKS had indicated that the Trust's mortality rate was 1.94% based on the number of deaths as a proportion of total admissions, and was below the national average for 2005/06 (2.02%).[417]
- Coders had audited a sample of notes and had found 80% of the diagnoses required recoding. Depth of coding was below that of the Trust's peer group.[418]
- The Trust was to participate in academic work commissioned by the SHA.[419]
- Resubmission of data would have a limited impact on the 2006/07 results to be published in 2008.
- Apart from coding improvements, other action taken included the setting up of a mortality group, active monitoring of Dr Foster's analysis by the clinical governance lead and the banning of signs and symptoms diagnoses.[420]
- The Trust's overall analysis was that:

  Its mortality rate has improved from 127 in 05/06 to c 101 between May and August 2007 as a result of significant focus on coding and mortality.[421]

4.401 It was suggested that the non-executive directors be "probed" on how they challenged the executive team on mortality and mortality monitoring.[422]

4.402 The CHKS report on coding and the Trust's response provided "some reassurance" to Mr Hill that the Trust had identified the issue of coding and was taking action.[423] Monitor's understanding was that CHKS had undertaken a coding audit, which contained a number of

412 MC/8 WS0000030779
413 MC/9 WS0000030833 MON00030012473
414 Hill T89.143
415 MC/8 WS0000030779
416 MC/8 WS0000030779
417 MC/8 WS0000030792
418 MC/8 WS0000030792
419 MC/8 WS0000030792
420 MC/8 WS0000030792
421 MC/8 WS0000030792
422 MC/9 WS0000030833 MON00030012473
423 Hill WS0000037918–19, para 73

recommendations, and had written to the Trust in April 2007 pointing to problems with the Dr Foster model and identifying the Trust's underlying mortality rate at 1.9 for 2005/06.[424]

4.403 Much of Monitor's understanding of the position was based on information from the Trust, which was summarised in a document exhibited by Mr Hill.[425] Some of the information supplied was misleading. No mention was made to Monitor by the Trust of the mortality alerts received from the HCC.[426] The Trust also claimed it had commissioned CHKS to review data in April 2007, citing a letter from the CHKS Chief Executive received on 27 April 2007, which was quoted from in relation to the reliability of Dr Foster's methodology.[427] In fact, as Paul Robinson, Head of Market Intelligence of CHKS, told the Inquiry, although CHKS had been commissioned to review the Trust's coding, this had been reported in January 2007.[428] This report pointed to a large number of deficiencies in coding at the Trust, but made no reference to its relevance to analysis of mortality rates. The summary of the recommendations in the Monitor briefing document is not consistent with the actual recommendations made in CHKS's January 2007 report.[429] The report was condensed into a slide presentation, dated 5 March 2007, a copy of which Mr Hill was also given.[430]

4.404 In April 2007, the CHKS Chief Executive wrote to all trusts making some general observations about the use of Dr Foster's figures.[431] This was in response to an article in a national newspaper and not to any enquiry by the Trust. The letter stated that deaths in hospital were "quite rare" and were running at about 2% in 2005/06 with a variation of between about 1.5% and 3%. The Chief Executive observed "Of course we should not be complacent about such variation, if it is avoidable."

4.405 He went on to describe as irresponsible an attempt to link the higher mortality rates with medical error, infection and failure to deliver quality of care, as there were many other reasons why patients might die.[432] As is observed elsewhere in this report, no credible attempt was made to investigate the causes, other than coding, of the Trust's high figures.

4.406 CHKS itself undertook no analysis of the Trust's mortality rates and therefore any comparison between it and a national figure must have arisen out of work done by the Trust. So the impression that the Trust's position had in some way been verified by CHKS was misleading.

4.407 On 26 June 2007, Dr Foster Intelligence's Head of Sales, Roy Forbes, met Martin Yeates to discuss the latter's complaint that the Trust had received no warning of a change in Dr Foster

424 Hill WS(2) WS0000078054, para 5
425 Hill WS(2) WS0000078053–4, para 2; DH/2 WS0000078058–61
426 DH/2 WS0000078058–61
427 DH/2 WS0000078058
428 Paul Robinson WS0000069265, para 3
429 Paul Robinson WS0000069267, paras 7–9
430 DH/55 WS0000039349
431 Paul Robinson WS0000069268–69, para 14; PR/6 WS0000069327–28
432 PR/6 WS0000069328

Intelligence's methodology, which had resulted in the predicted rating for 2005/06 being increased to 127.[433] On 29 June, Mr Forbes wrote to the Trust apologising for this, and undertaking to work with the Trust to improve its data quality. The letter also confirmed that the Trust's overall or "crude" mortality rate for all diagnoses for 2005/06 was 1.94% as against a national figure of 2.02%. For the HSMR group of diagnoses (the HSMR basket), the Trust's figures for the year were 6.31% against a national figure of 4.78% (cleaned to Hospital Episode Statistics (HES) standards) or 6.95% compared with a 5.69% (using data considered valid for Dr Foster Intelligence's tools).[434]

4.408 The Trust appears to have chosen to take reassurance from the "crude" figures as justifying their confident assertions that they had no problem with mortality. This was not something that Dr Foster advised them to do, and there was certainly no confirmation to that effect from CHKS. This was not comparing like with like.

4.409 Comfort was also drawn from the apparent reduction of the relative risk figure on Dr Foster's analysis from the 127 for the whole of 2005/06 to a "real time" figure of 106.8 for the period April to August 2007 and 101.3 for May to August 2007.[435]

4.410 Again this was not comparing like with like. According to Professor Jarman an annual figure could not reliably be compared with the rate obtained over a short period such as three months.[436] In any event, it might be thought that the figures still showed that the Trust's mortality rate was above the norm. This distracted attention from the need to review clinical practice to see if there were any clinical quality explanations for a poor performance.

4.411 Reliance was also placed on a report to the Trust Board by Dr Val Suarez and Dr Helen Moss, dated 7 June 2007.[437] Mr Hill told the Inquiry that the report, and the Trust Board's consideration of it in September, "Indicated that the Trust was aware of the issues".[438]

4.412 This report recorded that the mortality rate for 2005/06, placing the Trust as the fifth worst in the country, was of great concern for three reasons:

- It raised the question of whether the Trust had a "significant clinical problem which could be attributed to the apparently high mortality rates".
- The media coverage could lead to a loss of public confidence in the Trust's services.
- The reported result was higher than had been indicated by Dr Foster's representatives only two months previously.[439]

433 RT/6 WS0000052647
434 SHA0025000314–16, Letter from Rob Forbes (Dr Foster) to Martin Yeates (29 June 2007)
435 Hill WS0000037919–20, para 74; DH/54 WS0000039342
436 Jarman T.98.78–80
437 Hill WS0000037920, paras 74–75; DH/56 WS0000039361
438 Hill WS0000037920, para 75
439 DH/56 WS0000039361

4.413 The report contained a detailed analysis of Dr Foster's methodology and the Trust's clinical coding and data quality issues, but notably no review of clinical quality in the treatment of any of the diagnoses in which the Trust was an outlier on the figures. In spite of that omission, the authors felt able to conclude: "The Trust does not believe that it is has any significant clinical problems which can be attributed to the high mortality rates".[440]

4.414 However, the report listed a number of actions intended to "ensure that robust assurances are in place". These included:

- "Implementation" of governance structures (this might imply that there had been some deficiency);
- Development of new reports to the Board on clinical key performance indicators (this might imply that the Board had not been properly informed on clinical performance);
- Development of patient and staff strategies;
- Undertaking a full nursing skill mix review.

4.415 Both these latter points might have suggested that there were deficiencies in service which could have been relevant to the mortality rate.[441]

4.416 The recommendations included the setting up of a mortality group to audit case notes led by the audit clinical lead.[442]

4.417 Far from providing reassurance, this report was indicative of an organisation which did not have in place the means whereby it could have confidence that a high mortality rate was not, in part at least, attributable to poor quality. Its clinical coding was defective, depriving it of even the means to obtain information on which to make a judgement. There were apparent concerns about the provision of nursing services, and basic clinical governance structures, such as a mortality audit, that were not in place or functioning.

- The assessment team demonstrated some appreciation of this concern. In an email sent on 22 November 2007, David Hill asked Helen Moss a number of questions including:

  Are there any other factors causing high [standard mortality rate] *besides coding?*

  What evidence is there to support this?[443]

440 DH/56 WS0000039368
441 DH/56 WS0000039368-69
442 DH/56 WS0000039369
443 DH/58 WS0000039396

4.418 Helen Moss replied on the following day:

> *No, not that we have found. We are participating in the Birmingham University work commissioned by the SHA to see if there are any external contributory factors – this work is just under way.*[444]

4.419 With regard to evidence, Helen Moss claimed that Dr Foster and CHKS had examined the raw data and confirmed that the Trust was "within national limits", that current examination of data confirmed this, and that all Dr Foster's alerts were investigated by clinicians and reviewed both from a clinical and a coding perspective. She said that, to date, no clinical problems had been identified. She said the Mortality Group reviewed deaths.[445]

4.420 The force of this information is tempered by the knowledge that the academic work was almost entirely focused on coding and methodological issues, and that any clinical review of deaths was only just starting. Any possible reassurance for the future must have been limited, as the effectiveness of the steps only then being taken had yet to be demonstrated. With regard to the past, no thorough clinical review was being proposed and, therefore, there remained a prospect that it would transpire that the Trust had been delivering a deficient service. So there remained a risk to the Trust, even if only reputational, that had not been addressed. More importantly, the risk to patients had not been adequately considered.

4.421 The information provided in this email was another instance in which the Trust failed to take an opportunity to inform Monitor of the series of mortality alerts it had received. No review or analysis in relation to such alerts was ever offered to Monitor.

The board-to-board meeting of 5 December

4.422 A board-to-board challenge meeting was a routine part of the assessment process. It was predicted to be rigorous and the Trust Board underwent external training in preparation for it.[446]

4.423 The only record of this meeting are minutes prepared by Monitor staff, which set out questions asked by Monitor representatives, and a summary of the answers given by Trust representatives.[447] While it would, therefore, be unfair to consider it a verbatim account, no witness has suggested that it does not convey an accurate impression of the nature of the questions asked or the answers given. The minutes enable a judgement to be made on how rigorous, or otherwise, the scrutiny of the Trust's case for authorisation was, and where the focus of the questions lay.

444 DH/58 WS0000039396
445 DH/58 WS0000039396
446 Helen Moss T62.161
447 MC/11 WS0000030836–44

4.424 The meeting was attended by the full Trust Board, Bill Moyes, Stephen Hay, Miranda Carter, two non-executive directors of Monitor, the assessment team and various managers: a total of 22 people. After a short presentation by Martin Yeates, Dr Moyes made it clear that the questioning "would concentrate on financial viability and governance of the Trust".[448]

4.425 This proved to be the case. The 46 questions recorded in the minutes – accepting that there is in fact some overlap between the categories – were directed to finance, governance and quality of service in the following proportions:

Table 4.1: Questions asked by Monitor

Topic	No of questions
Finance	23
Governance	15
Quality	8

Questions on quality issues

4.426 The Trust was asked by a Monitor non-executive what information the Board received on clinical quality. Helen Moss answered:

> *Monthly performance figures include information on clinical targets and KPIs. Detailed clinical data is provided on a six monthly basis. Our* [standardised mortality rate] *is 101; we do not have a problem with mortality.*[449]

4.427 Asked what the Board did with this information, Helen Moss said the Trust had "robust" governance arrangements, and she described the committee structure. She said the Trust used Dr Foster data for benchmarking and independent reports where necessary.[450]

4.428 Asked what clinical departments the Trust was most concerned about, Toni Brisby is recorded as replying, "A&E gets a lot of attention at Board level".[451]

4.429 Trust Non-Executive Director David Denny expressed confidence that processes were in place enabling the Board to be aware of issues as they emerged. Dr Moss assured the meeting that the Board saw clinical and patient reported outcomes through "our clinical audit processes".[452]

448 MC/11 WS0000030837
449 MC/11 WS0000030841
450 MC/11 WS0000030841
451 MC/11 WS0000030841
452 MC/11 WS0000030841

4.430 In answer to a question by the other Monitor non-executive director present, about how the Trust ensured it did not compromise quality when cutting costs, Helen Moss replied "With the systems we have in place and constant monitoring, quality is what drives our business and makes people want to come to us".[453]

4.431 It was pointed out that the Trust would have an "amber" rating if authorised because of its failure to meet MRSA and thrombolysis targets; and Dr Moyes asked what plans the Trust had to resolve this. Martin Yeates explained in detail the measures taken, which, he said, had led to a reduction in the infection rate.[454]

Questions on finance and governance issues

4.432 A testing question was asked by Stephen Hay, bringing to light the low productivity of orthopaedic surgeons and overspending on bank and agency staff. In fact, he asked three supplementary questions, clearly designed to test the grip of the Director of Finance on these issues.[455]

4.433 In connection with cost improvement plans, there was detailed questioning about the impact of poor coding. This elicited an admission from Roger Carder, a Trust Non-Executive Director, that the problem should have been spotted earlier, and an explanation from Martin Yeates that an external report had been required to prove they had been correct. A Monitor non-executive director proposed that the coding problem suggested "A fundamental lack of clinical understanding and the need for a clinical buy in/development".[456]

4.434 The Trust Board agreed and pointed to changes they had made in response to the clinical letters issue, and to the setting up of the Mortality Group as an example of clinicians now wanting to be involved. A clinical development programme for all clinicians had been started. Mr Yeates asserted that clinicians had become more engaged in the previous two years. He claimed there was now stronger clinical leadership, as there were more clinicians now supporting the Medical Director, Dr Suarez. Of her he said "We were insistent when hiring [Dr Suarez] that we got the right Medical Director and advertised three times".[457]

Comments on the meeting

4.435 The role played by this meeting in the assessment process was defended by David Hill. He said it was an important and valuable part of it, and not just a "rubber stamping exercise":

453 MC/11 WS0000030841
454 MC/11 WS0000030844
455 MC/11 WS0000030838–39
456 MC/11 WS0000030842
457 MC/11 WS0000030842

They are typically robustly challenging, although I recognise it may not always be seen as such when reading the minutes in this manner. They are a robust meeting. And our board are given the key issues to really probe on the areas that the trust are not considered to be very strong on, such that they can really get a feel for how the board performs under pressure, how they would perform in a challenging environment, and how the non-executives and executives react in that situation.[458]

4.436 Dr Moyes, who as Executive Chairman of Monitor had attended about 200 board-to-board challenges, recalled nothing that stood out about the meeting with the Trust. He was not surprised that the focus had been on financial matters as the briefing pack suggested to him that this was the main cause for doubt about the Trust's future. He recalled that after the meeting he had thought that, although the Trust was not a straightforward case and that it would have financial difficulties in the future, these could be addressed through the compliance system.[459] His view was that the Trust had not been open with Monitor:

[Martin Yeates] *clearly, with the benefit of hindsight, was not open and honest with us. And had he been open and honest with us, or his medical director* [had] *been open and honest with us, then the authorisation process would have taken a completely different course.*[460]

4.437 Dr Moyes would have wanted to know about the mortality alerts and the RCS's report.[461]

4.438 In spite of his view of the lack of openness in what the Trust had disclosed to Monitor, he did not feel it would have been proportionate to undertake an extremely detailed exercise to confirm what Monitor were told:

I don't think it I would have been appropriate for Monitor to have devised a system in which every aspect of the trust, clinical and non-clinical, was tested in fine detail and certified by some expert external party. That would have been hugely expensive, very, very time-consuming and I don't think in most cases it would have particularly have been appropriate. One or two trusts maybe but not the generality.[462]

4.439 Others accepted a degree of retrospective criticism of the process. The past and future cost improvement plans referred to in the Monitor Board briefing were a significant proportion of the Trust's turnover, and necessarily appeared to involve reductions in staff. Stephen Hay accepted that the potential impact on quality was not considered sufficiently:

458 Hill T90.19–20
459 Moyes WS0000039648, para 60
460 Moyes T93.26
461 Moyes T92.185–187
462 Moyes T92.189

Looking back at the Board to Board pack now I recognise that there were signs Monitor could have picked up (and did not pick up) which indicated that we needed to press the Board more rigorously on the extent to which the CIPs programme had been tested in terms of its effect on quality.[463]

4.440 He accepted that the plans represented 7%–8% of the Trust's turnover and that on close examination the plans had involved cuts in nursing staff:

These figures show that significant staff reductions, particularly in nursing midwifery and health visitors were central to the Trust's cost improvement plan. With the benefit of hindsight we should have identified this and probed the Trust's board further.[464]

4.441 Miranda Carter told the Inquiry that Monitor did look at mortality rates as part of its assessment process and had previously deferred an application of another trust due to concerns over that board's understanding of the issue. In the case of the Trust, more attention was paid to the issue than would normally have been the case. She evidenced this by pointing out that an "entire page" had been devoted to the subject in the briefing pack.[465] She had felt that the evidence received from the Trust had been "clear". She clearly accepted as reassuring the information about a fall in the rate and about the crude mortality rate being in line with national figures:

In this case the Trust had picked up on the issue and they had done some work to look into the matter. The evidence was that the mortality rate was falling and was very close to the national average. We were reassured by this.[466]

4.442 At the Inquiry, when she was made aware of the scale of the mortality alerts issued to the Trust and the fact of an impending HCC investigation, neither of which had been revealed at the time of the assessment, she said that if these matters had been known Monitor would have wanted to consider them further before proceeding to authorise the Trust.[467]

4.443 She accepted that there had been insufficient challenge of the impact of the reductions in nursing staff, which had contributed to the cost improvement plans:

463 Hay WS0000041205, para 31
464 Hay WS0000041205, para 32
465 Miranda Carter WS0000030597, para 50; MC/8 WS0000030775
466 Miranda Carter WS0000030598, para 51
467 Miranda Carter T88.149

In retrospect I think we were too easily satisfied with the response that the Trust was aware of the problems and was recruiting staff ... We were not aware at the time of the extent of the gap in nursing establishment which was subsequently revealed in the skills mix review.[468]

4.444 Toni Brisby was somewhat non-committal about whether the RCS's report should have been disclosed to Monitor. It was unclear whether she herself had seen it at that time, although the original version of the report had been in existence for over two months. She was asked how the conclusion in the report that the surgical division was dysfunctional was consistent with the statement made at the board-to-board meeting that "quality is what drives our business", and whether the report should have been disclosed. Her replies are set out in full:

Q. How does that square with "quality is what drives our business"?

A. Because, for the reasons I've just described, these processes are very difficult. I could give you many examples from many hospitals where they've had the same struggle. It doesn't mean you're not driven by it. It means it sometimes takes a very long time to achieve it.

Q. If this (is) right, it means patients are actually being put in danger, doesn't it?

A. Yes, I'm sure it's right.

Q. Did you think that Monitor might be less into this

A. I didn't relate this to the Monitor board to board. As I said, Monitor had access to any papers that – Monitor was in the trust going through documentation for some three months, and I would have been quite surprised if they hadn't come across things like this.

Q. If you had known that they hadn't had it, do you think it would have been your duty to make sure they were at least aware of it?

A. I would have certainly have considered that.

Q. Well, that's not the same thing, is it? You would have considered it, what do you think your conclusion would have been?

A. I think I probably would have thought they should have been made aware of it.

Q. Does it disturb you, as chairman of the trust, that it seems that you didn't have sight of this report before you walked into that Monitor meeting? (Pause)

A. No, the focus of the Monitor meeting actually wasn't – wasn't largely on clinical issues. It was largely on finance.

468 Miranda Carter WS0000030599, para 53

Q. Well, largely –

A. But not exclusively, no, I accept that.[469]

...

THE CHAIRMAN: Would your answer be the same, that the version that was available in October 2007, even if not the final version, is something of which Monitor should have been made aware?

A. I suppose – I would have expected Monitor to be aware of it, given the time they'd been in the trust. I would have expected this area – particular area of concern to have been the responsibility of the Healthcare Commission and not of Monitor, given that Monitor's focus was primarily – well, was finance and governance. But – would – I would have wanted them to be aware of it, yes.[470]

4.445 Mr Yeates could not be questioned directly on these issues, but he did tell the Inquiry, in his written statement, that the significance of mortality alerts, as opposed to Dr Foster's HSMR rating, had not struck him. He would not have felt it necessary to mention them at the board-to-board meeting, even though the issue of mortality was raised. Although they had rung no alarm bells with him, he accepted they should have.[471] In general, his view had been that by the time they attended the meeting the governance of the Trust had improved dramatically, but he accepted that there remained problems in the surgical division. He had not found the RCS report much assistance.[472]

4.446 Helen Moss accepted that at the time of the board-to-board meeting she had no idea what the likely cost was going to be of providing a proper level of nursing staffing, as her nursing review was far from complete. If she had been asked about the costs, she would have had to say she did not know.[473]

4.447 With regard to the stance taken by the Trust on mortality – that the results from the period between May and August 2007 were encouraging – Dr Moss was aware that data over a short period was less reliable than that taken over a longer one.[474] She was asked whether her recorded statement to the Monitor Board that the Trust had "no problem with mortality" was "brave". She replied:

469 Brisby T129.96–97
470 Brisby T129.97–98
471 Yeates WS0000074958–59, para 120; Yeates WS0000074960, para 124
472 Yeates WS0000074951–52, para 101; Yeates WS0000074954–55, para 109
473 Helen Moss T62.135–136
474 Helen Moss T62.163

I think I said more than that in response to the question, because I would have referenced it to the mortality rate as it had been previously. And at that period in time the mortality rate was 101. And do we have a problem with mortality? Yes. I think that was probably a brave statement but taking each of the individual facts they were facts at the time. But we know now that coding wasn't purely the issue.[475]

4.448 With regard to her statement about the Trust having "robust" governance arrangements, she told the Inquiry that at the time she believed the governance arrangements to have been better than they turned out to be on examination by the HCC. She accepted that she had responsibility for that failure, both structurally and personally, as Head of Governance.[476] However, at the time she felt justified in saying that the governance system was "robust", although she had been aware that it needed improvement.[477] She accepted that even if the relevant policies were in place- and she had not looked at A&E policies at the time – she had not investigated to find out how they were working.[478]

4.449 Dr Suarez had not thought the Trust's clinical governance arrangements were up to the required standard when it embarked on the FT process. Given the HCC's findings, she had shared Dr Coates's surprise that Monitor had not spotted flaws in the Trust's governance procedures during it.[479] However, she told the Inquiry that during the assessment between October and December 2007 she had not believed the clinical governance arrangements were inconsistent with being granted FT status. She had found the Monitor process generally rigorous, but not with regard to clinical quality and governance issues.[480] The failure to inform Monitor of the RCS report she attributed to them not going into detail at departmental level.[481]

Conclusions

4.450 There was a stark contrast between the nature of the questioning at the board-to-board meeting on quality issues and that on financial and governance matters. Even allowing for the necessary latitude because of the summary nature of the minutes, it is clear that comparatively few questions were asked on quality. Such questions as were asked were superficial, and superficial answers were accepted without being followed up with more challenging supplementaries. As a result, bland assurances, such as the denial of a problem with mortality, were accepted at face value. The emphasis was in establishing that the Trust Board could demonstrate that they had known of and reacted to an issue, rather than an exploration of the quality of their understanding and the appropriateness of their response.

475 Helen Moss T62.167
476 Helen Moss T62.169
477 Helen Moss T62.170
478 Helen Moss T62.170–171
479 Suarez T59.175–176
480 Suarez T59.176–177
481 Suarez T59.184

4.451 It is concerning that the answer given by Helen Moss to the very valid question on the likely effect on quality of cuts in costs was accepted as sufficient. "Quality is what drives our business and makes people want to come to us" amounted to little more than a piece of advertising. Perhaps most surprising was the lack of follow-up to the bland answer given by Mrs Brisby about A&E getting "a lot of attention". There is little, if any, reference to A&E issues in Monitor's preparatory documentation and, therefore, it is difficult to see how Monitor's Board could have been expected to know what this answer meant without pursuing the point.

4.452 The approach to financial issues was very different. As illustrated above, several points were pursued and tested. Answers were often elicited from more than one Trust representative. At least some appreciation was demonstrated of the potential link between cost savings and quality, and the inferences that might be drawn from the coding failures about clinical engagement and governance.

4.453 This difference is in part explained by the make-up of Monitor's Board and assessment team. They were highly experienced in the financial and corporate aspects of leadership and management, but less well equipped to understand mortality statistics and quality issues. The Trust Board on the other hand had the apparent advantage of a Medical and Nursing Director who could be expected to understand these issues. Therefore, it is not entirely surprising that Monitor accepted assurances of clinical quality issues in a way that it did not do with regard to financial issues.

4.454 It is clear that the Trust were not open about a number of matters which might have given Monitor cause for concern. The Trust Executive's attitude towards disclosure appears to have been one of offering Monitor what it asked for and no more, without any thorough consideration of the requirements of candid disclosure.

4.455 As a result, there is unhappily little doubt that Monitor were misled at this meeting. Once again, they were not informed of the full range of mortality alerts the Trust was receiving. They were misinformed about the nature of the third-party analysis of mortality data. Again, no mention was made of the RCS review, even though that must have been of concern at the time.

4.456 The evidence does not support the suggestion made by Dr Moyes that this non-disclosure was dishonest, in the sense of being intentional. The nature and focus of the process for all concerned was on finance rather than quality issues, and therefore it is more likely that Martin Yeates and Toni Brisby did not address their minds, as they should have done, to the nature of disclosure that a proper scrutiny of the Trust required. However, they can properly be criticised for not thinking through what a candid disclosure entailed. There is also a collective responsibility for the misleading nature of the description of the work on mortality. This is likely to have come about through the careless elision of various reports and analyses, rather

than a conscious attempt to deceive. There was, however, an unhealthy attitude of leaving it up to Monitor to find what they were looking for, rather than the Trust openly and proactively seeking out information about the problems of which Monitor needed to be aware.

4.457 The position of Helen Moss and Val Suarez is more difficult. They could be expected, by reason of their professional training and position, to have a proper understanding of the significance of concerns about governance at the Trust; an awareness that its improvement was an unfinished work in progress, and knowledge of the almost non-existent review into the quality of care provided to the patients following the emergence of concerning mortality statistics. What was said to Monitor about mortality and governance, in particular by Helen Moss, but acquiesced to by Val Suarez, was inconsistent with the true position as they knew it to be.

4.458 Dr Moss's evidence was that she had harboured concerns about governance from the beginning of her employment at the Trust. She accepted that the deficiencies in governance identified by the HCC in May 2008 could have been found elsewhere in the Trust as well.[482] She had been raising governance-related issues since at least January 2007, and had been making attempts to improve the situation.[483] She accepted that, in her mind at the time of the HCC inspection in May 2007, there was not a governance system in place which was working well all over the Trust.[484] The Trust had supplied the HCC with evidence in accordance with their "key lines of inquiry" and no more.[485] She felt comfortable with declaring compliance with their standards because she believed they were making good progress.[486] She then took comfort from the fact that the HCC assessed the Trust to be compliant with the governance standard.[487] Against that background, a bold statement to Monitor in December 2007 that the Trust's clinical governance was "robust" was not a statement of the whole truth as the situation was then understood by Dr Moss. She did not disclose to Monitor her full understanding of the position.

4.459 The omission to make Monitor aware of the RCS report represents at least an economy with the truth, on the part of, in particular, the Medical Director who commissioned it, and the Director of Nursing who was aware of it and, even if she had not seen the full report, had been made aware of its effect. As qualified healthcare professionals they should have understood the relevance of the report to the FT process and ensured that it was disclosed to Monitor. Waiting to be asked directly about such material is an unacceptable way in which to treat a serious regulatory process, particularly when patient safety is in issue. Further, when a direct question was asked about what departments they were concerned about, to omit to mention the surgical division meant that Monitor did not receive a full and accurate answer.

482 Moss T62.60–61
483 Moss T62.61
484 Moss T62.67
485 Moss T62.68
486 Moss T62.69
487 Moss T62.69–70

Further information following the board-to-board meeting

4.460 After the meeting, Miranda Carter met the assessment team to identify areas to follow up.[488] Presumably as a result of this, further information was obtained from the Trust. This included the news that the NHSLA had accredited the Trust at its level two: high scores were reported for standards concerning governance and the competence and capability of the workforce.[489] As part of documentation submitted to Monitor to show implementation of the Trust's performance management strategy, the regulator received an HCC report of June 2006 on children's services and a further report in 2007 into heart services. Both of these reports rated the relevant services as "weak", and an action plan was produced for each report, also copied to Monitor.[490] A copy of the HCC email of January 2007, following the Hygiene Code inspection, was also disclosed; this stated that the writer had been impressed and reassured by the improvements made by the Trust.[491] Mr Hill accepted that Monitor did not follow up the action plans to assess whether they had been implemented.[492]

4.461 Grant Thornton were engaged to prepare a review of the Trust's working capital and financial reporting procedures, which was completed on 18 January 2008.[493] This substantial document effectively confirmed the Trust's view that it had sufficient working capital. It reported that the Trust had addressed all the issues raised in Grant Thornton's due diligence report on risk, governance and key risks.[494] However, it warned that any slight slippage in its projected trading income could leave it in deficit in future years.[495]

4.462 On 7 January 2008, Monitor received from Martin Yeates a required formal written confirmation by the Board of compliance with Monitor's requirements.[496]

4.463 On 28 January, Monitor asked the Trust for up-to-date information on its compliance with healthcare targets and standards. The Trust reported on the same day that it had achieved the thrombolysis target in 80% of cases in December and was therefore compliant – having found that one case could properly be excluded from the figures. A thrombolysis action plan was enclosed. However, it had not achieved compliance with the A&E waiting time figure, the result having gone down to 93.8 for the previous month.[497] This was the same day that the HCC wrote to the Trust to notify it that an investigation was to be launched.[498]

488 Miranda Carter WS0000030601, para 59
489 DH/22 WS0000038434
490 DH/23 WS0000038436; DH/24 WS0000038445; Hill T89.127
491 Hill WS0000037894, para 26
492 Hill WS0000037894, para 27
493 Hill WS0000037928, para 100; DH/42 WS0000038850
494 DH/66 WS0000039475
495 DH/42 WS0000038854
496 Hill WS0000037925; DH/63 WS0000039444
497 Hill WS0000037931, para 105; DH/69 WS0000039582
498 HW/3, WS0000025118

Briefing for Monitor Board

4.464 The assessment team prepared a briefing for the Board. It recommended authorisation with a side letter in connection with the performance with regard to MRSA.[499] When the Trust's application was considered on 30 January 2008, the assessment team presentation gave the Trust an "amber" rating for governance. The only issue referred to in the briefing document was the impending retirement of the Director of Finance.[500]

4.465 The Board considered the Trust's application along with those of four other trusts. All were granted authorisation. The minutes record that the Board noted the following issues:

- Dr Foster's HSMR of 127 for 2005/06, the Board noting that:

  This has reduced to c 101 between May and August 2007/08 as a result of significant improvements in coding for co-morbidities.

- Non-compliance with the MRSA target for 2006/07, the Board noting that the Trust was "above trajectory" ie, in excess of the rate required to meet the current year's target;
- Failure to meet the thrombolysis target during the first two quarters, although the Trust had met the target in the third quarter;
- Failure to meet the A&E standard in December;
- Some risks to activity levels in the medium term;
- A financial risk rating of 3 for 2007/08 and 2008/09.[501]

4.466 The Board accepted the assessment team's recommendation. The reasoning recorded in the minutes was as follows:

> *The trust met the requirement of section 35 of the 2006 Act and the Guide for Applicants. The Board agreed it should be authorised as an NHS Foundation Trust.*
>
> *The Board was concerned about the longer term financial challenges which the Trust may face, the Trust's failure to deliver the thrombolysis target in the first two quarters of 2007/08 and the A&E standard in December and its current failure to meet its MRSA trajectory. A letter should be sent highlighting Monitor's concerns in these areas.*[502]

4.467 It is worthy of note that the Trust was not the only applicant in respect of whom the Board recorded concerns:

499 MC/13 WS0000030850
500 DH/71 WS0000039595, Hill WS0000037931, para 107
501 DH/21 WS0000039605
502 DH/21 WS0000039605

- There were concerns about one trust's A&E scores for 2006/07 and the quality of its finance report, but it was stated that the trust was taking appropriate action.[503]
- In another, a women's hospital trust, the HCC had awarded only a fair rating for maternity services, but a quality improvement programme had been started "already" and this was "developing ... further" to "address gaps identified in the Healthcare Commission's review". This trust was authorised without a side letter.[504]
- A third trust had been the subject of a number of concerns:
  - It was found to have inadequacies in its self-certification process which Monitor had required the trust's audit committee to review;
  - Concerns had been raised in an external review into the care of older patients. A subsequent interim review had recognised that the trust had made "significant progress" in identifying the issues raised and a final 12-month review into these issues was due in March;
  - It had failed to achieve the 2006/07 MRSA target and had 18 reported cases in the year to date against a target of 12 for the whole year. However, the Board noted that it had achieved a reduction compared with the previous year;
  - A coroner had recently been critical of staffing levels in paediatric wards.

4.468 The Board agreed a side letter should be sent with the authorisation referring to the concerns about self certification, the care review and MRSA compliance.[505]

4.469 Following the Board's decision, Dr Moyes signed the formal authorisation on 1 February 2008.[506] This required the Trust to comply with the Act, the conditions of the authorisation and Monitor guidance. The conditions included the following:

> *6(1) the Trust shall put and keep in place and comply with arrangements for the purpose of monitoring and improving the quality of health care provided by and for the Trust.*
>
> *6(2) The Trust shall comply with statements of standards in relation to the provision of health care published by the Secretary of State* [under statute].[507]

4.470 On 6 February 2008, Dr Moyes issued the side letter to Toni Brisby as required by the Board. The letter highlighted the medium-term financial risks from 2010/11 onwards in respect of which it required the Trust to place a "high level of emphasis" on addressing those risks during the first three years of the plan. With regard to the healthcare targets not complied with by the Trust, Dr Moyes said:

503 DH/21 WS0000039605
504 DH/21 WS0000039606
505 DH/21 WS0000039607
506 MON00030012128
507 MON00030012133

Monitor may grant authorisation if it is satisfied as to specific matters and decides so to exercise its statutory discretion. The Monitor Board has previously agreed that, in certain circumstances and pursuant to that discretion, it will authorise an applicant that is not fully compliant with all healthcare targets ...

Having self certified that it has plans in place to ensure that all core national targets and standards for 2007/08 are met, Monitor expects the Trust to have in place action plans which will be successfully executed such that your board will be in a position to submit unqualified self-certifications in future monitoring cycles. It is your Board's responsibility to ensure that the action plans referred to are robust and implemented effectively so as to avoid breaches going forward.[508]

4.471 Monthly monitoring of this would be instigated.

4.472 While the authorisation was published, it was not routine for side letters to be made public.[509]

Comments on Monitor's decision

4.473 Dr Moyes told the Inquiry that in authorising the Trust, Monitor had made the only decision it could have made at the time:

I believe Monitor followed the process in place at the time, which led to a decision ... which was demonstrated by events to have been the wrong decision.[510]

4.474 He said that an amber governance rating was not a bar to authorisation, but meant that the Monitor Board would probe the application more thoroughly and, usually, issue a side letter setting out the issues, followed by more regular scrutiny after authorisation. He emphasised that:

Where problems were identified, at either the assessment stage or subsequently, it was not Monitor's responsibility to devise solutions or to take charge and remedy whatever failings, or potential failings, had been identified. That responsibility rests unambiguously with the board of the foundation trust or applicant. We needed to establish whether the board understood the problems the organisation faced and could tackle them effectively. In such cases we wanted the trust's board to come up with a plan to remedy the problem, which we could monitor after authorisation if necessary. If they were unable to come up with a sustainable plan, we would defer authorisation for a defined period or, in some circumstances, Monitor would reject the application at that point.[511]

508 DH/72 WS0000039612–13
509 Hay T92.44
510 Moyes WS0000039687, para 166
511 Moyes WS0000039643 -644, para 55

4.475 With regard to the mortality rate issues identified at the Trust, Dr Moyes said Monitor would have wanted to be satisfied that the Trust Board was taking appropriate action to improve the quality of coding and to identify areas of clinical performance or unacceptably high mortality rates and ensure these were remedied. He understood the actions taken in conjunction with the SHA, Dr Foster, CHKS and Birmingham University to represent:

> *A credible plan to work towards a solution. They showed that the board was investigating and investing in the problem and that it had put a good structure in place, which included a Mortality Group.*[512]

4.476 He told the Inquiry that Monitor assumed that if the Secretary of State gave statutory support to an applicant neither the DH nor the SHA had any concerns, and that if they became aware of concerns during the process they would inform Monitor.[513]

4.477 He accepted that, in hindsight, the authorisation of the Trust was a mistake. He contended, however, that the decision needed to be seen in the context that most applicants had problems of one sort or another, and most had cost improvement plans being implemented. Nothing in the Trust's cost improvement plan was out of the ordinary, but he accepted in hindsight that Monitor could have pressed harder to see if the Trust had considered fully the implications of the staff cuts.[514]

4.478 Stephen Hay agreed that in retrospect there were signs that could have been picked up on, indicating a need to press the Board more on the impact of the cost improvement plans on quality: the information provided by the Trust showed that the plans were dependent on significant staff reductions.[515]

4.479 Miranda Carter agreed that Monitor sought fewer independent assurances with regard to quality governance than it did for financial governance, and was too reliant on the existence of action plans.[516]

4.480 Following the announcement of the HCC investigation, Monitor undertook an internal review of its processes, as a result of which changes were recommended.[517] Commendably, Monitor commissioned an external review by KPMG following the publication of the HCC report.[518] Among other findings and observations were the following:

512 Moyes WS0000039646–47, para 59(e)
513 Moyes WS0000039650, para 65
514 Moyes WS0000039651, para 66
515 Hay WS0000041205–06, paras 31–34
516 Miranda Carter WS0000030602, para 64–65; WS0000030604, para 69
517 Miranda Carter WS0000030605, para 75; MC/18 WS0000030917
518 Miranda Carter WS0000030606, para 76; MC/19 WS0000030926

- Greater clarity was required about the relationship between clinical governance and clinical quality.[519]
- It was no longer clear what constituted the threshold for clinical governance for authorisation and compliance, or what was the scope of review required of clinical quality and governance; or, put simply, whether Monitor should focus more time and attention on clinical governance.[520]
- The evaluation of quality was based heavily on information from other stakeholders, little of which was specifically prepared for the purpose of Monitor's processes.[521]
- In contrast to the financial assessment, where external historical due diligence and other methods are used, there was no independent evaluation of quality performance measures.[522]
- The board-to-board challenge included challenge to quality performance but not necessarily in as structured a way as used for financial performance and did not consider the impact on quality of cost improvement plans.[523]
- The assessment team included no significant experience of clinical management.[524]
- No written confirmation was obtained from stakeholders that they had no outstanding concerns.[525]
- Monitor needed to work with its partners to redefine the standards for quality and clinical governance for use in the assessment process.[526]
- The report recommended a stronger focus in the assessment process on quality and clinical governance, and stronger assurances on the state of quality.[527]

Conclusions

4.481 Monitor's approach to authorisation was, in effect, to ascertain whether the applicant's board was capable of dealing with the problems a trust would face, whether financial, governance related or clinical. To do this, it would seek to establish whether the applicant understood the problems it faced, had identified solutions and was acting on them. Monitor did not consider it necessary to devise or propose solutions itself.

4.482 This approach was designed to reinforce the responsibility of FT boards and to support their autonomy. It was, however, an approach which suffered from a serious vulnerability. The purpose of regulation in the healthcare field should be to protect the public interest in a safe and sustainable health service. Such a service needs stable management of publicly provided funds, proper lines of accountability and an ability to deliver required services, but most importantly it needs to deliver a service which is safe, effective and meets at least the

519 MC/19 WS0000030930
520 MC/19 WS0000030931
521 MC/19 WS0000030935
522 MC/19 WS0000030936
523 MC/19 WS0000030936
524 MC/19 WS0000030936
525 MC/19 WS0000030936
526 MC/19 WS0000030932
527 MC/19 WS0000030933

minimum expected standards. If all healthcare providers achieved that, and could be trusted to do so, there would be no need for regulation. Regulation is not required because organisations are all fulfilling their duties; it is required because some are not doing so, but instead pose unacceptable risks for patient safety and public finances.

4.483 Dr Moyes disputed before the Inquiry the findings of the House of Commons Health Select Committee that the case of the Trust "exposed serious shortcomings in Monitor's assessment process"; and that "[Monitor] effectively allowed the Trust to compromise patient safety in premature pursuit of Foundation Trust status".[528]

4.484 He complained that the Select Committee had not taken detailed evidence from Monitor. It is unlikely such a complaint could be made of the evidence submitted to this Inquiry.

4.485 There can be no doubt that the decision to authorise the Trust was wrong. Even without the benefit of hindsight, there were any number of warning signs available had they been looked for, which would, or should have, caused Monitor at least to defer, if not reject, the application. It is not, perhaps, reasonable to have expected Monitor to have uncovered some of these signs, but others were either not detected at all because of the assessment system Monitor had in place, or were discounted without adequate inquiry being made about them.

4.486 Monitor's approach to authorisation was to make a number of assumptions, both in relation to applicants, and the regulatory process of which Monitor was a part, when there was a risk these were false. This led to the risk of creating a misleading picture of the very organisations the regulatory system was meant to protect the public against, namely those which were poorly led and managed. In the case of the Trust's application, Monitor assumed, among other things, that:

- The Trust was correct in attributing high mortality rates to coding issues;
- Its assurances that there were no clinical concerns underlying the figures were justified;
- Appropriate quality of care would follow from prudent financial control and proper governance structures;
- The AHC rating for the previous year represented a true and current assessment of the quality of care being provided;
- If there was cause for concern about clinical quality this would be drawn to Monitor's attention by the HCC or a stakeholder, whether or not Monitor expressly asked for such information;
- Any action plan would be implemented and be effective to address the problem identified in it;
- Cost improvement plans involving reduction in staff would be achieved without compromising quality;

528 Moyes WS0000039693–94 paras 184 -185; WM/91 WS0000040326, para 264

- Assurances made by Board members with regard to quality could generally be accepted at face value unless there was evidence to the contrary;
- Ministerial support signified that neither the DH nor the SHA had concerns about the applicant;
- If concerns developed during Monitor's assessment they would be made known to the regulator.

4.487 It is not appropriate to pass judgement on the merits of other decisions made by Monitor, which have not been examined at the Inquiry. However, it is noteworthy that at the same meeting which authorised the Trust, another trust was approved which, to the knowledge of Monitor's Board, had a number of outstanding issues relating to the quality of the service, including the standard of care given to elderly patients. The Board was prepared to authorise that trust on the assumption that the apparent process of improvement, which had been noted, would continue.

4.488 In the case of the Trust, Monitor also gave its authorisation even though aware that at that time it was not compliant with its terms, in the expectation that it would become compliant in future.

4.489 In other words, there was a continuation of the approach, which had been adopted by the DH, of assuming the best.

4.490 There were a number of faults in the process of assessing the Trust, for which Monitor's Board were responsible:

- No information had been obtained from the HCC as to their current view of the Trust, and no evidence was presented to the Board from which they could reasonably have believed such information had been obtained.
- The ability of the Trust to deliver a sustainable service compliant with minimum patient safety and quality standards was neither challenged nor assessed with a rigour comparable to that directed at financial and corporate governance.
- There was no investigation of the impact on the quality of the service of the cost improvement plans, past and future, and the associated staff reductions.
- A judgement was made on the implications of the mortality data, without expert advice or a proper understanding of the issues, by accepting the Trust's explanations at face value.
- No proper consideration was given to the implications of the negative staff survey data of which Monitor was aware.
- Monitor was prepared to accept assurances that action would be taken as an adequate response to potential bars to authorisation, rather than deferring authorisation until the proposed action had been shown to be effective.

- No adequate consideration was given, or investigation undertaken, in relation to the concerns about nursing standards expressed by the Trust Chair, the implications of the nursing skill mix review or the complaint about nursing staff shortages submitted during the public consultation.

4.491 This is not to suggest that Monitor wilfully disregarded adverse information. The deficiency lay in the importance Monitor attached to financial and corporate governance issues, which it understood, rather than clinical service and quality issues, in which it had limited expertise and experience.

4.492 The responsibility for the serious failure of Monitor's assessment process is, however, shared by others.

4.493 The Trust, principally through its Chair, Chief Executive, Medical Director and Director of Nursing, failed to ensure that it gave full disclosure to Monitor of all adverse matters potentially relevant to the assessment process. Such matters included:

- The HCC and Dr Foster mortality alerts;
- The implications of the nursing skill mix review;
- The HCC's expression of intent to consider launching an investigation;
- The RCS review and its critical findings.

4.494 The DH did not share with Monitor the concerns which had led it to consider the Trust to be a marginal case. This allowed Monitor to continue with its erroneous assumption as to the significance of Ministerial support.

4.495 Dr Moyes's criticism of the HCC for not alerting Monitor to the impending investigation is without foundation.[529] While it is true that a list of applicants was in the public domain, the HCC could not, unless previously agreed as part of the system of communication, have been reasonably expected to have a system in place to ensure that those with knowledge of impending investigations also considered if or when such information should be shared with Monitor. In the absence of an agreed system of communication in relation to applicant trusts, the responsibility was entirely Monitor's to ask for the information it needed. It was entirely understandable that the HCC should have informed only the SHA, as it was statutorily responsible for performance management of NHS trusts.

4.496 The WMSHA, on the other hand, did know that the Trust was applying for FT status and had actively supported it. It also knew, albeit at a late stage, of the HCC's intentions. It does not appear to have given any consideration to the need to alert Monitor to this development. It should have done so.

529 Moyes WS0000039650–651, para 65

Monitor's current processes

4.497 The DH and Monitor have reflected on the lessons to be learned from the Stafford experience and, following the commissioning of the internal report in May 2008 and the external evaluation conducted by KPMG in August 2009, have made significant changes to their processes.

4.498 The governance of quality is looked at more closely and has a separate criterion linked to a "minimum quality governance score against a detailed framework".[530] The definition of quality governance contained in the *2010 Guide To Applicants* includes a reference to the quality of care:

> *The combination of structures and processes at and below board level to lead on trust-wide quality performance including:*
>
> - *Ensuring required standards are achieved;*
> - *Investigating and taking action on sub standard performance;*
> - *Planning and driving continuous improvement;*
> - *Identifying, sharing and ensuring delivery of best practice;*
> - *Identifying and managing risks to quality of care.*[531]

4.499 Although Monitor still carries out the assessment of such governance itself, there now exists a pool of external quality advisers who challenge the regulator's decisions.[532]

4.500 The process of communication with the HCC, now the CQC, has also been improved. It became standard practice to contact the HCC local area manager and, where particular quality issues were raised, the HCC central teams as well. Later a centrally produced report, *The Way of Working*, was produced as a guide to implementation of the Memorandum of Understanding.[533] Following the arrival of the CQC, a quality and risk profile is now sought and obtained on applicants with a letter of assurance confirming whether the CQC has any specific concerns in relation to an applicant. A joint meeting with the relevant SHA and the CQC is held to share views on a trust's quality of service. Any concerns identified will be followed up.[534]

4.501 Action plans submitted by applicants are now assessed with specialists at the DH.[535]

530 Miranda Carter WS0000030587, para 22
531 MC/4 WS0000030744
532 Miranda Carter WS0000030607, para 78(vi)
533 Hill WS0000037917, para 69; DH/51 WS0000039325
534 Hill WS0000037917, para 69
535 Hill WS0000037894, para 27

4.502 Staff surveys are now examined systematically, as are complaints made to the trust board.[536] These are analysed together to identify whether shared trends indicate wider governance issues.

4.503 The potential impact of cost improvement plans on the quality of care is now considered in much greater detail than before:

> *In hindsight the CIP was implemented by the Trust at the expense of patient care and one of the key learnings for Monitor arising out of the assessment of the Trust was that we needed to focus more on the quality implications of CIPS. This is an area we consider in much greater detail now reflecting Monitor's new Quality Governance Approach.*[537]

4.504 Monitor now expects an applicant's board to have considered the impact of cost improvement plans on quality, to have consulted with clinical staff on the savings plans and to have in place measures to monitor any resulting deterioration in clinical performance.[538]

4.505 From 2013, the NHS Trust Development Authority will support NHS trusts in their development to FT status. This support is intended to include necessary improvements with regard to clinical quality, governance and management of risk.

Overall conclusions and recommendations

Conclusions

4.506 It is fair to point out that, even if Monitor had refused FT status to the Trust, this would not have avoided much of the suffering endured by so many patients before January 2008. The deficiencies which have come to light at the Trust subsequently are not attributable to FT status as such. However, there is no doubt that an elaborate regulatory assessment process of the nature required by the National Health Service Act 2006 ought to have brought those deficiencies to light, and its failure to do so calls into question the effectiveness of the process of authorisation as a whole. While the Inquiry has been warned, rightly, of the dangers of extrapolating from an extreme case, it has to be questioned whether the system could detect concerns relevant to patients of any significant nature if it could not detect a case as gross as that of the Trust.

4.507 FTs were originally intended to be exemplars of excellence, worthy of a large degree of independence from central control in order that innovation, improvements and flexibility could be enhanced within the overall NHS system. Because of the granting of such autonomy, a complex system of safeguards was created around the eligibility criteria and the provision of

536 Hill WS0000037901, para 34; Miranda Carter WS0000030607–08, para 80
537 Hill WS0000037912, para 55
538 Hill WS0000037912, para 55

regulatory assessment and oversight. Because at the outset only high performing trusts were to be considered, it was perhaps more understandable that the focus of regulatory assessment was on financial governance. However, the application process did provide an opportunity for a comprehensive investigation of an applicant's capability and capacity to deliver a consistent and sustainable service to its patients which was safe, effective and compliant with minimum safety and quality standards. It was clearly not intended that a trust suffering from a systemic failure to provide such a service should be authorised as an autonomous entity, thus removing it from the Secretary of State's sphere of accountability and control.

4.508 The consequences of the loosening of the eligibility criteria were not fully appreciated at the time, with the result that the assurance Monitor could take as to the standard of service candidates provided, and were capable of providing, was reduced. No balancing changes were made in the regulatory part of the process undertaken by Monitor; and Monitor continued to accord to the support provided by Ministers for applications (required by statute) a greater significance than those who formulated that support believed it had.

4.509 It is clear from the evidence that the Trust would not have been in a position to be authorised as an FT in early 2008 if:

- The eligibility criteria had not been loosened;
- A thorough assessment of the Trust's compliance with minimum patient safety and quality standards had been performed;
- The DH Applications Committee had been unwilling to support marginal cases;
- The Minister had been offered a full picture of the Trust when considering giving his support;
- Monitor had not relied on the Trust's assurances on quality issues;
- Monitor and the HCC had communicated with each other and shared their knowledge.

4.510 In short, an elaborate resource-consuming process failed to achieve what should have been its primary objective: ensuring that the only organisations authorised were those with the ability and capacity to deliver services compliant with minimum standards on a consistent and sustainable basis.

4.511 How did it come about that such an important policy initiative, genuinely intended to enhance the care of patients in the NHS, allowed a sufficient gap in the oversight and regulatory processes for the Trust to pass through undetected? The evidence makes it clear that there were a number of causes:

- A failure in the execution of the policy to make the welfare of patients the first priority: from the outset the focus was on financial viability and corporate governance systems, not the quality of the service provided.
- While some measures of quality and safety were looked at, they were inadequate and bore no comparison with the scrutiny given to financial and corporate matters.
- In particular, there was no attempt to take properly into account the experiences of patients cared for by the Trust, whether through the consultation process or by reviewing complaints, incidents, or similar information which might have indicated concerns about the effectiveness of the Trust in meeting patients' needs.
- The pressure on the system induced by the manner in which the policy to make FT status universal was implemented, and the timetable for that change, impacted upon the assessment of trusts, so that:
  - It became easier to rely on positive assumptions and trust in the competence of local management and leadership than to undertake a truly comprehensive review of the effectiveness of organisations;
  - Considerable strains were placed on an organisation in financial difficulty to meet required financial targets;
  - Inadequate consideration was given to the risks such strains posed on the standard of service;
  - The benefit of the doubt was given to marginal cases, which called for more rigorous scrutiny, and applications were let through which, even on the basis of the existing criteria, called for circumspection;
  - Failure to achieve FT status at some point was not an option consistent with the preservation of the careers of those held responsible.
- The assessment of compliance with care standards was almost entirely separated from the assessment of financial and corporate governance requirements.
- Failures in communication, in spite of the general recognition of its importance, left different parts of the system ignorant of information of sufficient significance to have altered the relevant assessments.
- An absence of a perceived obligation of utmost good faith on the part of the Trust Board to make full and frank disclosure of all matters that might be material to the authorisation process, whether or not adverse to the application.

4.512 There is a danger of history repeating itself. It is not possible to be sure that other Staffords do not exist within the system. The policy of converting all trusts to FTs persists, as does a timetable for achieving this. Almost by definition the trusts now left to apply are those giving rise to particular difficulties, although not all will be related to quality and safety issues. While considerable improvements are said to have been made in communications, and greater attention is paid to quality and safety performance, the impact of the stresses of achieving apparent financial viability on patient care is still the subject of uncoordinated consideration by two separate bodies.

4.513 Now, as before, the consideration of quality and safety issues is separated from that of financial and corporate governance. The two areas are principally dealt with by separate regulators, which have developed their own expertise. As consideration of the unhappy story of the Trust has shown, good quality care can be seriously impacted upon by financial management that does not take quality and safety sufficiently into account, and no doubt a clinically incompetent approach to the delivery of the service can impact on financial health. Therefore, it is imprudent to separate the responsibility for regulating each strand, as there is a serious danger of the impact of one on the other being missed. This can be mitigated, to some extent, by good and systematic communication, but organisational boundaries, uncoordinated methods of working and different sources of intelligence are all much more difficult to overcome if there is no common leadership and accountability. It becomes all too easy to assume, or suggest, that something is someone else's responsibility. There is an urgent need to address this issue, which is just as relevant to the continuing enforcement of compliance with quality and financial standards after authorisation, as it is to the authorisation process itself. Therefore, it is in the public interest that the regulation of quality of service and governance (clinical, financial and corporate) of healthcare providers be the responsibility of a single regulator rather than two.

4.514 The application process has been considered as a hurdle to be overcome, not as an essential protection for all parties to assist in the maintaining of proper standards. As a result, the Trust put forward its best face and restricted its production of information to what it was asked to produce. It gave no adequate consideration to what, if any, adverse matters it should disclose. It is unlikely that the Trust is unique in that regard, or that the attitude will change for the better as the pressure to overcome this regulatory hurdle increases. It needs to be universally recognised in the healthcare system that there is a duty of utmost good faith on healthcare organisations to inform regulators of any significant matter pertinent to the performance of their regulatory duty. An application for FT status should be capable of being invalidated by a failure in material disclosure.

Summary of recommendations

Recommendation 64

The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which should incorporate the relevant departments of Monitor.

Recommendation 65

The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application.

Recommendation 66

The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that:

- Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards;
- An accessible record of responses received is maintained;
- The responses are made available for analysis on behalf of the Secretary of State, and, where an application is assessed by it, Monitor.

Recommendation 67

The NHS Trust Development Authority should develop a rigorous process for the assessment as well as the support of potential applicants for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard.

Recommendation 68

No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance manager (the Strategic Health Authority cluster, the Department of Health team, or the NHS Trust Development Authority) is satisfied that the organisation currently meets Monitor's criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards.

Recommendation 69

The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust.

Recommendation 70

A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.

Recommendation 71

The Secretary of State's support for an application should not be given unless he is satisfied that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to be able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator.

Recommendation 72

The assessment for an authorisation of applicant for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards.

Chapter 5
Mortality statistics

Key themes

- The Trust, the West Midlands Strategic Health Authority (WMSHA) and the Department of Health (DH) all focused attention on coding issues, at the expense of considering whether a high Hospital Standardised Mortality Ratio (HSMR) indicated concerns about patient care.
- The Trust and the strategic health authority (SHA) failed to disclose concerns about the Trust's HSMR to Monitor as part of the foundation trust (FT) application process.
- Dr Foster Intelligence (DFI) were, in hindsight and unintentionally, overly reassuring to the Trust about its HSMR, reinforcing a focus on coding.
- The SHA focused on supporting the Trust and rebutting DFI's figures, by commissioning analysis from Birmingham University, rather than examining whether there was genuine cause for concern.
- There was a widespread lack of understanding and scepticism in relation to the significance of the figures, which provided fertile ground for a failure to take action. Although steps have been taken to improve the understanding of (what are now) Summary Hospital-Level Mortality Indicators (SHMIs), specific efforts are needed to ensure a better understanding of them, both by clinicians and by the public.

Introduction

5.1 The warning sign that initially triggered the Healthcare Commission's (HCC) concern about the Trust arose from mortality data. The presentation and use of mortality data has caused a considerable degree of confusion for the public and, more importantly, distress to the loved ones of those patients who died under the care of the Trust during the period under review. The first inquiry and the evidence before this Inquiry uncovered an alarming lack of consensus on the reliability and significance of patient death rates. As a result, to this day, there is no generally accepted means of producing comparative figures, and unjustifiable conclusions continue to be drawn from the numbers of deaths at hospitals and about the number of avoidable deaths.

5.2 It is clear that this debate distracted not only the Trust's management but also the WMSHA, South Staffordshire Primary Care Trust (SSPCT) and the DH from taking the steps necessary to protect patients. An unjustified assumption was accepted that the apparently concerning

figures were due to data quality and analytical deficiencies rather than poor care. Insufficient consideration was given to whether deficiencies in the standard of care might be at least part of the explanation. In addition, Trust leaders failed to understand the significance of the ratings produced by the DFI and the mortality alerts produced by the HCC and the Dr Foster Unit (DFU). As a result, Monitor was not advised as to the whole picture.

5.3 While much of this unhappy story was told in the report of the first inquiry, the wealth of evidence available at this Inquiry requires the issue to be reconsidered. It is an object lesson in the importance of keeping patient welfare as the first priority, even while there is a struggle to understand the significance of complex information. That struggle should never be used as an excuse for inaction in protecting patients, or for a lack of transparency. While steps have begun to be taken to achieve a consensual means of measuring hospital mortality rates, there are lessons to be learned in order to avoid the loss of focus on the true priority of healthcare provision: the quality and safety of patient care. Furthermore, there is an urgent need for more measures to be developed that provide a clear, accurate assessment of the quality standard of service provided in healthcare organisations such as the Trust.

The introduction of Hospital Standardised Mortality Ratios

5.4 The Bristol Inquiry uncovered a highly concerning lack of reaction to evidence that the perioperative death rate for paediatric cardiac surgery patients at Bristol Royal Infirmary was very much higher than at comparable units. The evidence included a specialist report commissioned by the DH's supra-regional Services Advisory Research Group which contained information about poor outcomes at the Bristol Royal Infirmary, and an envelope containing surgery data handed by an anaesthetist to a DH medical officer. The Bristol Inquiry concluded that there was no clarity as to who was responsible for monitoring the quality of outcomes. The conclusion of that inquiry on the DH's role bears repeating here:

> *We conclude, therefore, that the DoH stood back from involvement in the quality of clinical care. It had not created systems to detect or act on problems of clinical care, other than by referring them back to the district or hospital concerned.*[1]

5.5 This Inquiry received evidence from Professor Sir Brian Jarman, a member of the Bristol Inquiry panel, senior general medical practitioner, former President of the British Medical Association (BMA), member of the DH Standing Medical Advisory Committee and other senior leadership posts. He first received the English Hospital Episode Statistics (HES) in 1987/88 at Imperial College in order to assist with the calculation of the formula for the allocation of resources to NHS hospitals.[2] HES receives data from all NHS providers on a routine basis. There are hundreds of different items of data submitted for each patient episode.

1 Jarman WS0000042748, para 35
2 Jarman WS0000042743, paras 16–17

5.6 As part of that work, he started to develop a measure of adjusted hospital mortality to see whether it was relevant to resource allocation. From this, the HSMR emerged. In the mid-1990s, he used HSMR in a review of the contribution of academic hospitals, produced at the request of the DH. He recalled that he had been required to sign the Official Secrets Act and had permission from the Secretary of State for Health to use the necessary data.[3]

5.7 In a paper published in the *British Medical Journal* (*BMJ*) in June 1999, Professor Jarman and others set out to ascertain hospital inpatient mortality in England, and to determine which factors best explained variation in standardised mortality ratios.[4] In the same year, during the Bristol Inquiry, he sought permission from the then Secretary of State, Frank Dobson, to publish the HSMR as described in the *BMJ* paper, naming the hospitals. Permission was refused.[5] Two weeks after the *BMJ* paper was published, the DH produced data comparing named hospitals within its own Clinical Indicators. When a television broadcaster wanted to use Professor Jarman's research in a programme and sought DH agreement to the naming of the hospitals concerned, the DH sought to prevent this. In a letter to the broadcaster, a DH press officer stated that, if it intended to use information beyond that made public by the DH, no hospital should be named as the data had been provided to Professor Jarman on a confidential basis.[6]

5.8 In 2004, a peer-reviewed follow-up paper was co-authored by Professor Jarman and Dr Paul Aylin, among others, and published in the *BMJ*. This resulted in a complaint against Dr Aylin to the General Medical Council (GMC) by cardiologists at a hospital which the published figures showed to have significantly high mortality. The complaint was rejected.[7]

5.9 Professor Jarman was alarmed that the events at Bristol had not been brought to light sooner and believed that statistical examination was one of the ways in which that could have been achieved. However, he was concerned that the DH would be unwilling to undertake such an exercise following his previous attempts to publish information as described.[8] His past experience did not suggest to him that the healthcare system would welcome this sort of scrutiny, even after the Bristol scandal. Therefore, he founded the DFU within Imperial College to produce and analyse HSMRs.[9]

5.10 In 2000, Professor Jarman was approached by Tim Kelsey, then Editor of the *Sunday Times*, and Roger Taylor then a correspondent for the *Financial Times*, in connection with the difficulty in naming hospitals in published HSMRs. They arranged a meeting with the Special Adviser to the then Secretary of State, Alan Milburn, to discuss this. The result of the meeting

3 Jarman WS0000042744, para 19
4 Jarman, Gault *et al*, *Explaining Differences in English hospital death rates using routinely collected data* (1999), BJ/8 WS0000042878
5 Jarman WS0000042751, para 41
6 Jarman WS0000042751, para 42; BJ/3 WS0000042863
7 Jarman WS0000042749–50, para 39
8 Jarman WS0000042751–752, para 44
9 Jarman WS0000042752, para 45

was that the adviser wrote to Professor Jarman on 21 September 2000 confirming that the HES-derived analyses for named trusts could be published. Advance notice of publication was requested.[10] This enabled Professor Jarman to receive data from HES on a regular basis and update his analyses accordingly.[11]

5.11 Dr Foster first published its *Good Hospital Guide* in 2001 and this has been published annually since then.[12]

5.12 In 2002, Dr Foster negotiated to receive HES data on a monthly basis, which could be "cleaned" and processed, also monthly. Between 2002 and 2006, the monthly data received by HES originated from the Patient Administration System (PAS). Since then, it has been received by HES from the Secondary Uses Service (SUS).[13]

The providers of mortality rate analysis

Dr Foster Unit

5.13 Professor Jarman founded the DFU, which is and always has been distinct from the DFI.[14] DFU is partly funded by DFI, which is itself 47% owned by the DH, and also from various other national and international medical research institutes. No members of the DFU hold shares in DFI, or receive expenses or any direct salary from it. The funding received from DFI varies but was, at the time Professor Jarman gave evidence, a little over half the DFU's income. He was paid a consultancy fee by Dr Foster in 2004, related to international work, and has not claimed any expenses from either DFI or Imperial College.[15] He does not necessarily agree with all that DFI says in its publications, and is not consulted in advance about all of them. For example, he was unaware of its use of a quality account measure in the 2009 *Good Hospital Guide*.[16]

5.14 In addition to its general analysis of HES data for the HSMR, the DFU also issues mortality alerts each month to providers who appear to be outliers. These are not shared with the DFI.[17]

Dr Foster Intelligence

5.15 DFI was originally founded in 2000 to exploit the work of Professor Jarman at the DFU. In 2006, Dr Foster Holdings LLP and the NHS Information Centre entered into a joint venture, establishing DFI. On 9 July 2010, the NHS Information Centre transferred its shareholding in DFI to the DH.

10 Jarman WS0000042752, para 48; BJ/5 WS0000042867
11 Jarman WS0000042753, para 49
12 Jarman WS0000042753, para 51
13 Jarman WS0000042759, para 66; T98.19
14 Jarman WS0000042754, para 54
15 Jarman WS0000042755, para 57
16 Jarman WS0000042755, para 58
17 Jarman WS0000042753, para 52

5.16 DFI is therefore an entity quite distinct from the DFU. It is a commercial organisation whose purpose is to improve the quality and efficiency of health and social care through better use of information, and to publish such information in a form that can be used by the public. In particular, it has used the HSMR data as a tool to inform its publications. It is DFI's view that the public are entitled to the best available information about the quality of care delivered in the hospitals they are considering using.[18] Roger Taylor, DFI's co-founder and currently its Director of Research and Public Affairs considers that the public understand that analyses such as HSMR are not perfect and can make allowances for this. He also believes that the response of the healthcare system and those working within it to information depends on whether it is publicly available. Further publication ensures that the inevitable debate about the correct way to measure outcomes such as mortality is transparent and open to scrutiny:

> *It seems to me that the only way we get through this difficult issue of how do you measure accurately and correctly the quality of clinical care is by doing it in a very transparent manner and that means you have to publish your high level results.*[19]

5.17 In addition to the *Good Hospital Guide* 2001 DFI also produces a number of other publications on the availability and standards of services.

5.18 DFI had a commercial relationship with most acute trusts in the West Midlands. It provided its Real Time Monitoring (RTM) service and various other services to the Trust from April 2006 until March 2012, and from March 2010 to date its Clinical Outcomes and Benchmarking (COB) system. For the financial year 2008/09, its services were provided free of charge.[20] The Trust appears to have been the first acute trust in the West Midlands to contract with DFI in this way, but four others joined in April 2007, a further eight were recruited in 2008, and three in 2009. Five trusts did not renew their contracts, mainly in 2011, but the rest continue to receive DFI's services.[21] DFI was also commissioned by the WMSHA in January 2007 to undertake work on quality metrics.[22]

The Healthcare Commission

5.19 The HCC also undertook its own mortality analyses and issued alerts. Starting in the summer of 2007 it developed an analysis of mortality data and a system for following it up, initially through a pilot scheme. The HCC also came to an arrangement with DFU to receive from it copies of mortality alerts sent by DFI to individual trusts. It was because of this arrangement that the HCC received copies of the DFU alerts sent to the Trust.[23]

18 R Taylor WS0000042609, para 2; T99.8
19 R Taylor T99.8–11
20 R Taylor DRF0000000037–39
21 DRF0000000040
22 RS/1 WS0000018579
23 N Ellis WS0000027762–3, paras 52–54

Hospital Standardised Mortality Ratios

5.20 HSMR is a method of seeking to establish whether hospital mortality is higher or lower than expected. It cannot and does not claim to establish whether any particular death or group of deaths was avoidable. HSMR compares the levels of deaths of patients in hospitals (hospital mortality) in different years, or between different groups of patients/ailments in the same year. So as to create a measure that allows mortality to be compared between differing hospitals, the method for calculating HSMR takes account of differences in case mix, and makes adjustments for variables which are not directly related to the quality of treatment and care provided in a particular hospital. The variables for which adjustments are made include: age; ethnicity; admission source and type; level of deprivation; period of admission; and co-morbidity.[24] HSMR are also specifically calculated with reference to the 56 diagnostic groups which between them are said to account for 80% of all hospital deaths.[25] Currently, the figures are also adjusted according to whether or not palliative care was provided.

5.21 As stated above, since 2006 the data used by DFU in the calculation of HSMR is derived from the data that hospitals provide every month via the SUS. Formerly, the data came from the PAS (between 1996 and 2005) and then the HES (between 1996 and 2006).[26] The relevant data is collated by hospitals through their 'coding' processes. As at May 2011, there were 13 million hospital admissions in England each year, 5 million of which were day admissions. Hospital admissions are coded according to the internationally recognised International Classification of Diseases (ICD-10) and the Clinical Classification System (CCS). That is to say that an individual code is attributed to every admitted patient's condition, based on the primary diagnosis made on the occasion of the first episode of care. A hospital may well attribute a second code to a secondary diagnosis made during the first episode of care. However, in calculating HSMR, DFU make use of the first non-vague diagnosis coded by a hospital.[27]

5.22 It is inevitably the case that a certain level of death is expected in respect of a diagnostic group. The number of expected deaths in a diagnostic group is the sum of the estimated risk of death for each patient in it.[28] The HSMR is calculated by dividing the number of 'observed' deaths – ie deaths actually occurring – by the number of expected deaths, multiplied by 100. The national mortality baseline is therefore 100. If the mortality levels are higher than expected, the result will be more than 100; if less than expected, it will be less than 100.[29]

5.23 The HSMR results for each hospital are grouped into three categories: "high"; "within the expected range"; and "low" mortality. The categorisation exercise is conducted by use of a "funnel" plot which identifies the mean ratio (100) and an upper and lower "control limit".

24 Co-morbidity is a description of the incidence of two or more ailments in one patient upon their admission to hospital (as opposed to the incidence of additional ailments which arise during the course of the episode of care): Jarman T98.44–45
25 Jarman WS0000042759 para 67; BJ/9 WS0000042889
26 Jarman WS0000042756, para 66
27 Jarman WS0000042759, para 67
28 Jarman WS0000042756–7, para 60; R Taylor WS0000042611, para 7
29 Jarman WS0000042760, para 70

A result falling *within* the upper and lower control limits is one in which the difference between the hospital result and the mean average is consistent with a random or chance variation. A deviation *outside* that range is unlikely to have arisen by chance and is classified as an "outlier". A 99.8% control limit is used for the data published by DFI. A result occurring outside that control limit has only a 0.2% probability of being attributable to chance. In DFI's RTM Tool (see below) a control limit of 95% is used: in this case there is a higher, but still small (5%), probability of the result outside the limit being attributable to chance.[30]

5.24 The HSMR thus seeks to convert hospital mortality rate data into a statistically robust, fair and useful performance indicator.[31] A fuller and more technical description of the methodology behind the HSMR can be found in the evidence.[32]

The intended use of Hospital Standardised Mortality Ratios

5.25 Roger Taylor made it clear in his evidence that HSMR is not intended to be punitive but to assist organisations to monitor their mortality. DFI recommends that outlying organisations should take the following steps:

- They should check to see whether incorrect data has been submitted, or whether an approach to coding which differs from other organisations' approach has been adopted;
- They should consider whether something extraordinary has occurred which explains the result;
- They should consider whether their healthcare partners work in ways which are different from those in other areas;
- They should consider whether there are any potential issues with regard to the quality of care;
- Where consideration of the above matters points to a particular team or individual, the trust needs to focus on them and see what extra support is required to ensure that the best possible care is provided.[33]

5.26 Roger Taylor summarised this as amounting to two lines of inquiry:

> *One of which is "How much attention should I pay to this number? How good a measure is it?" And the second is, "What else – what other evidence – actually what is going on* [on] *the ground? Is there anything to* [find] *out there that would support this apparent finding?*[34]

30 R Taylor WS0000042610–2, paras 6–13
31 BJ/9 WS0000042888
32 BJ/9 WS0000042886; BJ/10 WS0000042920; BJ/11 WS0000042926
33 R Taylor WS0000042612–3, para 14
34 R Taylor T99.111

5.27 Professor Jarman argued that one of the most important features of mortality as a statistical measure is that death is a definitive and unique event, whereas other measures, for example those that measure morbidity, can be continuous and difficult to measure accurately. Professor Jarman said that the Bristol Inquiry had found that centres with a better mortality rate had a better record for overcoming complications.[35] He accepts, and has always accepted, that there are limitations to the use of HSMR. However, he has also looked at whether there was an association between HSMR and patient survey results. Professor Jarman found that there was a significant association between hospitals which had the highest HSMRs and the number of "dissatisfied" responses to questions in patient surveys about:

- Whether doctors discussed patients' anxieties and fears with them;
- Whether relatives had sufficient chance to talk to a doctor;
- Whether a member of staff explained the purpose of medicines to be taken home;
- Whether the patient was told about medication side effects;
- Whether the patient would recommend the hospital to a friend or family.[36]

5.28 He made it clear that it is not possible to calculate the exact number of deaths that would have been avoidable, nor to identify avoidable incidents because those tasks would require expert review of all the relevant case notes. The statistics can only be signposts to areas for further inquiry.[37]

5.29 It will be apparent from the foregoing that it is not possible to conclude, without more information than the HSMR alone, that a high outlier is attributable to poor care. Nor is it possible to say that any specific number or proportion of deaths was from an avoidable cause. Nothing to the contrary has been suggested.

Real Time Monitoring tool

5.30 As a commercial service, DFI supplies to paying organisations a suite of data analyses at four main levels: a monthly HSMR overview of adjusted hospital mortality; the standardised mortality ratios for the "basket" of diagnoses that constitute the highest HSMR; disease-specific mortality alerts; and individual patient-level data.[38] It generates an alert where the organisation is an outlier for either the rate as a whole or for individual diagnoses. Customers are provided with support and training in the use of the tool. In particular, DFI recommends that, where a trust receives an alert, it conducts a trend analysis to identify if there was a point in time when the trust became an outlier, so it can understand what, if anything, changed at that point.[39] The purpose of the tool is to promote consistency in clinical audit, with the assistance of elements of benchmarking, and to allow problems to be identified

35 Jarman WS0000042757, para 51
36 Jarman WS0000042769–70, para 88
37 Jarman WS0000042770, paras 89–91
38 Jarman WS0000042786, para 125
39 R Taylor WS0000042613–4, paras 15–17

closer to the time when they arise. It allows trusts to access more detailed analyses by reference to diagnosis, length of stay, and other factors.[40]

5.31 A version of the RTM which shows all alerts raised is available to SHAs and primary care trusts (PCTs), but Roger Taylor accepted that it would not be productive for them to investigate all alerts as many would turn out to be caused by matters of no real concern.[41]

Mortality alerts

Dr Foster Intelligence

5.32 The DFI RTM tool generates and communicates mortality alerts to its users, triggered by results exceeding a 95% confidence interval, as opposed to the higher threshold set by DFU for its alerts (see below). The intended purpose of this was to give hospital managers an early warning of a possible problem. Roger Taylor considered that it should be investigated immediately:

> *I would expect a Trust, acting responsibly, to investigate each alert in an open and transparent way. In some cases it may be readily apparent that the alert is not a cause for concern, but the result of data or other issues that do not relate to the care provided. In other cases, it may require further explanation. I would expect the Trust to involve its clinicians in any investigation, i.e. at mortality and morbidity meetings. The Trust should check the quality of its coding data and not just simply assume that the alert is the result of a coding error.*[42]

Dr Foster Unit

5.33 Since April 2007, DFU has prepared and issued monthly mortality alerts for 43 diagnoses and 76 procedures.[43] A cumulative sum (CUSUM) analysis is performed on SUS data and is designed to detect a doubling of the odds of death for each diagnosis and procedure. Alerts are then filtered to restrict those issued to those where there is a less than 0.1% chance of a false alarm. Some procedures and conditions are then excluded. The alerts are sent to the trust concerned and copied to the HCC, now the Care Quality Commission (CQC). The HCC started routinely forwarding the alerts to SHAs and Monitor from about February or March 2008. The CQC appears to have added PCTs to the circulation list. They are not sent to DFI or published. These alerts are intended to identify issues which hospitals may wish to look at and do not of themselves indicate that there is a major problem of concern.[44] Professor Jarman considers that trusts that act decisively in response to these alerts can put themselves in a

40 Jarman WS0000042757, para 62
41 R Taylor WS0000042624, para 46
42 R Taylor WS0000042616, para 22
43 Jarman T98.163
44 Jarman WS0000042781–3, paras 112–118

good position to address the causes of high mortality, improve patient care and reduce the number of hospital deaths.[45]

Frequency and outcomes of alerts

5.34 According to Professor Jarman, in August 2010, the CQC published on the internet details of the 87 mortality alerts it had reviewed and closed since the programme started in 2007. Of that total, 74 (85%) had been generated by DFU and 13 (15%) by the HCC. The most common subjects for alerts were coronary arteriosclerosis and other heart disease, septicaemia except in labour, and urinary tract infection. Thirty-seven alerts were followed up with the trusts and 42 were closed after internal analysis. Only eight were escalated for further action, all involving the Trust.[46]

The treatment of the Trust's mortality statistics

Use of Real Time Monitoring

5.35 The Trust purchased DFI's RTM tool in February 2006 and would have had access from that time to the monthly mortality alerts generated by the system. It gave access not only to the HSMR issues monthly, quarterly and annually, but also to the rates for the various diagnostic groups and the mortality alerts for the past three months. While Trust staff were receiving training and support from DFI, the RTM tool was being accessed frequently: 52 times in March 2006. However, this reduced substantially so that over the period until March 2008, the usage averaged only eight "times-accessed" per month. It appears that the usage increased following the start of the HCC investigation.[47]

Trust Hospital Standardised Mortality Ratio 2000 to April 2007

5.36 Before it purchased the RTM tool, the Trust would only have had access to the annually published HSMR. Table 5.1 below reproduces figures supplied by Professor Jarman to the first inquiry. Professor Jarman also provided an updated table as exhibit 14 in his statement to this Inquiry (Table 5.2 below). The figures differ slightly, reflecting updates to the system, but it is clear from both tables that the HSMR shows a rising trend from 1996 to a peak in 2006/07. Looking at Professor Jarman's original table, the average HSMR for the period 1996 to 2008 was 114, within a 95% confidence interval range of 112 to 116. DFI published a *Good Hospital Guide* in December 2006, which included the HSMR for 2004/05. The Trust's figure was 109.[48] The Trust had been consistently, except for one year, above the national baseline since 1997.[49] On Professor Jarman's more recent figures, even the HSMR for that year is above the average.

45 Jarman WS0000042785, para 123
46 Jarman WS0000042791, para 138
47 Jarman WS0000042797, para 150
48 *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009* (24 February 2010), Vol I, pp.360–361
49 Jarman WS0000042796–7, para 149

Table 5.1: Observed minus expected deaths at Mid Staffordshire Hospital 1996/97 to 2007/08

						95% Confidence intervals around HSMR		95% Confidence intervals around observed deaths		95% Confidence intervals around observed – expected deaths	
Financial year	Admissions	Observed deaths	Expected deaths	Observed – expected deaths	HSMR	High	Low	High	Low	High	Low
1996/97	11,088	774	782	-8	99	106	92	831	720	48	-62
1997/98	10,954	765	702	63	109	117	101	821	712	119	10
1998/99	11,635	794	733	61	108	116	101	851	740	118	7
1999/2000	11,776	801	754	47	106	114	99	858	746	105	-7
2000/01	11,496	718	670	48	107	115	99	772	666	102	-4
2001/02	12,156	821	736	85	112	119	104	879	766	143	30
2002/03	12,398	794	674	120	118	126	110	851	740	177	66
2003/04	12,315	841	668	174	126	135	118	900	785	232	118
2004/05	13,781	882	766	116	115	123	108	942	825	176	59
2005/06	14,073	878	707	171	124	133	116	938	821	231	114
2006/07	16,569	870	683	187	127	136	119	930	813	247	130
2007/08	16,433	947	813	134	116	124	109	1,009	888	196	74
1996/97–2007/08	154,674	9,885	8,688	1,197	114	116	112	10,082	9,691	1,394	1,003

Table provided by Professor Brian Jarman to the first inquiry[50]

50 *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009* (24 February 2010), Vol I, pp.360–361

Table 5.2: Mid Staffordshire NHS Foundation Trust: All Hospital Standardised Mortality Ratio diagnoses admissions

		Observed – expected	Observed – expected	Observed – expected	Observed – expected	95% Confidence intervals HSMR	95% HSMR	95% Observed – expected	95% Observed – expected
Financial year	Admissions	Deaths	Deaths	Deaths	HSMR	High	Low	High	Low
1996/97	11,071	772	761	12	102	94	109	-42	68
1997/98	10,941	763	690	73	111	103	119	19	128
1998/99	11,615	796	725	71	110	102	118	17	128
1999–2000	11,739	799	726	73	110	102	118	18	130
2000/01	11,485	717	694	23	103	96	111	-29	77
2001/02	12,132	821	738	83	111	104	119	28	141
2002/03	12,364	794	684	110	116	108	124	55	167
2003/04	12,294	843	689	154	122	114	131	98	213
2004/05	13,731	883	808	75	109	102	117	18	135
2005/06	14,109	879	749	130	117	110	125	73	190
2006/07	16,457	853	693	160	123	115	132	103	219
2007/08	16,396	946	836	110	113	106	121	51	173
2008/09	17,410	818	888	-70	92	86	99	-125	-12

Table provided by Professor Brian Jarman to this public Inquiry[51]

Reaction to publication of Hospital Standardised Mortality Ratios in April 2007

Early concerns about Trust mortality

5.37 At the beginning of 2007, there was evidence that the Trust was considering the implications of its apparently high mortality rate. At a clinical governance meeting on 5 January, it was recorded that:

> *There continue to be problems with the rate of mortality in connection with the day of admission to this hospital ... it is still phenomenal after a 56 month period.*

5.38 It was agreed that Dr Phillip Coates would: "Look at why mortality rates are high on a Saturday and a Sunday and will ask Clinical Audit to come on board".[52]

5.39 In preparation for the publication of the 2007 *Good Hospital Guide*, a representative of DFI visited the Trust to discuss its HSMR and the forthcoming guide. At that time, the RTM tool was indicating an annual figure of 114 for 2005/06, with the Trust being an outlier on 95% confidence limits. According to Roger Taylor, the representative advised the Trust that there

51 BJ/14 WS0000042972
52 HM/8 WS0000009626

was no way of knowing whether it would be identified as "high" in the guide as the figures published would be rebased. She also communicated an understanding that the Trust was not one of the 10 highest-scoring trusts.[53]

5.40 At what must have been about the same time, on 28 February 2007, the Trust's Executive Governance Group noted that the HSMR was 114 and that "The results could be down to a coding problem in the areas of syncope and mental health."[54]

5.41 Martin Yeates told the Inquiry that there had been "No previous alarm bells ringing".[55]

5.42 At the next meeting of the Group on 26 March 2007, it was reported that Dr Coates had looked at the weekend mortality rates and would be happy to look at other aspects of Dr Foster's figures if asked to.[56]

5.43 Until April 2007 there was, therefore, some evidence that the Trust was beginning to consider its high mortality rate, but not with any degree of urgency or particular concern that a patient safety issue might have been revealed. With hindsight, it is possible that the Trust could have taken a degree of false reassurance from the information received at the time from DFI. While this was not DFI's intention, the executive leadership of the Trust was advised that the apparent deviation in mortality from the norm *could* be due to coding, and also that the Trust would not be one of the worst performing in the country. Such advice, so far as it went, was correct but the question remains whether it went far enough. DFI did not indicate to the Trust that coding was the only possible explanation, but, looked at with hindsight, nothing in its communications to the Trust at the time explicitly suggested any urgent need to take action in addition to that already in place. This may unintentionally have contributed, to some extent, to the reaction of the Trust and the WMSHA to what followed, but a careful reading of DFI's publications at the time would have made it clear to the reader that explanations other than coding should also be sought.

Dr Foster Good Hospital Guide*, April 2007*

5.44 On 24 April 2007, the *Daily Telegraph* published Dr Foster's *Good Hospital Guide*. It came as something of a shock for the Trust to learn that its HSMR for the past year was 127, as opposed to 114, and that it was ranked fourth worst performing trust in the country. This meant it was one of the six trusts in the WMSHA region which were listed in the group of 10 worst performing trusts in the country. The Trust was also shown to be the fourth worst performing trust in the country over a three-year period, with a score of 125.[57]

53 R Taylor WS0000042617–8, para 26
54 HM/10 WS0000009642
55 Yeates WS0000074957, para 117
56 H Moss WS0000009483–4, para 86; HM/11 WS0000009646–7
57 R Taylor WS0000042618, para 28; RT/4 WS0000042642–3

5.45 The Trust was not alone in the West Midlands in having a high HSMR, as illustrated by the annex to a WMSHA report on quality and safety, showing the overall mortality rate.[58]

Table 5.3: Overall mortality rates in West Midlands NHS trusts

Trust	3-year	1-year 2005/06
George Eliot Hospital NHS Trust	132	143
University Hospitals Coventry and Warwickshire NHS Trust	120	123
Good Hope Hospital NHS Trust	123	132
Heart of England NHS Foundation Trust	109	110
South Warwickshire General Hospitals NHS Trust	108	110
Sandwell and West Birmingham Hospitals NHS Trust	106	102
University Hospital Birmingham NHS Foundation Trust	111	105
Burton Hospitals NHS Trust	135	130
Walsall Hospitals NHS Trust	110	110
The Dudley Group of Hospitals NHS Trust	119	126
University Hospital of North Staffordshire NHS Trust	100	88
The Royal Wolverhampton Hospitals NHS Trust	104	110
Mid Staffordshire General Hospitals NHS Trust	**125**	**127**
Shrewsbury and Telford Hospitals NHS Trust	94	91
Hereford Hospitals NHS Trust	104	103
Worcestershire Acute Hospitals NHS Trust	110	109

5.46 The abrupt change in the Trust figures had resulted in part from the recalculation of the national baseline figure. At the time, DFI gave no advance indication to trusts of what the adjustment was likely to be. Now tools are provided to give an estimate of the likely baseline. DFI had also introduced some modifications to the methodology by including a wider range of factors, including co-morbidities and palliative care. Significantly, according to Roger Taylor, the revised methodology "was more accurate when the coding was correct but could penalise a trust with weaker coding".[59]

The Department of Health reaction

5.47 When the Dr Foster's *Good Hospital Guide* was published in April 2007, the DH prepared a briefing on it and the "lines to take". It issued a public statement, which read:

> *We need to be careful in using just one measure to assess safety in our hospitals. Some have higher mortality rates because they take on more complex work, but obviously patient safety will always be the key priority.*

58 SHA0025000276, *Quality and Safety* (28 May 2007), WMSHA
59 R Taylor WS0000042619, para 31

At present it can be difficult for patients to get a true picture of a hospital's overall performance from the available data because it covers so many different areas. We will, however, be bringing all the available data together in the new website which will help patients make informed choices about their health and healthcare.[60]

5.48 The briefing drew attention to a reservation in the report about the quality of coding of secondary diagnoses, meaning that it was not possible to make a valid comparison between individual trusts. It is not clear how widely this note was disseminated. It sought to play down the significance of the mortality figures:

The proportion of admitted patients who died in hospital was 2.0% in 2005/06, so 98% of all patients survived their stay. Most of the deaths were of patients who were already extremely sick.

In terms of NHS workload, death in hospital is a relatively rare event and it is misleading to judge the performance of individual hospitals with widely varying profiles, on the basis of the outcome of a relatively small number of extremely sick patients.[61]

5.49 Professor Sir Bruce Keogh NHS Medical Director, pointed out in his evidence to the Inquiry that this statement did not say, as had been stated at the WMSHA Board meeting on 28 May 2007 (see below), that the HSMR findings should not be used as an indicator of patient safety.[62] His position at the time and since has been that:

Potentially "avoidable" deaths cannot be identified a priori*, with the result that there can be no "gold standard" against which to assess the sensitivity and specificity of purely statistical measures such as HSMRs; and that no single measure can possibly encapsulate all aspects of the quality of care offered by a hospital. Equally, the DH has always recognised that minimising avoidable mortality is an important objective of health care, and that there is no alternative to using such imperfect measures in this field. I have major reservations with the presentation of simplistic "league tables" of HSMRs (such as those presented in the* [2007 guide]*).*[63]

5.50 Sir Bruce said that he had always been in favour of publishing data in order to drive improvement. To avoid the "league table" approach, he favoured categorising trusts' performance as being above, within, or below the expected range.[64]

60 BK/36 WS0000066044
61 BK/36 WS0000066045
62 Keogh WS0000065294, para 129
63 Keogh WS0000065294–5, para 130
64 Keogh WS0000065295–6, para 133

The letter from Caspe Healthcare Knowledge Systems

5.51 In April 2007, the Chief Executive of Caspe Healthcare Knowledge Systems (CHKS) wrote to all trusts making some general observations about the use of Dr Foster's figures.[65] The letter stated that deaths in hospital were "quite rare" and were running at about 2% in 2005/06, with a variation of between about 1.5% and 3%. The Chief Executive observed:

> *Of course we should not be complacent about such variation, if it is avoidable.*

5.52 He made criticisms of the HSMR methodology and, in particular, its restriction to diagnostic groups representing 80% of deaths, and described as irresponsible an attempt to link the higher mortality rates with medical error, infection and failure to deliver quality of care, as there were many other reasons why patients might die.

The reaction of the Trust

5.53 Given this background, it is not entirely surprising that the Trust did not accept the figures reported at face value, and, as will be seen, it was far from the only organisation to attribute poor results to poor coding.

5.54 On 30 April 2007 the Executive Governance Group was told by Dr Suarez that:

> *It is thought that the poor outcomes are related to clinical coding. Work is ongoing to determine if there are any other areas of concern.*[66]

5.55 In May 2007, the Trust appears to have looked at the figures available on the RTM for 2005/06 and for 10 months of 2006/07.[67] These figures were more detailed than those published and included those for individual diagnoses. Table 5.4 shows figures derived from those results which were statistically significant, in the sense that the lower limit of the confidence interval (CI) exceeded 100.

65 P Robinson WS0000069268, para 14; PR/6 WS0000069328
66 HM/13 WS0000009670
67 TRU0001001305; TRU00010013059

Table 5.4: Figures from the Trust's RTM results for 2005–2006 and 10 months of 2006–2007

Diagnosis group	2005–2006 HSMR	CI lower limit	CI upper limit	2006–2007 HSMR	CI lower limit	CI higher limit
All	**126.4**	118	135.2	**124.4**	115.7	133.5
Abdominal pain	**219.7**	136	335.9	**261.3**	169.0	385.7
Acute bronchitis	**173.1**	129.2	226.9	**179.2**	130.7	239.8
Coronary atherosclerosis and other heart diseases	*134.4*	*61.3*	*255.2*	**349.7**	213.5	540.1
Cardiac dysrhythmia	**204.5**	111.7	343.1	*163.5*	*87.0*	*279.6*
Other lower respiratory diseases	**189.4**	103.4	317.8	**205.6**	109.4	351.6
Chronic obstructive pulmonary disease	**148.8**	108.1	199.8	*111.3*	*74.5*	*159.8*
Syncope	**301.2**	200.1	435.3	**242.8**	143.8	383.8
Senility and organic mental disorders	**233.9**	146.5	354.2	**188.8**	113.6	294.8
Peritonitis and intestinal abscess	**264.1**	126.4	485.7	*96.9*	*10.9*	*349.9*

5.56 The figures in italics are included for comparison only as they are not statistically significant. However, within the limitations of the HSMR methodology, these figures show that in May 2007 there was an apparent continuing excess mortality of statistical significance not only in the overall figure but also in a number of diagnostic groups.

5.57 The Trust's mortality data was discussed at a meeting of the Trust's Clinical Quality and Effectiveness Group on 4 June 2007. The minutes show that Dr Coates, Dr Moss, Dr Suarez and Martin Yeates had met with DFI on 1 June 2007 to understand why the Trust's HSMR was 127 instead of the 114 they had been led to expect. It was stated that a further investigation would take place, with the notes of every patient who died in 2006–2007 to be revisited to establish whether the coding was correct. There would also be a ban on the use of syncope and abdominal pain as coding entries when a patient is discharged. It was stated that the Trust was "taking the negative data from Dr Foster seriously". However, the focus of the discussion was exclusively on coding, with the minutes recording that "The Trust is of the opinion that the level at which Dr Foster is stating that the Trust is at, is incorrect".[68]

5.58 The steps taken during this period, leading up to the report to the Trust Board meeting in June 2007 (covered below), do not therefore appear to have addressed the immediate and continuing implications for patient safety at all.

68 HM/14 WS0000009680

Initial analysis by West Midlands Strategic Health Authority

5.59 Steve Allen, the WMSHA's Director of Performance, was critical of the practice of publishing HSMR ratings. He told the Inquiry that he thought it was "inappropriate" that the public should know of high HSMRs and was concerned that the reporting of low ratings might give them false reassurance. With regard to high ratings, he was concerned about the response from the public, because they had not been given the means to understand the information. He viewed HSMR with "deep scepticism", as it was "inconceivable" to him that half the deaths at George Eliot Hospital were avoidable. He thought that it was very difficult, if not impossible, to discern by this methodology what proportion of the death rate could be attributed to quality of care, and he thought it was "irresponsible" to publish the figures without such information. In his view, the responsibility for filling that gap lies with the publisher of the statistic.[69] He regretted that the NHS had not done more in this area and had effectively ceded this sort of measurement to others. He was not against commercial providers of information generally and thought they could add value to official statistics, but did consider that "the official statistic that is known to the public about deaths in their hospital should be based on a methodology that's open to scrutiny."[70]

5.60 The view of Peter Shanahan, the WMSHA's then Director of Finance and Capacity, was different in emphasis; he told the Inquiry his view had always been that Dr Foster was an indicator of concern that needed to be explored:[71] "clearly, the figures – until we knew one way or the other what the issues were behind them – were a cause for concern."[72]

5.61 However, he had not felt "unduly concerned" by the publication of the Dr Foster report because:

> *... there was no other evidence. So ... there weren't things being raised by the overview and scrutiny committees, MPs weren't raising it. You know ... there was no other indicator which said, "Well, the HSMR's high and there's all these other issues".*[73]

5.62 Mr Shanahan's focus was on patient studies:

> *I was always aware that that statistic might mean a problem, and indeed as ... the inquiry went forward, what I tried to do is to stop people focusing on the HSMR and look at some of the case studies that were in the report, because they were real people, so they couldn't dispute those.*[74]

69 Allen T70.151–156
70 Allen T70.167–169
71 Shanahan T72.132
72 Shanahan T72.151
73 Shanahan T72.135, T72.154–155
74 Shanahan T72.136

5.63 However, this position as stated to the Inquiry was inconsistent with his statement to Monitor at a meeting in October 2007. The minutes of that meeting record Mr Shanahan, acting as representative of the WMSHA, as confirming that there were no concerns over quality at the Trust.[75] Mr Shanahan expressed doubt[76] that the WMSHA's view would have been put in those terms, as there were concerns about the Trust's MRSA rates. However, there is no indication in the minutes of the meeting that any other safety concerns were raised, and it seems unlikely that Monitor, which had knowledge of issues around HSMR, MRSA and A&E pressures, would not have recorded any such concerns that were raised.

5.64 Mr Peter Blythin, the WMSHA Director of Nursing and Workforce, did not consider that the figures could be brushed aside:

> *I think it ... was ... taken very, very seriously by the SHA, and I don't think we were in denial that it couldn't be 2,000 deaths but it was an extraordinary figure that warranted further investigation. I think ... we didn't just accept that there were 2,000 deaths. We wanted to understand it.*[77]

5.65 Elizabeth Buggins, Chair of the WMSHA, had found the results surprising, not least because of the apparently encouraging results for the two trusts in the region which were among the best results in the country. She had felt this was not very consistent with the financial difficulties they had been experiencing. She felt it was necessary for work to be undertaken to find out how reliable HSMR was as a quality indicator. In principle, she was very enthusiastic about developing quality metrics.[78]

5.66 In spite of the reservations held by some within the organisation, the WMSHA reacted swiftly to the publication of the data in April 2007.

5.67 On the day the DFI results were published, Steve Allen commissioned an analysis by his team which he then circulated widely within the WMSHA to the leadership team. Mr Allen's tone was sceptical about DFI's work:

> *Given that Dr Foster refuse to publish their full methodology (based on "commercially valuable intellectual property" apparently) it's difficult to do more than* [the piece of analysis carried out by the team] ...

75 Shanahan WS0000020515; PWS/13 WS0000020779–81
76 Shanahan T72.156–163
77 Blythin T69.181–182
78 Buggins T74.90–92

If you accept the Dr Foster data at face value, the scale of the apparent excess deaths in West Midlands hospitals is shocking – about 2,000 more deaths in NHS hospitals in our patch in 2006 than one would expect – or about 3% of all deaths in the West Midlands. It is hard to believe that this differential is all accounted for by failures of hospital care in our patch, particularly since other more specific measures of hospital mortality do not reflect the same message (see below). However, at this stage we can't explain all of the variance and need further work to do so.[79]

5.68 The analysis argued that, if the high mortality rates for patients apparent from the HSMR were genuine, they would be expected to have an effect on the overall comparative mortality rates for the population in the West Midlands; the rates in the areas concerned, however, were in line with demographic expectations.[80] The analysis considered the alternative measure provided by the National Centre for Health Outcomes Development for mortality within 30 days of various surgical procedures. This showed rates for the West Midlands which were "marginally higher" than the national average, but the difference was not statistically significant. Statistics for the place of death showed that, while total death rates in the West Midlands were not unusual, a higher proportion of those deaths occurred in hospital. The analysis suggested that this could account for a quarter of the excess deaths in the HSMR and that the cause of this was the comparative lack of palliative care in the community within the region. It was recognised, therefore, that this could not account for the whole of the excess.

5.69 The conclusion of the analysis was that "We will need to do more work to understand the factors underlying the apparent high death rates in our hospitals."[81]

5.70 Mr Allen proposed that "a genuinely independent" analysis of the issue be conducted, "based on a methodology which is open to scrutiny".[82] His motivation in suggesting this was, he told the Inquiry, to enable the WMSHA:

"to understand this, not to explain it away".[83]

5.71 As was implicitly recognised in the analysis, reference to other statistics could not provide a complete answer to the excess suggested by the HSMR. In any event, the analysis suffered a weakness in not comparing like with like. A general figure for the population of a region could conceal excesses in particular catchment areas for the hospitals in question. For example, the excesses could be balanced, in part at least, by the lower than expected figures from other hospitals. It is, in any event, difficult to understand why the relatively small numbers involved

79 RS/22 SHA0013000088
80 RS/22 SHA0013000089
81 RS/22 SHA0013000090
82 RS/22 SHA0013000088
83 Allen T70.170

in one hospital should have a noticeable impact on the very much larger figure of the total deaths in the region.

West Midlands Strategic Health Authority meetings with trusts

5.72 The WMSHA swiftly arranged a series of meetings with the trusts concerned. It was clearly aware of the potential relevance of the HSMR results to patient safety, in spite of the reservations that had been expressed by Mr Allen. In its letter inviting the Trust to a meeting it stated that it anticipated the meeting to be a:

> *constructive dialogue as part of our overall drive to improve patient safety … The overall aim of the exercise is to assess the true extent of excess mortality in the West Midlands that requires further scrutiny and whole systems action to improve patient safety.*[84]

5.73 The one FT with a higher than average mortality (Heart of England NHS Foundation Trust, which had an HSMR of 110) refused to meet the WMSHA, and the PCT was therefore asked to engage separately with this trust on that issue.

5.74 The WMSHA met the Trust on 16 May 2007. Mr Blythin told the Inquiry that he had been reassured by the Trust's presentation at the meeting because it had come prepared and were taking the issue seriously.[85] Dr Rashmi Shukla said that she had had no reason to doubt the assurances that the Trust offered.[86] They had had less confidence that two of the other trusts were taking the appropriate action.

5.75 The meeting was not minuted but the letter[87] written subsequently by Dr Rashmi Shukla and Mr Blythin to Mr Yeates, and copied to Stuart Poynor of the PCT and Cynthia Bower, Chief Executive of the WMSHA, contained some information about what took place. The letter noted that the Trust's own analysis revealed issues in common with other trusts that were in a similar position. These issues included the quality of coding, limited palliative care services in the community, and different results produced by CHKS. The WMSHA asked for a report to be sent to the Trust Board, detailing the WMSHA's investigation and action plan, its clinical audit plan, and its strategy for developing further the Trust's focus on quality and patient safety. Mr Yeates was also asked to keep the WMSHA informed of any explanation he obtained from DFI for the change in the figures. Progress was to be reviewed in a month in conjunction with the PCT.

84 RS/19 SHA0039000181; CLO0000000151 WMSHA Closing submissions (section D) para 40
85 Blythin T69.169
86 Shukla WS0000018550, para 73
87 PB/11 SHA0025000260

5.76 The WMSHA felt so little concern about the Trust's position that, in its feedback to the DH expressing support for the Trust's FT application,[88] it made no mention of the issue. Peter Shanahan accepted in his evidence that it ought to have been mentioned.[89] Cynthia Bower was more qualified in her assessment:

> *Well, I think it would be helpful and certainly a more defensible position now had it done that ... the only thing I would add is that no one would, I think, defend now the extent to which there was a sort of robust challenge on quality as part of that – that phase of the FT process. We weren't being asked at that stage to focus on quality as part of the judgement that we were making ...*
>
> *I accept that it would have been better had we referred to it. The only thing I can say in mitigation, if you like, is firstly, that, as I say, by and large it wasn't asking us for an overall statement about quality in the organisation. I'm sure had they done, we would have raised this issue ... And secondly that – sorry – that – the fact of the high HSMR was in the public domain. It wasn't privileged information that we held.*[90]

5.77 At the time, she said, a high HSMR was not viewed as an automatic indicator of poor-quality care. She accepted, however, that at this time the WMSHA did not know whether or not the HSMR represented poor care and, therefore, that they should arguably have informed the DH of this in the feedback.[91]

Report to West Midlands Strategic Health Authority Board, 29 May 2007

5.78 A report by Mr Blythin and Dr Shukla for the WMSHA Board meeting on 28 May was enclosed with the letter.[92] This indicated the potential scale of the problem that had been disclosed:

> *The Dr Foster data suggests that on average there is an excess of 2000 deaths in the acute hospitals each year in the West Midlands that cannot be accounted for by factors such as age, socio-economic deprivation, other* [sic] *significant illnesses. Clearly this is a matter of concern for the SHA and requires further investigation. In addition the variability across our hospitals as indicated by the Dr Foster data needs to be challenged and rectified where shortcomings in patient safety and quality of care are identified.*

5.79 The report identified common themes that had emerged from the meetings with five trusts, including the Trust itself:

88 PWS/10 WS0000020759
89 Shanahan T72.131–132
90 Bower T73.114–115
91 Bower T73.116
92 SHA0025000269–70; this report contains the matters described in the bullet points below.

- All trusts were preparing action plans to be presented to their boards and to be shared with the SHA;
- All trusts had looked at whether there was "dubious" clinical practice "and reported that this was not the case in relation to their high rates". However, there was a "variable" approach to quality improvement:
  In the main there appeared to be a lack of a systematic approach to clinical audit, management of serious adverse events, complaints and use of benchmarking internally of Clinical Indicators on a regular basis. It was not clear how much engagement there was on this at board level. This is an area that [sic] *the SHA will be expecting early actions;*
- Quality of coding was identified by all five trusts as a significant factor. There was incomplete coding of the main primary diagnoses, of co-morbidities and of palliative care. Trusts that had improved coding had reduced their mortality rates by this action alone;
- Some trusts reported that a comparison of Dr Foster data with CHKS data produced different mortality rates and the issues raised by this would be followed up;
- Lack of palliative care in the community and associated poor coding for such care were cited as factors.

5.80 The steps WMSHA intended to take included:

- Commissioning an independent analysis from Professor Richard Lilford and Dr Mohammed Mohammed of Birmingham University to determine whether there were actually excess deaths in the West Midlands. This would look at:
  - The effect of coding quality and completeness;
  - The level of palliative care available in the community;
  - The effect of Dr Foster's selection of diagnoses;
  - Whether any aspects of the DFI HSMR methodology had a disproportionate effect in the West Midlands;
  - The differences between HSMR and CHKS methodologies; and
  - Aspects of trust governance systems associated with lower mortality.

- Following up with the trusts on the agreed actions:

  ... with a specific expectation of ensuring there is a robust systematic approach to quality and patient safety and that there is clear evidence of board engagement and ownership of these issues.

5.81 Each trust would be asked to identify for the Birmingham University team a "tracer condition" which it thought might have contributed to a "selection bias". A further four tracer conditions would be included.[93]

93 Stroke, fracture of neck of femur, acute myocardial infarction and colectomy; see RS/25 WS0000018850-2

5.82 In response to questions from non-executive directors, one of the directors[94] advised at the board meeting that the concern was that:

> *There are different methodologies used. The DH when releasing the Dr Foster report made a clear statement that the report and its findings should not be used as an indicator of patient safety.*[95]

5.83 The WMSHA submitted, not unreasonably, that too much should not be made of a brief minute, and that whatever it understood the DH guidance to be, this did not lead it into considering that no action was required.

5.84 The Board agreed the report's recommendation and required that a report be presented at its meeting in January 2008, eight months later.[96]

5.85 It is notable that, in its letter to the Trust, the WMSHA gave no hint that the Trust should be undertaking any form of retrospective analysis of its own. Instead, it merely sought to assure itself that a clinical audit system was in place, and to see what the Trust had done with regard to the HSMR result. Peter Blythin accepted in his evidence that the WMSHA had in effect assumed that trusts would take the action outlined in their plans:

> *Whilst the accounts* [given by different trusts] *were variable, what we did see is that Mid Staffs Trust gave a good account of what they were doing. What we did not do was to check that the strategy and the Clinical Audit Plan were actually in place and being enacted. We expected that where actions had been agreed, they would be followed through.*[97]

5.86 The emphasis, both in the letter and in the report, was on challenging the significance and reliability of the DFI data, by looking at data quality, coding and methodological issues, rather than on taking whatever steps were necessary to protect patients, including actually examining patient outcomes during the relevant period. The consideration of clinical governance was to be limited to trusts with low mortality rates in order to attempt to identify the feature of governance associated with lower levels of hospital mortality. This was a very restricted approach, given the potential extent of excess deaths in the West Midlands. It remained a possibility that these deaths, or at least a proportion of them, were attributable to poor care. Consequently, there was an urgent need to examine that issue in order to protect patients now and in the future. Furthermore, without such an exercise, the duty to inform those affected by harm done to patients could not be fulfilled. Instead, the instinctive reaction of the WMSHA was to look to challenge the credibility of the data, rather than to

94 CLO0000000148 WMSHA closing submissions section D para 33
95 RS/23 WS0000018831
96 RS/23 WS0000018831
97 Blythin WS0000019664, para 97

assess its serious implications for patient safety. The owner of a nuclear power station told by an apparently bona fide source that there might be a leak of radiation, would immediately examine the plant to see if there was a leak and would be heavily criticised if its primary focus was to challenge the credibility of the informant.

Commissioning of the West Midlands Strategic Health Authority study

5.87 A meeting between the WMSHA, Professor Lilford and Dr Mohammed to discuss the scope of the study took place on 21 June 2007. Representatives of the affected trusts attended but no representatives of the PCT were present.

5.88 Professor Lilford was Professor of Public Health and Epidemiology at Birmingham University, and Dr Mohammed was a research fellow in the same department. Both were highly regarded in the field of mortality analysis; Professor Lilford was described by Professor Sir Liam Donaldson as a "doyenne *[sic]* of health statistics".[98] In 2004, they had published an article that was critical of HSMR type methodology and the use to which it was being put. In the article, they had said:

> *... the danger ... is that in the search for improvement, comparative measures of mortality and morbidity are often overinterpreted, resulting in judgements about the underlying quality of care. Such judgements can translate into performance management strategies in the form of capricious sanctions (such as star ratings) and unjustified rewards (such as special freedoms or financial allocations). The resulting risk of stigmatising an entire institution injects huge tensions into health-care organisations and can divert attention from genuine improvement towards superficial improvement or even gaming behaviour (ie, manipulating the system). These dangers apply particularly to measures of outcome and throughput. We argue that comparative outcome data (league tables) should not be used by external agents to make judgements about quality of hospital care. Although they might provide a reasonable measure of quality in some high-risk surgical situations, they have little validity in acute medical settings ... We argue further that although outcome data is useful for research and monitoring trends within an organisation, those who wish to improve care for patients and not penalise doctors and managers, should concentrate on direct measurement of adherence to clinical and managerial standards.*[99]

5.89 Dr Shukla did not recall that the proposed researchers came to the proposed subject of research with pronounced views,[100] and there is no evidence justifying a conclusion that any knowledge of their previously expressed views played a part in their appointment for this task.

98 Donaldson WS0000070150, para 140
99 Lilford R, Mohammed MA, Spiegelhalter D, Thomson R. (2004) Use and misuse of process and outcome data in managing performance of acute medical care: avoiding institutional stigma, *The Lancet*, volume 363, pages 1147–1154
100 Shukla T68.146–7

5.90 At the scoping meeting on 21 June 2007, it was agreed that the scope of the analysis would address:[101]

- The extent, if at all, to which variable quality and completeness of coding affected the results;
- The level of hospice and community palliative care provision around each hospital;
- The effect of the selection of diagnosis codes used in Dr Foster methodology on the results;
- Whether there were other aspects of the Dr Foster methodology which "has a disproportionate effect on" the results;
- The "key differences" between the methods used by Dr Foster, CHKS and other agencies;
- The features of hospital governance systems associated with low hospital mortality.

5.91 Other issues were identified for further consideration, including:

- Risk adjustment bias;
- Tracking HSMR against crude mortality rates;
- A "re-do analysis" by Dr Foster "pending better understanding of the detail and methodology";
- A review of the provision of end of life care;
- Use of laboratory data to adjust for case mix;
- Training of coders and changes in coding;
- An investigation to establish the proportion of deaths at the trusts which were within the 56 diagnoses included by Dr Foster.

5.92 All the above issues, namely the seven points and the matters identified for further consideration above, concerned the methodology of Dr Foster, and a search for statistical factors which might explain the results. The one item for further consideration that was relevant to the standard of care lying behind the figures was, as foreshadowed in the WMSHA Board report:

> *Consideration of audit against the standards for tracer conditions with limited sample size. Suggestions for tracer conditions included stroke, facture neck of femur, acute myocardial infarction.*[102]

5.93 These were selected because, in each case, nationally agreed process measures were available for them.[103] With regard to this proposal it was agreed that each trust would in

101 RS/25 WS0000018850
102 RS/25 WS0000018851
103 Allen T71.9 Shanahan T72.142

addition identify "a tracer condition that in the opinion of the trust may contribute to a selection bias".[104]

5.94 Another issue identified for further consideration was:

> *testing of the hypothesis of whether the quality of care is poor ... using a number of methodologies including mortality rates, case notes review, staff surveys, etc*[105]

5.95 In general, therefore, the focus of the intended research was on issues connected with coding, data quality and methodology and other issues which might demonstrate a statistical bias. The tenor of the meeting, even if not intentionally, was one of starting from a premise that the HSMR did not assist in identifying poor quality of care and that such a link needed to be disproved.

5.96 A steering committee was set up to oversee the research. It was chaired by Dr Shukla, and other members included Steve Allen and Steven Wyatt of the WMSHA as well as representatives of each of the acute trusts affected and some PCTs.[106]

DFI apology to the Trust

5.97 Martin Yeates met the DFI representative on 1 June 2007, following which Rob Forbes, Head of Sales at DFI, wrote to Mr Yeates on 4 June.[107] With regard to the change in the Trust's HSMR, Mr Forbes suggested:

> *There are a number of possible explanations for this movement, for example, it may be that the trust's coding of secondary diagnoses is relatively weak.*

5.98 He recognised there had been a lack of an opportunity to understand the changes and offered an apology for the "negative impact" this had caused to the Trust. DFI offered to work with the Trust to identify areas for improvement:

> *By tackling potential coding issues at this early stage, the trust may be able to resubmit data via the monthly upload to HES. This may then have a positive impact in your 2006/07 HSMR, if the underlying issue is around data quality.*[108]

5.99 This letter undoubtedly emphasised poor coding as a possible explanation for the figures and offered support to improve this in an attempt to see if the figures improved. No other step

104 RS/25 WS0000018852
105 RS/25 WS0000018852
106 For a full membership list, see SHA0020000023
107 RT/5 WS0000042645
108 RT/5 WS0000042646

was suggested. However, the letter was explicit in stating that poor coding was not necessarily the whole or even partial explanation, and did not suggest that improvement of coding was the only step to take. What was disclosed was an unsatisfactory situation from the Trust's point of view. Its management had been left to handle the consequences in public of a sudden upward shift in its HSMR, with no notice and with little indication of whether the figure might be capable of correction by resubmission of data. Unfortunately, this understandable difficulty contributed to a shift by the Trust and others away from the need for a thorough examination of clinical performance and outcomes and towards a focus on challenging DFI methodology.

Report to Trust Board, 4 June 2007

5.100 On 4 June, at a Clinical Effectiveness and Quality Group meeting with DFI, Dr Coates reported that he was looking at mortality rates in two patient groups of 100 patients and that work on this was "ongoing".[109] However, in a report on the meeting, it was recorded that:

> *The Trust is of the opinion that the level at which Dr Foster is stating that the Trust is at, is incorrect. As a result further investigation is to take place with the notes of every patient who died during 2006/7 to be re-visited to establish if the coding was correct.*[110]

5.101 The intention was to submit the corrected data to DFI to enable them to report the correct data. Other steps taken included a ban on the use of codes for syncope, and for abdominal pain when a patient was discharged. It was noted that there was excessive mortality in the diagnostic groups of syncope, abdominal pain and confusion.

5.102 On 7 June, Dr Helen Moss submitted a report on the issue to the Trust Board, which was shared with the WMSHA.[111] The report identified three reasons why the published HSMR was of "great concern" to the Trust:

- It raised the issue of whether the Trust had a "significant clinical problem";
- There was a risk of a loss of public confidence from media coverage;
- There was the question of why the published result was higher than that discussed two months previously with DFI's representative.

5.103 Dr Moss reported that in order to establish whether there was a "potential overarching clinical problem a simple analysis was undertaken of the Trust's raw data to establish an overall Trust mortality rate".

109 HM/14 WS0000009678
110 HM/12 WS0000009664
111 PB/15 WS0000019882

5.104 Using this method, the Trust's mortality rates for 2005/06 and 2006/07 were calculated as 1.5% and 1.3% respectively. They fell, therefore, within the national range of an overall trust percentage as identified by CHKS (1.5%–3.0%). From this exercise Dr Moss drew the conclusion that:

> *It appears that the trust's overall mortality rates are at the lower end of the national benchmark. The trust can therefore be assured that there are no obvious major underlying problems in terms of the overall mortality rate.*[112]

5.105 The rest of the report focused on the quality and accuracy of the Trust's coding "On the basis that overall mortality did not appear to be a significant issue for the Trust".

5.106 A case note review was conducted of the diagnostic groups which were the highest rated in the HSMR: syncope and abdominal pain. However, this focused on the accuracy of coding, rather than the quality of the care. In the case of syncope, for example, nine out of 14 recorded deaths were reviewed and the diagnosis coding was changed in six cases.[113] Similarly, of the six out of 11 deaths in the abdominal pain group, all were recoded. It was observed that the first diagnosis recorded at the Trust was often a sign or symptom, rather than a definite diagnosis.

5.107 The report stated that a total of eight actions had been taken. These included improvements to coding, implementation of corporate governance structures and development of new reports in clinical key performance indicators for the Board.[114] A further action listed was the undertaking of a nursing skill mix review. There was no explanation offered in the report of why this was an action in response to the HSMR.

5.108 Eleven recommendations were made.[115] Again, these were mainly aimed at improvements in coding quality, but also included the establishment of a mortality group "to audit case notes led by the clinical lead for audit, with a weekly review by consultants".

5.109 At the Board meeting, it was recorded in the minutes that "The trust's overall mortality rate was at the low end of the national bench mark. There were no obvious major underlying problems."[116]

5.110 There was concern that DFI might not accept corrected data, and that coding had to improve in spite of the issue having been raised with consultants the previous year. It was believed that the Trust was not being paid properly as a result of incorrect coding.

112 PB/15 WS0000019883
113 PB/15 WS0000019885
114 PB/15 WS0000019889–90
115 PB/15 WS0000019890-1
116 ESI00029784 Minutes of private meeting of Trust (7 June 2007)

5.111 Professor Jarman was asked to comment on the analysis in the board report and was heavily critical of it. It was not, he thought, appropriate to compare Trust and national crude death rates because no adjustments had been made for any variable, unlike the HSMR in which a large number of variables had been taken into account. Crude mortality did not compare like with like. Even if there was any validity in comparing the Trust's crude mortality with a national rate, he calculated that, for non-elective admissions, in which category the great majority of deaths understandably occurred, the mortality rate was higher than the national average by 9% in 2005/06 and 30% in 2006/07. Therefore, properly viewed, little comfort could be taken from that rate.[117] Professor Jarman also considered that the death rate reported to the Board as being 1.3% (see above) should have been 1.9%.

5.112 Roger Taylor of DFI told the Inquiry that it was extremely unlikely that coding alone could have explained the high HSMR, but explained that DFI never gave such an opinion to trusts, in part because:

> *... you can't really move the debate forward until people have dealt with that issue* [data quality]. *Unless you've got some degree of agreement around the data, you're never going to get anywhere ...*
>
> *We would never say to a customer, "We know this is clinical quality", because we don't* [...] *And we would never say, "We know for a fact that it isn't due to coding of data", because we don't know that. All we can do is say, "Yes, you need to make sure your data's right". And we can say, "It's probably not going to be coding at the end of the day."*[118]

5.113 Professor Jarman rejected the notion that the HSMR used coding of signs and symptoms; he clarified that HES and SUS use the first primary diagnosis. He quoted the HES guidance:

> *HES/SUS use primary diagnosis as the patient diagnosis for (1) the main condition treated or investigated during the relevant episode of healthcare and, where there is no definite diagnosis, the main symptom or abnormal findings or problem.*[119]

5.114 This appears to mean that there are, in fact, circumstances in which a sign or symptom is used in HES, and in any event syncope and abdominal pain, which are clearly signs rather than diagnoses, appear in the list of codes used (CCS groups 245 and 251). Professor Jarman provided one explanation in a published article, in which he stated:

117 Jarman WS0000042798, para 155
118 Taylor T99.185
119 Jarman T98.75–76

For each spell we assign a diagnosis based on the primary diagnosis in the first episode of care. However, if the primary diagnosis is a vague symptom or sign we look to the subsequent episode (of a multi-episode spell) to derive a diagnosis.[120]

5.115 Without intending to suggest Professor Jarman is wrong in his description of or his reaction to the Trust's analysis on this point, it is understandable that, at least in 2007, those less expert than he might consider that coding for certain signs and symptoms was taken into account and that a recoding of such cases might be a valid exercise. It was also predictable that confidence in the reliability and significance of HSMR would be damaged by the inadequate notice and explanation of changes to the methodology. To provide comparative data, the recording, classification and interpretation of HSMR data is unfortunately a highly sophisticated statistical exercise: those not familiar with its advantages and limitations may easily make fallacious deductions.

5.116 These points, however, do not excuse a failure to think first of what was necessary to safeguard patients. In its partial review of past deaths the Trust looked only at coding accuracy, and otherwise contented itself with putting in place some audit measures for the future. As it could not be said that the HSMR, for all its possible problems, was not an indication of a need to review the effectiveness of clinical practice as advised by DFI, such a review should have been undertaken thoroughly. There was, at the time, absolutely no justification for unequivocal statements that the Trust had no problem with mortality.

"Red" rating given to Trust by West Midlands Strategic Health Authority

5.117 On 16 June, Jonathan Lloyd of the WMSHA generated a document containing a risk rating for each of the trusts in the region. The Trust was rated red by the WMSHA for quality and safety and was scoring poorly against the 18-week target. Out of 22 trusts, eight were given an overall "high" or "red" rating for quality and outcomes, including the Trust. The reasons listed in the document for the Trust's rating were Dr Foster, HSMR and a high rate of healthcare associated infections (HCAIs) with no plan to reduce *C. difficile*. Three other trusts were also given high ratings for the same reason: Burton, the Dudley Group and University Hospitals Coventry and Warwickshire.[121] Mr Allen's oral evidence was that this rating did not particularly distinguish the Trust from its peers. In addition to the other trusts listed in this document, there were two foundation trusts causing concern with regard to their HCAIs. The WMSHA was the worst-performing SHA in England in relation to HCAIs and *C. difficile* at the time that he took up his performance post.[122]

120 BJ/11 WS0000042926; Jarman WS0000042756, para 59
121 STA/8 WS0005000279
122 Allen T71.54–59

Trust meeting with Dr Foster Intelligence on 28 June 2007 and offer of help

5.118 On 28 June, a representative of DFI met Martin Yeates to discuss the issues with the Trust's HSMR. In a letter dated 29 June,[123] following the meeting, the representative apologised for DFI's "mishandling" of communication of the revisions to the HSMR and publication of the data. DFI offered to work with the Trust to improve its data quality: revised data submitted in August could be uploaded that month. There was also an offer, not taken up, for the Trust to work with DFI in a project to understand data quality for a set of patient safety indicators.

5.119 A summary analysis of the Trust's crude mortality was enclosed. According to Roger Taylor, the purpose of doing this was to emphasise that the rate offered no assurance that the Trust's mortality was within normal limits:

> *... [it] was to tell them that they should take no comfort from the fact that the overall crude mortality rate was normal, as this did not contradict the finding that they had a high HSMR. It appears that at some point someone has taken the wrong message.*[124]

5.120 He accepted, however, that this message was not explicitly conveyed to the Trust. He felt that this should not have been necessary when communicating to anyone working with statistics in the NHS, as to use crude figures in that way would have been an "extreme misuse" of them.[125] That assurance was taken later on from the crude figures in the information given to Monitor was, he thought, "extremely worrying".

5.121 Mr Taylor was very critical of a presentation given by the Trust to the WMSHA in November 2007 (see below) and, in particular, the statement in it to the effect that, at the June meeting, DFI had confirmed that the Trust's mortality was within national norms.[126]

5.122 DFI is obviously not a regulator and has no responsibilities other than as a commercial provider of information to trusts under contract and to the public, but it did not offer complete clarity with regard to the significance of the information it was providing to the Trust: namely that, although erroneous coding might be an explanation for the figures, it would also be prudent to carry out a review of possible clinical causes. Quite properly, DFI was bound not to overstate that significance beyond what was supported by the evidence. To have done so would have been counterproductive, would have increased the scepticism already harboured in some quarters and could have resulted in an even greater focus on the accuracy of the figures. Nonetheless, both problems could have been avoided by a polite reminder that the results were consistent with a patient safety issue which should therefore be investigated and ruled out, even while coding was also being reviewed.

123 RT/6 WS0000042648
124 R Taylor WS0000042629, para 62
125 R Taylor T99.94–95
126 R Taylor T99.85

5.123 DFI was possibly more diffident than it might have been in its advice to the Trust because of the genuine misunderstanding that had resulted from the failure to give sufficient warning of the change. This made it more difficult for DFI to make blunt statements about the meaning of the HSMR results and what steps the Trust ought to consider in response to these results in the interests of patient safety.

5.124 DFI's unassertive approach was in part due to a wish to persuade the Trust of the usefulness of a method that, at the time, was controversial, and not to deter it from being more open about its outcomes.

West Midlands Strategic Health Authority receipt of information on action by the Trust Board

5.125 On 15 June, the Trust sent the WMSHA documents evidencing its action plans.[127]

5.126 On 17 July, Martin Yeates sent the WMSHA a copy of DFI's letter of 29 June (see above).[128] Mr Yeates wrote:

> *As I mentioned to you when I last saw you Dr Foster have now confirmed that in the overall assessment of mortality rates, our Organisation is at the low end of the spectrum in terms of a national benchmark across all diagnoses.*
>
> *This assessment further corroborates the view we had reached following the letter from CHKS which was produced in response to the media coverage on the Dr Foster's information. Clearly this gives the organisation, and particularly our clinicians some comfort that in overall terms, our mortality rates do not appear to provide any significant concern.*
>
> *It does reiterate for us, the importance of our data capture and coding which, as I have indicated to you previously, needs some attention and on this Issue* [sic] *we have invested additional resource ... The clinical body are also obviously far more focused on this issue and we anticipate that marked improvements will be shown in future.*[129]

5.127 Mr Yeates claimed that an audit had been carried out of all the case notes of patients who had died in the hospital during the last quarter of 2006/07, but it is clear that this was in relation to coding to enable revised data to be submitted, rather than being a clinical audit.

5.128 He also claimed:

> *As you recall Dr Foster used 56 diagnoses rather than overall mortality rates, this being the reason for the skewed results for this Trust.*

127 RS/27 WS0000018856, correspondence and Patient and Public Partnership Plan; SHA0011000021, Clinical Audit Annual Plan
128 RT/6 WS0000042648
129 RS/26 WS0000018853–5, WS0000018553, para 84

5.129 He noted that DFI had apologised but accepted that lessons had been learned. However, these appear to have been entirely in connection with coding:

> *Our need to significantly improve* [sic] *our overall data capture and coding is of paramount importance and as indicated earlier arrangements are now in place to assure us these improvements are being taken forward.*

5.130 The WMSHA was satisfied with the Trust's approach. Dr Rashmi Shukla thought it was "reasonably robust" and better than others received by the WMSHA.[130] She told the Inquiry that she had had no reason to believe that the Trust was not following through with its plans. She added, however, that, if encountering the same circumstances again, she would now consider the information collated in the WMSHA's "clinical quality dashboard" and would review the clinical audit plan against national standards on audit, and seek assurance that the Trust Board understood the importance of clinical audit. She would make enquiries about the leadership and culture of the Trust, matters in which she hoped the WMSHA's relatively recently devised "appreciative inquiry" scheme would assist.[131] Peter Blythin also thought that the Trust had given a "good account" of its actions.[132]

5.131 Professor Ian Cumming, Chief Executive of the WMSHA at the time of this Inquiry's hearings, accepted in his evidence that, "with the benefit of hindsight", the Trust's approach was "very clearly wrong". He went on to accept that it could be said to have been wrong "even without the benefit of hindsight".[133]

5.132 For the reasons considered above, Professor Cumming was right to accept that the Trust's analysis was wrong, but there is no indication that the WMSHA did anything other than accept it at the time. Indeed, the WMSHA pursued the approach with some vigour through its commissioning of the analysis by Professor Richard Lilford and Dr Mohammed Mohammed.

5.133 Martin Yeates's letter contained unintentionally misleading statements, in that:

- DFI had not confirmed that the Trust was at the low end of the spectrum. It had produced crude mortality figures at the Trust's request;
- The crude figures did not, when properly viewed, indicate there was no concern about the Trust's mortality rates;
- The DFI results were not "skewed" by reason of focusing on 56 diagnoses. While there was, and remains an argument between statisticians over the merits of amalgamating the figures for a more limited number, as done by DFI, or including all diagnoses, as now done by SHMI statistics, the point of both exercises is to compare one hospital's performance

130 Shukla T68.138
131 Shukla WS0000018554–5, paras 87–89
132 Blythin WS0000019664, para 97
133 Cumming T67.76–77

with all similar hospitals in relation to the same group of diagnoses. A deficiency in coding quality should not have been expected to be limited to the Trust. It might be thought that the variability of such deficiencies between trusts would diminish their effect;
- Whatever action the Trust had taken, it had not included a retrospective clinical audit of the relevant cases.

5.134 These inaccurate statements by Martin Yeates were probably due to his lack of understanding of the implications of the statistics, rather than any intention to mislead. Another factor may have been the views being expressed by clinicians. On 30 July, Dr Val Suarez and Dr Philip Coates reported to the Trust Executive Governance Group that "It was established that the poor result was due to the coding issue."[134]

5.135 From this point on, the Trust consistently represented itself to others as having "no problem with mortality".

West Midlands Strategic Health Authority meeting with Dr Foster Intelligence, August 2007

5.136 On 22 August 2007, Dr Shukla, Steve Allen and Steve Wyatt, among other representatives of the WMSHA, along with a member of Dr Mohammed's research team, met representatives of DFI. According to Dr Shukla, the purpose of the meeting was to discuss the WMSHA's "concerns", in particular their presentation of information and use of a "league table",[135] and to explore the differences in approach.[136] In the SHA's letter to DFI inviting it to the meeting, among the material asked for was any research evidence that higher HSMRs were attributable to poor quality of care, medical error or infection.[137]

5.137 DFI gave the WMSHA a presentation which indicated that, whichever of the three different methodologies (normal method HSMR, last admission HSMR, and all deaths within 30 days of admission HSMR), was used to calculate HSMRs,[138] "In general, NHS Trusts with high HSMRs are high using all three methods."[139]

5.138 Copies of the HSMRs for all West Midlands trusts for 2005/06 were provided. In response to requests from the WMSHA, DFI provided copies of the HSMRs, diagnosis by diagnosis, for the West Midlands trusts, including the Trust.[140] A summary of the figures provided is set out in Table 5.5.

134 ESI00217986 Trust Executive Governance Group notes dated 30 July 2007
135 Shukla WS0000018555, paras 90–91
136 Shukla T68.177
137 RS/29 WS0000018876
138 Jarman WS0000042800, para 158; BJ/42 WS0000043134. The results for the Trust were: normal HSMR 127; last admission HSMR 116; 30 Days of admission HSMR 120.
139 RT/16 WS0000044113
140 RT/17 WS0000044120–55; Shukla T68.174–175

Table 5.5: West Midlands Strategic Health Authority mortality rates, financial year 2005/06 – all diagnosis groups[141]

Trust	Spells	Deaths	Crude rate	Expected	HSMR	Low	High
University Hospital of North Staffordshire NHS Trust	41,192	1,485	3.60%	1,672.5	88.8	84.3	93.4
Shrewsbury and Telford Hospitals NHS Trust	27,052	1,172	4.30%	1,277.9	91.7	86.5	97.1
Sandwell and West Birmingham Hospitals NHS Trust	33,995	2,062	6.20%	1,996.2	103.3	98.9	107.9
Hereford Hospitals NHS Trust	9,958	7,33	7.40%	707.2	103.6	96.3	111.4
University Hospital Birmingham NHS Foundation Trust	32,655	1,753	5.40%	1,883.1	104.2	99.3	109.1
Worcestershire Acute Hospitals NHS Trust	27,922	2,014	7.30%	1,836.4	109.7	104.9	114.8
Walsall Hospitals NHS Trust	19,935	1,180	5.90%	1,070	110.3	104.1	115.8
South Warwickshire General Hospitals NHS Trust	13,179	921	7.10%	830.3	110.9	103.9	118.3
The Royal Wolverhampton Hospitals NHS Trust	28,037	1,629	5.80%	1,463.5	111.3	106	118.8
Heart of England NHS Foundation Trust	57,581	3,213	5.60%	2,754.4	118.7	112.7	120.8
University Hospitals Coventry and Warwickshire NHS Trust	31,625	2,164	6.90%	1,761.3	122.8	117.7	128.1
The Dudley Group of Hospitals NHS Trust	23,885	1,575	6.60%	1271	123.9	117.9	130.2
Mid Staffordshire General Hospitals NHS Trust	14,073	878	6.30%	698.6	125.7	117.5	134.3
Burton Hospitals NHS Trust	14,835	929	6.30%	711.4	130.6	122.3	139.3
George Eliot Hospital NHS Trust	11,468	1083	9.60%	745.5	146.3	136.8	154.2

5.139 The SHA could not produce a note of the meeting and that made by Dr Foster[142] does not assist on whether any answer was given to the question about research evidence on the attributability of high HSMR to quality of care.

5.140 After mentioning the areas of statistical interest for the SHA, the DFI note reported that "In all it was a very positive meeting. The SHA is obviously keen to get on top of the issue."[143]

141 Figures taken from RT/17 WS0000044120–55
142 RT/15 WS0000044105
143 RT/15 WS0000044105

5.141 It is not clear what, if any, use the WMSHA made of the more detailed mortality information. A significant number of West Midlands trusts, as indicated in the 2007 *Good Hospital Guide*, appeared to have significantly high mortality in a number of diagnostic groups, but there does not appear to have been a discussion about specific trusts.[144] Dr Shukla was also unable to recall what, if anything, the WMSHA had done with this information:

> *Q. My question is, when you received that information, what did you do with it? Did you do anything with it?*
>
> *A. Well, we discussed it at the meeting. This was – this was sent in advance of the meeting, and I cannot recall all of the conversation because I have to admit some of it was statistical conversation which –*
>
> *Q. Okay?*
>
> *A. – I don't have the necessary expertise in.*
>
> *Q. All right. But – it sounds as though this didn't happen, please tell me if it did, you didn't take the disease breakdown and look at particular diagnoses and say "That pathway seems to be particularly problematic, let's do some investigation around why that might be"?*
>
> *A. Not on the Dr Foster data, no.*
>
> *Q. Why not?*
>
> *A. I can't recall that. We'd already identified ... at the time, three – four conditions that we were going to look at, and we didn't have a single pathway across the trusts. And, again, I'm recalling from memory, that was specific problem across all the trusts, because ... the University of Birmingham was kind of an overarching piece of work, and if there were particular conditions, and they might have been worth looking at.*
>
> *Q. It seems curious to seek this data in order to look behind the figure, but not really to do anything with it. It's as though you tried to identify particular problem areas but then that was where it ended, if you did identify them; is that fair?*
>
> *A. I can see why it ... can be construed as such. But the ... meeting was primarily to try and get some sort of discussion about the approaches and the views of the different organisations, at the SHA and the Dr Foster. So it was a starting point for a conversation between ourselves and Dr Foster around their approach to quality of care and our approach to quality of care.*[145]

144 Shukla WS0000018555, para 91
145 Shukla T68.175–177

5.142 The WMSHA at the time was clearly not convinced of the significance of the HSMR. As Dr Shukla explained, it was hearing comments from clinicians and others in the NHS about the effect of coding and palliative care availability on the ratings, among other issues, and it was not sure of the extent to which this was true. Dr Shukla was asked:

> *Q. Was there a danger that the SHA was a little bit too concerned with the debate about the value of the statistic overall to the NHS and not sufficiently concerned with what the statistics might tell it about the institutions under its management?*
>
> *A. No, I don't think so. I think ... that what we undertook to do was over and above what might have been expected for the SHAs. I don't recall any external body saying to us that "You must take heed of the HSMR. The HSMR is the standard measure for quality and, therefore, you must be looking into it in this way or that way". What we did do was talk to the individual trusts. I appreciate with benefit of hindsight that there are a lot of issues that perhaps weren't shared or available at the time. And we did undertake this piece of work as a genuine desire – aside from any, you know, personal views about HSMR, as a genuine desire to really add to the knowledge around HSMRs. Although I can understand that others may construe it in a particular way, that was not the reason for doing the piece of work.*[146]

Monitor interview of West Midlands Strategic Health Authority representatives, October 2007

5.143 As noted in *Chapter 4: The foundation trust authorisation process*, the Monitor assessment team interviewed representatives of the WMSHA as part of the FT application process. No mention was made then of the HSMR or the work being done about it. Peter Shanahan was recorded by Monitor as saying that there were no problems with quality at the Trust. Cynthia Bower had claimed in her witness statement to the Inquiry that Monitor had been informed of the work commissioned by the WMSHA, but in oral evidence she could not provide any information as to when this had occurred.[147] She pointed out that, at the time, the WMSHA did not believe that the HSMR meant that there was a problem with quality at the Trust; otherwise, it would have raised the matter with Monitor:

> *... I am confident that had we believed that the work that we had undertaken had revealed significant problems in the quality of care in the organisation that the organisation wasn't addressing, then we would have flagged that up with them. That's not – however erroneous that might have been, that's not the position that we believed we were in with this trust at the time that the authorisation was given.*[148]

146 Shukla T68.133–134
147 Bower T73.119–120
148 Bower T73.121

West Midlands Strategic Health Authority meeting with Trust, November 2007

5.144 On 20 November 2007, Dr Shukla met representatives of the Trust, including its Chief Executive, Martin Yeates, Dr Philip Coates, the Clinical Governance Lead and Phil Smith, the Information Manager. A representative of the SSPCT also attended. A presentation was given, which continued the line previously taken by the Trust that the crude mortality analysis showed that it did not have a problem. The slides and the SHA notes of the meeting included a number of reassuring statements:

> *Fosters confirmed that Mid Staffs mortality rate was within national norms:*
>
> *Rate across all England acute trusts when cleaned to HES standards (2005/06) = 2.02%*
>
> *Mid Staffs overall mortality rate = 1.94%*[149]
>
> *Mortality group has been up and running in the trust and undertakes case note audits of mortality occurring over one week period (around 25 cases per week).*
>
> *General overview of quality and safety – actions being taken forward as per the reports in previous communication with the SHA, back in May and the various action plans/ strategy shared with the SHA. All actions progressing and no particular areas of concern raised.*[150]

5.145 Dr Shukla felt that there was no reason to assess the Trust's clinical services while she was there and considered she had no reason to doubt the assurances she was given, in particular by Dr Coates.[151] She recalled, however, that she challenged the assertion that it had been agreed at the meeting with the WMSHA in May 2007 that the Trust's overall mortality was within national norms; the WMSHA had not given an indication one way or another on the assertions made by the Trust.[152]

5.146 She accepted in retrospect that the focus had been almost exclusively on the coding issue, but at the time, she had felt reassured that the Trust was doing more than that:

> *... the trust spent, obviously – and again with benefit of hindsight – a disproportionate amount of time focusing on coding. That's quite evident. At the time I did challenge the overall mortality rate ... and the crude mortality rate was not a measure that we particularly thought was a useful – it's a measure that's helpful but we wouldn't put any huge emphasis on that. And looking back on it, the trust kept coming back to it, which clearly was a sign of them constructing a particular approach.*

149 RT/18 WS0000044156, page 8
150 SHA0027000009
151 Shukla WS0000018556, para 93
152 Shukla T68.183

Q. You sound as though you're saying you can only see that with hindsight, but was it not obvious that you were being to a degree – that the issue was being heavily spun at the time?

A. I think because of the conversation with the clinicians, and ... both with Phil Coates on the day of the meeting in November and ... with the input from the trust around the various documentation that we requested, there was still the sense that the trust was doing more than just coding at that time. I accept that there was little substance behind those conversations. And however it might feel now, given what we now know, at the time we took it in good faith what was being told, that what was being said in terms of the assurances, the trust was undertaking because at that time there wasn't the indication that the trust wasn't following through on their plans.[153]

5.147 Roger Taylor of DFI was asked at the Inquiry to comment on the Trust's presentation, which he had not seen until then. He disputed the statement that DFI had confirmed that the Trust's mortality was within national norms; he asserted that DFI had in fact told them it should not regard a crude mortality rate as contradicting a high HSMR.[154]

5.148 Dr Shukla's explanation of the WMSHA's view of this presentation is difficult to understand. If, as she told the Inquiry, the WMSHA did not agree that the crude mortality rate was "useful", there is no evidence that she or anyone from the WMSHA discouraged the Trust from relying on it in the future, or that the WMSHA communicated it's view to Monitor. The unjustified reliance on crude mortality might have led the WMSHA to be concerned at the Trust's approach to the mortality issue as a whole, as might the very obvious focus on coding and data quality issues. Dr Shukla was no expert in mortality statistics and therefore cannot have been expected to be capable of a more than superficial assessment of the expert debate about the methodology. As a public health doctor, however, it is perhaps surprising that, even without the benefit of hindsight, she did not at the time look more deeply into whether patients' interests were being protected adequately by the steps being taken by the Trust. The opportunity was not taken at this meeting to discuss with DFI what scrutiny of individual trusts it would recommend; instead, the focus was on looking at the challenges to their methodology. The focus of the WMSHA remained, therefore, very similar to that of the Trust.

West Midlands Strategic Health Authority Board consideration of mortality after May 2007

5.149 After the WMSHA Board had agreed in May 2007 to the commissioning of the research by Professor Lilford and Dr Mohammed, it did not consider the matter again, apart from a brief mention at a meeting in November 2007, when it was informed that a report would be presented later. In March 2008, the Board discussed the announcement of the HCC investigation.[155] At that meeting, Cynthia Bower was recorded as saying:

153 Shukla T68.184–185
154 R Taylor WS(2) WS0000044092, paras 11–13
155 ESI00001976; Buggins T74.106

The chief executive said the Dr Foster data had been taken very seriously by the SHA and was acted upon immediately including the commissioning of Birmingham University to review the information in the report. She said there appeared to be nothing to indicate that anything out of the ordinary was taking place on mortality. A follow-up report will be available for the board meeting in May.[156]

5.150 Elizabeth Buggins, the WMSHA Chair, disputed that the WMSHA Board had in effect put the mortality issue "on the backburner" after commissioning the Lilford and Mohammed report, although she accepted that the formal board minutes might give that impression. She described how the WMSHA set about trying to identify ways in which an SHA could effect improvement in the commissioning and provision of services:

... there was a huge amount of activity and deep thought and intelligence gathering going on around the board table at that time, and we really tried to develop the board around this central issue of – of quality and improvement of services through the board development programme that we were running through that period.[157]

5.151 This work did not in fact appear to be directly related to the implications of the Dr Foster report. Ms Buggins had not seen the diagnosis-specific HSMR figures, which DFI had supplied to the WMSHA at or as a result of its meeting with Dr Shukla in August 2007. Having seen them in the course of the Inquiry, Ms Buggins agreed with the suggestion that they were "quite frightening".[158]

The reaction of South Staffordshire Primary Care Trust

5.152 The SSPCT became aware of the report concerning the Trust's high HSMR shortly after it was published in April 2007. Yvonne Sawbridge, Director of Quality and Nursing at SSPCT submitted a report on the issue to the PCT Board in May 2007.[159] She relied heavily on the assurances offered to the WMSHA by the affected trusts. For example, in the "key findings" of the report, she stated that:

All Trusts were confident that they had the processes in place to identify clinical practice that could have placed patients at risk and potentially contributed to high mortality rates. They had all looked at this particular issue and reported that this was not the case in relation to their high rates. Quality of coding was identified by all 5 Trusts as a significant factor in the trust performing so poorly.[160]

156 CURE0003000345 Unconfirmed minutes of WMSHA Board meeting (Tuesday 18 March 2008)
157 Buggins T74.109
158 Buggins T74.109–110
159 SP/21 WS0000014476
160 SP/21 WS0000014478

5.153 It is clear that the SSPCT did not have its own expertise to enable it to evaluate the validity of the assertions being made by the trusts and that it relied on the lead taken by the WSMHA to address the issue by commissioning the Lilford and Mohammed study.

5.154 Stuart Poynor, Chief Executive of SSPCT, told the Inquiry that, subject to that step, the SSPCT accepted the assurances given, including those of the Trust:

> *Given this context, the Trust's explanation was thought to be reasonable, pending the receipt of the SHA study commissioned from the University of Birmingham, and the PCT Board raised no further questions.*[161]

5.155 Yvonne Sawbridge said:

> *We were unsure about* [the HSMR's] *importance as a true indicator of concern. This was one indicator alone and we were not aware of any other significant issues. We felt assured by the responses we had received from the Trust that this was not a clinical issue and based on all the information available at the time (given that this was not just a local issue) it did appear that the answer could be poor coding.*[162]

5.156 She believed that the Lilford and Mohammed work would extend beyond methodological to quality issues, but she could only refer in that regard to the "few tracer conditions" that were to be reviewed.[163]

The Lilford and Mohammed report

5.157 Professor Lilford and Dr Mohammed finally produced their report[164] in June 2008, about a year after it was commissioned, four months later than planned, and three months after the start of the HCC investigation.

5.158 The overall conclusion of the report, as summarised in its executive summary, was as follows:

> *We found little evidence to support a systematic link between the Dr Foster SMR and quality of care or organisational failure. Instead we found credible evidence that the Dr Foster SMR penalises hospitals with less complete clinical coding and apparently penalises hospitals with less provision for the dying in the community. However our most crucial finding is that the methodology used to derive the Dr Foster SMR is riddled with the constant risk-adjustment fallacy and so is not fit for purpose.*[165]

161 Poynor WS0000014312–4, paras 129–138
162 Sawbridge WS0000013408, para 66
163 Sawbridge WS0000013407, para 62
164 RS/30 WS0000018879
165 RS/30 WS000001885

5.159 The report examined five hypotheses:

- Quality of coding could explain, at least in part, some of the results;
- Lack of palliative care could influence the place of death of patients;
- A hospital with a high HSMR was likely to be a failing organisation;
- A high HSMR reflected poor quality of care; and
- The "constant risk-adjustment fallacy" (CRF) affected DFI methodology.

Quality of coding hypothesis

5.160 The study could only reach preliminary conclusions in relation to the coding hypothesis. The authors could only study the coding in the three high-HSMR hospitals and one low-HSMR trust that had used DFI's RTM. They concluded that under-coding had "seriously undermined" the HSMR in two trusts (the Trust and George Eliot Hospital NHS Trust). They also found that there were "remarkable" reductions in the HSMR, partially explained by an increase in expected mortality, but also because of a fall in observed mortality. It was suggested that this coincided with an increased percentage of zero length of stay admissions. The study recommended that further investigations be carried out.[166]

Place of death hypothesis

5.161 A correlation was found between lower provision in the community for the care of the dying and higher HSMR.[167]

Failing organisation hypothesis

5.162 The report noted that, according to "disaster theory", poor performance in an organisation usually shows itself in a number of ways, and accordingly patient and staff surveys and staff absence rates were examined. While it was not possible to establish a causal relationship between poor survey results and absence rates, the researchers concluded that:

> *The results ... suggest that it is generally the hospitals where staff and patients feel better treated and more satisfied where mortality is lower. Even if there is no direct causal link shown, it seems reasonable to suggest that an emphasis on the general welfare of staff and patients is unlikely to have a deleterious effect on patient care and may indeed lead to greater positive outcomes.*[168]

166 RS/30 WS0000018894–5
167 RS/30 WS0000018897
168 RS/30 WS0000018911

5.163 In a descriptive summary of the results, this was said of the Trust:

> *Mid Staffordshire General Hospitals NHS Trust was in the lowest 10% of trusts nationally for Job satisfaction, Quality of supervision and Organisational climate, and amongst the highest 20% of trusts for Intention to quit. Conversely, both patient survey scores were much higher than average, with Respect and dignity shown amongst the highest 20%. Mortality was in the top 5% nationwide.*[169]

5.164 Like the Trust, Burton Hospitals NHS Trust, although in the worst 20% for staff survey variables, was above average in patient surveys, although its mortality rate was higher than that of the Trust. Similarly, the Royal Wolverhampton Hospitals NHS Trust scored poorly in most staff survey variables but did comparatively well in patient surveys. George Eliot Hospital NHS Trust was not only in the worst 10% nationwide in all four staff survey variables, but was also in the lowest 20% on patient survey scores. The Dudley Group of Hospitals NHS Trust was in the worst 20% for staff and patient surveys and in the highest 10% for mortality.

5.165 Whether or not there was a statistically provable association between poor patient and staff survey results and high mortality, it can surely be said safely that, where a trust is performing poorly on all three measures, this is one set of circumstances in which a serious look needs to be taken at its quality of care.

Quality of care hypothesis

5.166 The provisional conclusion was that no systematic relationship could be detected between quality of care and HSMR. It was noted, however, that there was "clear room for improvement at all our hospitals in one or more aspects of care (and/or its documentation)".[170]

5.167 There were a number of difficulties for the recipients in respect of this part of the report:

- It was only an interim report because it had not proved possible for logistical reasons to complete the necessary work for a full report. In particular it had not been possible to recruit full-time nurses to collect data.[171]
- As a result, it was not possible to review two out of the four higher-risk tracer conditions chosen (see above), or the two low-risk tracer conditions that were chosen for review at the trust with the highest mortality rate, George Eliot Hospital NHS Trust;[172] The tracer conditions were selected because they were high-volume, involved medical and surgical specialities, and had evidence-based process of care measures;

169 RS/30 WS0000018921
170 RS/30 WS0000018931
171 RS/30 WS0000018923
172 Shukla T68.198

- The factors used to demonstrate good quality of care were process measures such as whether or not a brain scan had been performed on a stroke patient, rather than outcome measures such as patient satisfaction;
- There was also a premise that high HSMR hospitals tended to have high ratings in the tracer conditions. This was not the case with the Trust, which had HSMRs of 109 and 113 for the two diagnostic groups that were tested. The review did not include diagnostic groups in which the Trust had particularly high HSMRs. Consequently, unless, by chance, poor care was detected by proxy measures in the selected groups at the Trust, no other measure of care relating to the deaths was used. Peter Blythin, when asked about this, found this difficult to explain:

  ... I think ... we perhaps should have broadened that debate out to accommodate that, but that wasn't what we discussed or agreed ...

  THE CHAIRMAN: Bearing in mind, and I understand the point that you weren't the statistician or the expert on the statistical approach, but it might be said you were the expert on the nursing factors.

  A. Yes.

  THE CHAIRMAN: Therefore why wasn't there, even without the benefit of hindsight, more emphasis placed on looking at those sort of factors from you?

  A. The honest answer is, I don't know why I didn't do that at the time. The ... conversation about the HSMRs was focusing on the methodology and the assumptions made about coding and I didn't draw those connections and insist that we should do some work on nursing or a broader set of investigation about quality. I just didn't do that.[173]

5.168 Of the 250 low-risk deaths at George Eliot Hospital NHS Trust that were reviewed, there were notes available for 231 cases. Of those, a total of 69 (or 30%) showed areas of concern that may have contributed to the death, and a further seven (or 3%) showed areas of concern that caused the death of a patient who may have been expected to survive. 26 (nearly 40%) of the group of 69 cases were attributed to hospital-acquired infections, primarily *C. difficile*, and the rest to a wide variety of matters.[174] Dr Rashmi Shukla told the Inquiry that this finding enabled the hospital and its PCT to "see what the standards of care were very specifically in a very detailed way".[175]

173 Blythin T69.203–4
174 RS/30 WS0000018929
175 Shukla T68.198

5.169 The report was somewhat dismissive of the utility of the HSMR in bringing this to light:

> *... given that GEH was known to have one of the highest Clostridium difficile infection rates in England in 2005, it is not surprising that about 40% of the cases, where concern was raised ... related to hospital acquired infections. GEH has focused efforts ... to reduce Clostridium difficile and more recent data has confirmed that their Clostridium difficile rates have been falling towards the average.*[176]

5.170 While it may have been known from other sources in this case that there were a high number of deaths from an identified cause for concern, this exercise might also be said to have demonstrated that the HSMR was a means by which such matters could be brought to light.

Constant risk fallacy

5.171 The constant risk fallacy (CRF) is said to be an assumption that the risk of an occurrence is the same; in this case, at all hospitals in the country. The report made a strong attack on the validity of DFI HSMR methodology in this regard, and contended that there was strong evidence of substantial non-constant risk; it contended that this seriously undermined the methodology's validity.[177]

5.172 The impact of CRF in HSMR is an issue which was considered by the first inquiry into the Trust; this found that purported CRF can potentially be related to differences in the accuracy and depth of coding (as discussed above).[178]

Consideration of report by West Midlands Strategic Health Authority Board

5.173 The Lilford and Mohammed report was presented to the WMSHA Board on 24 June 2008, attached to a report[179] on the mortality issue, submitted by Dr Shukla and Steven Wyatt.

5.174 This noted that:

- The Lilford and Mohammed report had on an interim basis found that there was no systematic relationship between quality of care and the HSMR, although some quality of care issues had been identified;
- Some 30% of the variation in HSMR could be explained by coding issues;
- The DFI model did not fully adjust for availability of alternative settings for end of life care;

176 RS/30 WS0000018931
177 RS/30 WS0000018933–40
178 *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009* (February 2010), Volume 1, page 446, paras 24–25
179 RS/32 WS0000018956

- There was no evidence that hospitals with high HSMRs were failing across the board, although there was "weak" evidence of a non-causal link between HSMRs and patient privacy and dignity, staff support and organisational climate;
- Although not part of the original brief, a methodological error in the DFI model had been found, which appeared to affect the ability of the model to standardise risk factors accurately. This raised further questions about the validity of the data.

5.175 Dr Shukla and Mr Wyatt reported that the WMSHA was continuing work on production of an alternative system of measuring hospital mortality, the importance of doing so to improve the quality of care being acknowledged. Furthermore, the findings of the quality of case note review carried out by Lilford and Mohammed had been shared with the participating trusts who had agreed to address areas of concern.

5.176 At the Board meeting,[180] Steve Allen praised the work that had been done on producing an alternative measure as:

> *... it was important to investigate high death rates and to ensure the development of the correct methodology to find reasons why without incorporating a blame culture.*

5.177 Elizabeth Buggins, the WMSHA Chair, commended the report and said "it should resonate through the whole of the NHS and private sector".

5.178 A Non-Executive Director, Donald McIntosh, said "the paper should give comfort to patients who may be using the choice agenda in choosing hospitals for treatment".

5.179 Thus the Board, on professional advice, appears to have accepted that the Lilford and Mohammed report sufficiently discredited DFI's HSMR method to enable it to ignore it, other than to ensure that the relevant trusts took action on the very limited quality of care concerns that had been brought to light. No account seems to have been taken of the provisional nature of the Lilford and Mohammed report, particularly in relation to its review of the relevance of quality of care issues. It is hard to avoid the conclusion that the Board valued this work as a means of defending the reputations of the trusts involved, and perhaps viewed the validity of the report as endorsed by the intention to publish it in a peer-reviewed journal. It was not thought necessary to consider whether further investigation was needed in relation to the quality of care at the hospitals concerned.

180 RS/32 WS0000018971

Comments on Dr Foster Intelligence's Hospital Standardised Mortality Ratio

5.180 The Inquiry received voluminous and detailed evidence and analyses from Professor Jarman. This was obviously much more detailed than was made available to the Trust or the WMSHA at the time but it does tend to demonstrate that, whatever may be the vulnerabilities of HSMR to coding and data quality deficiencies, the Trust's results were significantly and consistently high over many years. Professor Jarman produced an analysis that he had shared with the HCC in December 2008, in which the Trust's HSMR for every quarter from 1996 to the third quarter of 2008 was shown. It demonstrates that the Trust's HSMR was significantly high for every quarter in that period apart from two, which were almost significantly high, and for the last two quarters, which were not complete.[181] He also produced a breakdown of the HSMR by diagnostic group for the period April 2005 to March 2006: 13 out of the 56 groups were significantly high and none was significantly low.[182]

5.181 Dr Aylin had demonstrated, at his meeting with the WMSHA in August 2007 (see above), that the unexpected mortality rate remained high using various methods and approaches.

5.182 No method of analysing death rates is likely to be perfect, and all will be prone to variations due to the quality of data input. It is, however, difficult to avoid the conclusion, from the almost universal direction of the analyses available at the time, that the Trust had a problem with mortality that should not have been attributed solely to coding issues, and that it warranted an urgent and comprehensive investigation of the quality of care.

5.183 Steve Allen told the Inquiry:

> *... in hindsight it is clear to me that the WMSHA should have gone further in looking at the standards of care at all five of the trusts flagged in the Dr Foster report as having high HSMRs. I think that the WMSHA response at the time was appropriate ... Nevertheless, given the concern raised we should have also had a look at the basic standards of care in each of these hospitals.*[183]

181 Jarman WS0000042793, para 142; BJ/33 WS0000043053
182 Jarman WS0000042793, para 144; BJ/34 WS0000043057–8
183 Allen WS0005000190, para 145

5.184 Cynthia Bower said much the same:

> *The work undertaken by Birmingham University would have been much more effective if it had included a patient or carer voice as part of the assessment, or indeed by observing patient care, rather than solely using an audit of notes to pick up problems ... However, neither of these two elements were a routine part of clinical audit, and an SHA sending staff onto wards to observe care would have been highly unusual ... That is what causes me the most sorrow about the work we did with the University of Birmingham. When we started the clinical audit, if we had actually observed the care and interviewed the patients, we might have seen what the HCC saw.*[184]

5.185 She did not accept that the omission to raise with Monitor the possibility that the high HSMR was a potential indication of poor quality care was a failure on the part of the WMSHA. She argued that Monitor was as well equipped as was WMSHA to make a judgement about that. She accepted that in hindsight the WMSHA had relied on a working assumption that problems arising would have emerged as poor performance in other areas or be detected by other external scrutiny.[185] Their view had been that they had sought assurances from the trusts concerned, and the work undertaken on behalf of the WMSHA had not indicated a problem with quality. She pointed to other work undertaken regarding concerns such as HCAIs:

> *... we* [were] *trying to look for organisations that were honestly trying to tackle issues, being open. Of course, all these things are not now associated with Mid Staffordshire hospital, to say the very least. But – that* [is] *not an absence of problems, but a willingness to tackle problems, to be open with organisations that challenged them, to have an open debate with their patients about them. Now, again, all these things we now know are ... absent from Mid Staffordshire but we were looking for that assurance as much as we were looking for an absolutely clean bill of health from every organisation that was going through that process.*[186]

5.186 As described above, when asked why he had not required more work on quality to be undertaken, Mr Blythin was unable to give a reason.

184 Bower WS0000021022, para 161
185 Bower WS0000021023, para 163
186 Bower T73.124

5.187 There has been much controversy around the validity of the HSMR methodology inspired, in particular but by no means exclusively by the work of Lilford and Mohammed as evidenced in their report for the WMSHA. According to Professor Sir Bruce Keogh,[187] the validity of the HSMR has been debated for many years, albeit that the majority of statisticians have accepted that it may be of value for detecting real differences in death rates. This debate has been ventilated, often in somewhat passionate terms, in the columns of learned medical journals. This Inquiry is not an occasion on which to pass judgement on the merits of the competing arguments. Were a conclusion to be sought, it would be of little utility to those managing and regulating healthcare provision; the arguments will proceed in any event and will no doubt change as the new SHMI process is developed. For this reason, the authors of the paper, Professor Lilford and Dr Mohammed, were not invited to submit evidence to the Inquiry and they volunteered none. It is important to emphasise that they and their work were not on trial. It is necessary, however, to make a few observations, given the criticisms made about their work, in particular, by Professor Jarman.

5.188 The WMSHA was criticised for commissioning the study. Given the controversy surrounding the HSMR, it was not unreasonable for such work to be commissioned. It is not surprising that a steering group was set up to liaise with the study team. Such a group was bound to include representatives of organisations affected by high HSMRs; it was they who wished to obtain a better understanding of the significance of HSMR. It is not unreasonable to expect senior and reputable academics to maintain and protect their independence of judgement, and there is no evidence before the Inquiry that they did not do so.

5.189 Professor Lilford and Dr Mohammed never sought to assert that a high HSMR could not be indicative of poor care, only that there were other possible explanations, and that there were limitations to the interpretation that could be placed on results. If criticism were to be made of the very limited attention paid in the study to the investigation of clinical care issues, that is the responsibility of the WMSHA and the relevant trusts, not the academic study team, who do not appear to have been furnished with sufficient resources even to complete the limited case note review originally envisaged.

5.190 The debate about the merits of the HSMR methodology, however understandable and necessary, had the unfortunate consequence of diverting attention from the risk that an unexpectedly high death rate, as calculated by this method, was the result of poor care contributing to an increase in mortality. Consequently, while it is correct, as pointed out by Sir Bruce, that, at the time the HSMR was an "unknown quantity" and "an unresolved debate and an emerging methodology",[188] this was no justification for not addressing that risk urgently and thoroughly.

187 Keogh WS0000065293, para 127
188 Keogh WS0000065293–6, paras 127 and 135

5.191 Professor Sir Ian Kennedy, the former Chair of the HCC, told the Inquiry that, at the time, the HSMR was not widely accepted as predicting risk or underperformance.[189] The evidence before the Inquiry shows that this is plainly correct, but the question has to be asked why the possibility that it did predict those matters, or at least assist in doing so, was not followed up, particularly at a time when there were few obviously better alternatives available. One reason is likely to have been a natural institutional reaction at all levels in the healthcare system to defend and manage organisational reputation before taking steps to protect patients from risk, unless and until such a risk was proved to be present. Put more simply, there was a willingness to assume that a proper service was being provided on the basis of unvalidated statements of assurance from those least likely to be objective, namely those whose service was under scrutiny. Even if they were entitled to rely on such assurances until a question was raised about their reliability, the HSMR, for all its uncertainties, provided just such a question. This question was all the more pertinent in light of the background of deficient management and other issues of which the SHA was aware. Such assurances were given more weight than analyses that sought, however imperfectly and provisionally, to call them into question. The assurances of compliance were not investigated with the same rigour as was the credibility of potentially objective evidence. It was, perhaps, too easy to focus on objections to "league tables", alleged lack of transparency of methodology, and the difficulties raised by publication of the results in national newspapers, rather than making the best use of what evidence had been made available.

5.192 There is now a consensus that significantly high HSMR/SHMI results should trigger a serious consideration of whether poor care is an explanation for them, whatever other steps are also taken. In any event, the explanation of poor coding offers little reassurance that there is no matter of concern. It means that there is a serious deficiency in the information available to the relevant provider trust itself, and also to the regulators and the public, on which outcomes can be assessed and compared. Weak data management is a sign of weak clinical governance.

189 Kennedy WS(2) WS0000075703, para 37.1; see also Burnham T115.116–117

Mortality alerts

Alerts issued

5.193 Two types of mortality alert were generated about the Trust in the course of the period under review, those from the DFU and those from the HCC. These were as follows:

Table 5.6: Mortality alerts generated in relation to the Trust

Date sent	Source	Diagnostic group	Excess deaths	Relative risk (RR)	Lower CI limit	% chance of false alarm	Date of RR
3.7.2007[190]	DFU	Jejunum	6.1 (17.9%)	224.3	111.8	0.4	Apr 2007
2.8.2007[191]	DFU	Aortic peripheral and visceral artery aneurysms	5.2 (12.1%)	189.1	94.3	0.4	Mar 2007
2.8.2007[192]	DFU	Peritonitis and intestinal abscess	3.6 (14.4%)	140.5	45.3	0.2	Mar 2007
August 2007[193]	HCC	Diabetes					
September 2007	HCC	Epilepsy and convulsions					
October 2007	HCC	Repair of abdominal aortic aneurysm					
1.11.2007[194]	DFU	Other circulatory diseases	12.4 (5.3%)	288.0	173.3	0.5	Jul–Aug 2007
October 2008	HCC	Non-transient stroke					
October 2008	HCC	Other non-viral infections					
7.11.2008[195]	DFU	Pulmonary heart disease	9.7 (10.6%)	215.9	127.9	0.09	Aug 2008
11.7.2008[196]	DFU	Chronic renal failure	3.8 (18.1%)	272.6	99.5	0.09	Apr 2008
17.12.2008[197]	HCC	Non transient stroke or CVA (3 quarters)	23.6				2007/08 Q2–4
14.9.2009[198]	DFU	Coronary atherosclerosis and other heart disease	9.1 (1.5%)	202.5	120.0	0.08	Jun 2009
30.4.2010[199]	DFU	Coronary atherosclerosis and other heart disease	13.4 (3.1%)	191.8	127.4	0.10	May 2009–Jan 2010

5.194 The number of alerts sent to the Trust by the DFU between April 2007 and November 2010 was eight, second highest in the country for that period.[200]

190 BJ/37 WS0000043066–70
191 *Investigation into Mid Staffordshire NHS Foundation Trust* (March 2009), Heathcare Commission, page 146
192 BJ/37 WS0000043071–73
193 *Investigation into Mid Staffordshire NHS Foundation Trust* (March 2009), Heathcare Commission, page 146
194 BJ/37 WS0000043083–87
195 BJ/37 WS0000043093–97
196 BJ/37 WS0000043088–90
197 HCC0046000167–179 Letter from David Harvey to Martin Yeates dated 17 December 2008
198 BJ/37 WS0000043098–102
199 BJ/37 WS0000043103–7
200 Jarman WS0000042794, para 146

Healthcare Commission action

5.195 In each case of a DFU alert, the HCC was informed and sought to pursue the matter with the Trust. On 23 January 2008, the HCC undertook a review of the mortality information it held on the Trust. The position, as at the time of the review, was as follows:[201]

- A request for information about the jejunum alert had been sent to the Trust and a letter[202] of 3 September 2007 had been sent by Martin Yeates. The letter asserted that all the patients concerned had been higher risk and that an investigation of the matter was due to be reported that month. He undertook to send a copy of the investigation report once complete. In spite of two follow-up letters from the HCC to the Trust,[203] no report was received from the Trust. When the HCC reviewed the information it held on 23 January 2008, it concluded that the figure generating the alert might have been due to miscoding of operations on the ileum (which is a section of the small intestine) under this code. Furthermore, it was noted that there had been a real-time decrease in mortality since;
- Similarly, in respect of the aortic, peripheral and visceral artery aneurisms alert, a request for information had been sent to the Trust on 10 October 2007,[204] but no response was received. The review conducted on 23 January 2008 thought that there might have been a coding issue to explain the figures;
- Inadvertently, no action was taken with regard to the peritonitis alert until November 2007, when it was decided to close the matter. When the HCC undertook its review on 23 January 2008, it considered that some patients might have been counted twice. Furthermore, only a small number of cases were involved, so that statistical significance had yet to be reached, in spite of a trend upwards;
- The alert for diabetes generated by the HCC was reviewed in November 2007. At the review, coding was identified as a possible issue;
- The HCC closed its alert for epilepsy and convulsions in October 2007, but in November decided to review it, as there had been more than one alert for the Trust. At the review, it was thought that the position had improved since 2006/07;
- The same decision was made with regard to the DFU alert for other circulatory diseases. The review noted that that a high proportion of cases had been coded in an unspecified category and that this might have had an effect on the result. The HCC queried whether there had been a change in practice to account for the change in result.

5.196 The review meeting also looked at overall mortality and noted an increasing trend in the mortality for emergency admissions, although that for elective admissions was decreasing. It was felt that the elective admission figures might be disguising an increase in the overall rate.

201 HCC0035000190–1 Summary of outlier alerts for the Trust as at 9 January 2008
202 HCC0030000067 Letter from Martin Yeates to David Harvey dated 3 September 2007
203 HCC0030000069 Letter from David Harvey to Martin Yeates dated 17 September 2007; HCC0030000073 Letter from David Harvey to Martin Yeates dated 25 October 2007
204 HCC0030000070 Letter from David Harvey to Martin Yeates dated 10 October 2007

5.197 It was this meeting that resulted in the HCC letter[205] to the Trust of 28 January 2008, seeking information to enable the HCC to decide whether to launch an investigation.

5.198 On 8 January 2008, Chris Sherlaw-Johnson of the HCC emailed Dr Paul Aylin to request an analysis of the diagnoses for which the DFU had generated alerts for the Trust, set at 1% as opposed to the 0.1% threshold at which the alerts had been sent out originally. He explained that:

> *We have been having growing concerns about the number of mortality alerts for* [the trust]*, not just those generated by yourselves but also generated internally through our own analyses.*[206]

Healthcare Commission contact with West Midlands Strategic Health Authority

5.199 The HCC intended to inform the WMSHA about its specific alerts to the Trust at a meeting arranged to take place on 12 November 2007, the alerts being referred to in a briefing note that was prepared for the meeting.[207] The meeting, however, was cancelled and this information was not shared until shortly before the HCC investigation was announced. An HCC representative attended the WMSHA Quality and Safety Group meetings during this period, but the alerts were not mentioned.

5.200 In fact, the HCC was still in the process of developing its alert methodology, and those sent to the Trust were among the first sent. There may therefore have been some reservation about the significance to accord them at the time. In any event, the reception of the HSMR by the Trust and the WMSHA does not suggest that a more positive reaction would have been obtained to this slightly different form of alert from the HCC, as opposed to those from the DFU.

5.201 The Trust, which undoubtedly did have these alerts, from the HCC and DFU could have informed the WMSHA, but failed to do so. Similarly, it failed to inform Monitor. As described in *Chapter 10: Regulation: Monitor*, Martin Yeates explained that he did not understand their significance.

5.202 The first information received by the WMSHA about the HCC mortality alerts was in the letter to the Trust of 28 January 2008, a copy of which was sent to the WMSHA. The initial reaction of the WMSHA was to offer support to the Trust. In an email[208] to Cynthia Bower the next day, Dr Rashmi Shukla summarised the work that had been commissioned in relation to the HSMR. It appears to display an understanding that the HCC was relying only on mortality alerts

205 TB/116 WS0008001534
206 Jarman WS0000042790–1, para 137; BJ/30 WS0000043043
207 AG/43 WS0000024465
208 STA/12 WS0005000306

generated by DFI or the DFU rather than its own analysis. Dr Shukla repeated the statement that "the issue of coding has been a significant factor" but that:

> *We cannot explain the high rates to be solely due to coding inaccuracies – so we are auditing care for 3 specific conditions to examine as a proxy* [of] *the quality of care provided by the trusts.*

5.203 She described the topic as a "potential minefield" and said that on some sub-analyses "there is bound to be at least one or more statistically significant abnormal results".

5.204 Steve Allen replied:

> *I agree entirely with Rashmi. I think we should do everything we can to support Martin* [Yeates] *in responding. I also think as an SHA we should write separately to HCC to ask them to justify this approach to generating 'alerts' given the high 'false positive' rates which will arise.*[209]

5.205 Cynthia Bower told the Inquiry that the WMSHA was surprised not to have been told about the alerts before. Had they been, she liked to think that the WMSHA would at least have challenged the Trust about them and encouraged them to respond positively to the enquiries being made by the HCC. Even though the alerts were in a developmental stage, if the point had been reached where the HCC felt that there was concern about an individual trust, she felt the SHA ought to have been told.[210]

Conclusions on mortality alerts

5.206 In theory, alerts triggered by real-time data analysis revealing significant deviations from the norm should be a useful tool assisting trust leadership, performance managers and regulators in their tasks. During the period under review, the concept was under development so far as the HCC was concerned, and the significance of the DFU's alerts was not well understood, at least by the Trust's Chief Executive. Their effect was likely to be reduced by the debate about the HSMR.

5.207 Alerts derived from the HSMR would have been available to trusts taking and paying attention to the RTM service. It is remarkable that an available measure that potentially showed up areas of serious concern in identified trusts relied, for its distribution to those not paying for the RTM service, on the voluntary efforts of an independent academic. If it is believed that mortality alerts based on HSMR (or SHMI) are a useful adjunct to the protection of patients, then it is important that a system is developed which does not rely on the goodwill – and

209 STA/12 WS0005000306
210 Bower T73.160–162

availability – of two researchers, however distinguished. It is also important that this system ensures consistent distribution of relevant information to all those with a duty to act on such indicators.

5.208 As for the alerts issued in respect of the Trust and considered above, it may be that they added little of significance to the overall picture capable of being derived from analysis of the HSMR and, in particular, the real-time information available in respect of diagnostic groups. Many of the alerts appear to produce results with a lower confidence interval level of below 100, meaning that they show a possible trend, rather than a statistically significant deviation. The HCC's analysis at the time seems to suggest that coding issues may indeed have been the explanation for at least some of the results.

5.209 The DFU had no responsibility to take even the action that it did, other than possibly through a professional ethical obligation, as identified by Professor Jarman from the General Medical Council's *Good Medical Practice*.[211] Neither he nor the DFU had any duty or power to follow up what, if any, action was taken to address alerts. The DFU did share the information with the HCC, which had such powers.

5.210 During the last half of 2007, the HCC did take action on the alerts, mainly in the form of seeking more information from the Trust. Given the state of its own analytical capability at the time and the less than unequivocal inferences to be drawn from the results, its actions were reasonable. The information from the alerts did constitute a factor in the eventual decision to launch an investigation. Given the experience of the Trust, however, it is to be hoped that there would now be a greater sensitivity to this sort of sign of a possible risk to patients and a more urgent reaction as a result.

5.211 The position has now improved. Roger Taylor has confirmed that mortality alerts are shared with Monitor. He forwarded to the Inquiry confirmation from the CQC that whenever it receives a mortality alert from Imperial College, it informs the trust concerned, copying the information to the PCT and Monitor or the SHA as appropriate.[212] More generally, the NHS Information Centre now publishes the new SHMIs quarterly, making these available on its website; the first publication was in October 2011 as an experimental Official Statistic.

Use of palliative care coding

5.212 Professor Jarman contended to the Inquiry that a fall in HSMR ratings in three trusts in the West Midlands, between 2007 and 2008, could be accounted for by a change in their approach to the use of the codes for palliative care. He described this as "manipulative coding". A great deal of evidence, oral and written, has been devoted to this subject; this has

211 Jarman WS0000042751, para 43
212 DRF0000000037 Email from Roger Taylor to the Inquiry (13 July 2011)

been set out and analysed with great clarity by Counsel to the Inquiry in their closing submissions and to avoid repetition, the entirety of that section can be found in his closing submission at Chapter 22: Dr Foster Unit (Part 2), pages 1586 to 1635.[213]

5.213 Professor Jarman's argument ran as follows:

- In March 2007, Connecting for Health's Coding Clinic changed its instructions for coding palliative care. The effect of this change was that if a patient was admitted for a condition for which there was "no effective treatment" and was "receiving support from a member of a specialist palliative care team", the episode should be coded as palliative care. According to Professor Jarman, this extended the use of the relevant codes to patients not suffering from terminal illnesses,[214] and therefore those patients whose likelihood of death was not as high as that of patients who would have traditionally attracted the palliative care code (ie patients suffering from terminal illnesses). This, it was implied, had the impact of making what may well have been unexpected deaths appear "expected".
- Professor Jarman noted that between 2007 and 2009 palliative care coding increased at the Trust. At the same time, the rates of unexpected deaths improved – expected deaths increasing by 50 and observed deaths decreasing by 130 – and the Trust's HSMR improved too.[215]
- The thrust of Professor Jarman's suggestion was that the Trust's increased use of palliative care coding had the effect of raising the number of expected deaths, thus making it appear that a larger proportion of deaths at the Trust occurred among patients whose likelihood of death was high in the first place. This, it was suggested, lowered the HSMR because HSMRs are calculated by dividing the number of observed deaths by the number of expected deaths, and multiplying by 100 – a higher level of expected deaths would thus yield a lower HSMR figure.
- It was suggested that the extent and the timing of the Trust's change of its palliative coding practice was particularly significant. The increased rate of palliative care coding reached a climax by the fourth quarter of 2008.[216] At this time, only five trusts nationwide had more than 25% of care coded under the palliative care code. Three of those trusts were in the West Midlands. They were the Trust, the Walsall Hospitals NHS Trust, and the George Eliot Hospital NHS Trust. The range of average change, over a six month period, to the rate of palliative care coding in these trusts was 8%–46%, whereas the national rate of change was 6–9%. These changes occurred between the end of the first and the third quarters of 2008, after the announcement of the HCC investigation into the Trust.[217] Professor Jarman stated in his oral evidence that, so far as these West Midlands trusts were concerned, the increase in palliative care coding could not, in his opinion, be genuine or represent reality unless those trusts had become "terminal care hospitals" overnight,

213 CL0000002817, Council to the Inquiry closing submissions, Chapter 22: Dr Foster Unit (Part 2)
214 Jarman WS0000042772–3, paras 99–100; Jarman T98.59
215 Jarman WS0000042803, paras 166–168
216 BJ/85 WS0000065203
217 Jarman WS0000042804, para 170

which was not the case[218]. He also noted that the changes at the three West Midlands trusts occurred around March 2008 – a year after Connecting for Health issued its change of instructions. Another one of the five outliers as at the fourth quarter of 2008 was the Medway Foundation Trust. Medway's increase, it appears generally accepted, was caused by innocent inattention to detail. What Professor Jarman thought significant in those circumstances was that Medway commenced its increased use of the palliative care code immediately after the issuance of the new Connecting for Health guidance in March 2007; whereas the West Midlands trusts changed their practices shortly after the announcement of the HCC investigation.[219] As is explained below, written responses to Professor Jarman's oral evidence on these matters were received from the Walsall and George Eliot trusts. Any imputations as to their conduct were not pursued by Professor Jarman thereafter, and I make clear at this early stage that there is no evidence to suggest that the West Midlands trusts conspired together to lower their respective HSMRs.

- On a related issue, Professor Jarman further noted that, additionally, the Trust changed its practice as regards the coding of fractured neck of femur, which was an ailment that attracted a high HSMR at the Trust, around the first quarter of 2008.[220] The change involved ceasing to record fractured neck of femur as the primary diagnosis so frequently, and increasingly recording it as the secondary diagnosis. The effect of this, it was said, was to lower the individual HSMRs relating to fractured neck of femur on the basis that the DFU's calculations would focus on the primary diagnosis. However, it was maintained by Professor Jarman that the principal reason for the change in HSMR at the Trust was its change in the use of palliative care coding.
- Overall, therefore, Professor Jarman's initial contention was that it appeared possible that conscious manipulation of coding may have occurred at the Trust.

5.214 The Inquiry received evidence from the two trusts other than Mid Staffordshire identified as manifesting significant changes in the use of palliative care coding. The Medical Director of George Eliot Hospital NHS Trust relayed the explanation of his predecessor, that there had been a change in coding practice but this had not been due to the investigation into Stafford.[221] He challenged the suggestion that the increase in palliative care coding in his trust had been as much as 46%, contending that the increase was consistent with the national increase. Professor Jarman's riposte was that his 46% figure related to the proportion of palliative care codes in cases of death, as opposed to those for patients overall. He produced a graph[222] showing that this trust's use of palliative care coding in cases of death increased very sharply in the first quarter of 2008 and continued to rise to the 40% level in the third quarter. A further graph[223] shows that this trust's HSMR fell the most sharply in the same third quarter.

218 Jarman, T98.108–109
219 Jarman WS0000065183, para 22
220 Jarman WS0000042803, para 165s WS0000065178, para 16.2–16.11
221 OTHER0000002668
222 BJ/97 WS0000065250
223 BJ/97 WS0000065255

5.215 Walsall Hospitals NHS Trust responded with a comprehensive document[224] described by Professor Jarman as "impressive". It appears that, following the Dr Foster report in April 2007, the Walsall trust undertook a review of its coding and discovered an underuse of palliative care codes. An instruction was issued internally to remedy this, which was misread by coders as requiring the use of palliative care codes even where this was not appropriate. This resulted in the large increase detected by Professor Jarman, whose figures the Walsall trust did not dispute. The instructions to coders were corrected, as was the trust's practice. A graph[225] was produced showing a correlation between the period of increased coding of palliative care and a decrease in the HSMR. The Walsall trust denied that there was any deliberate attempt to lower its HSMR in this way, and concluded that there had been a miscommunication with the coders.

5.216 This evidence appears to confirm that there was a change in coding practice detectable statistically and that this did indeed coincide with a period of decreased HSMR. The effect of the coding change in isolation is difficult to identify at this trust, as it appears it took a number of steps to address its high HSMR at around the same time.

5.217 Mid Staffordshire NHS Foundation Trust's initial response was to acknowledge that there had been a real change in coding practice about one year after the coding guidance was changed, but that this was in advance of a similar change occurring in trusts across the country. It also contended that the decrease in unexpected mortality rate was real and not due to the coding change.

5.218 The Inquiry received a statement[226] from Mrs Sandra Haynes-Kirkbright, who was recruited as Coding Manager at the Trust in July 2010. On arrival, she identified a wide range of deficiencies in the coding department[227] and sought to correct these. In February 2008, she personally started to code all cases of death in the Trust, out of respect for those who had died "to assure that every person who passed away at our Trust got the extra personal attention their case deserved".[228]

5.219 She accounted for the changes in fractured neck of femur by the fact that guidance required the coding to be for the primary diagnosis during the patient's admission to hospital, which was not necessarily the same as the diagnosis on admission. In the case of this particular condition, patients might be detained for some time after admission with a long bout of pneumonia, which would become the primary diagnosis.

224 OTHER0000002658
225 OTHER0000002664
226 Haynes-Kirkbright WS0000069504
227 CLO000002832 Listed in Counsel to the Inquiry's closing submissions, chapter 22, para 121
228 Haynes-Kirkbright WS0000069515, para 41

5.220 Professor Jarman produced in response further analyses for the Inquiry apparently showing that the three West Midlands trusts' use of palliative care coding increased significantly, not only against the national average, but also against a peer group of nine trusts, which, it emerged, had originally been selected by the Trust and CHKS for other comparison purposes in a report by CHKS from January 2007. He also contended that the statistics showed that the decrease in quarterly HSMRs at the Trust was not replicated within this peer group. He stated that the change in palliative coding practice was not the result of any perception of the deficiencies present when Mrs Haynes-Kirkbright arrived, as palliative coding had not been mentioned in the reports on the state of coding in the Trust, which were prepared before her arrival but relied on by her.

5.221 Professor Jarman conducted a further analysis of the diagnostic groups which accounted for the highest crude death rates at the Trust in 2007/08. This showed that there was a decrease in the cases coded by the Trust as primary diagnoses within all these groups, which was not replicated either nationally or in the peer group. He contended that such a change would have been likely to lead to a lower HSMR for those diagnoses.[229]

5.222 The changes involved between 2007/08 and 2008/09 are very obvious, as Table 5.7 shows[230].

Table 5.7: Analysis of diagnostic groups

Diagnostic group	Reduction in primary diagnosis (%)	Reduction in SMR for group
Peripheral and visceral atherosclerosis	8.9	42 (from 112 to 70)
Non-infectious gastro-enteritis	12.2	52 (from 65 to 13)
Urinary tract infections	13.3	56 (from 62 to 6)
Acute bronchitis	18	72 (from 96 to 24)
Fractures (not neck of femur)	31.7	102 (from 135 to 33)
Cardiac arrest and ventricular fibrillation	52.9	116 (from 119 to 13)
Rectal cancer	62.5	116 (from 136 to 20)
Fractured neck of femur	69.8	166 (from 259 to 93)

5.223 In each case, the change in coding coincided with a dramatic fall in HSMR.

5.224 Professor Jarman also noted that the downward trend in the coding of these groups began to reverse in the fourth quarter of 2008/09. He found that the percentage of deaths coded as primary diagnoses in each of these conditions returned to near the national average at this

229 Jarman WS(2) WS0000065179, para 16.4
230 Jarman WS(2) WS0000065179, para 16.5; BJ/92 WS0000065229–30

time. He suggested that this coincided with a CHKS press release issued in December 2008[231] that suggested there was an under-coding of palliative care and that correction of this would result in a favourable alteration of the HSMR. He pointed to a letter from CHKS to seven trusts[232] to the same effect, although he had to accept that the Trust was not one of the addressees. Shortly after this, the DFU and DFI had "mentioned to some trusts" that they were considering publishing data about the effect of the changes in palliative care coding on the HSMR.[233]

5.225 Pausing there, it is not entirely clear why such observations about palliative care coding, even if known by the Trust, would have motivated it to change its practices with regard to these diagnostic groups. In any event, while there was an increase of this type in some diagnoses, this was not the case for the diagnoses with the largest numbers of deaths.

5.226 The Trust sought to challenge the validity of the peer group of trusts, as referred to by Professor Jarman, and asserted, through Jonathan Pugh, Information Service Manager at the Trust, that it had always argued that the group was not representative of the Trust. It said that a considerable amount of work had been done to improve end of life care, and this had made it more clear to the coding department which cases should be coded as palliative care. Mrs Haynes-Kirkbright denied that she had changed the coding practice because of the HCC investigation, and said that the change had started before the investigation had been announced. She also denied that she had been influenced by CHKS. She provided a number of explanations for why coding of certain conditions had decreased. For instance, she stated that 'cardiac arrest' was an inexact term, now largely eliminated from the records. Further, patients who were in reality deceased on arrival had previously been recorded as being admitted. No specific explanations, other than an improvement in coding practice, were offered by Mrs Haynes-Kirkbright for the increases in diagnoses referred to above.

5.227 Professor Jarman conceded that, if coding practice was changed only in relation to deaths, as opposed to in other cases as well, the effect on the figures might be disproportionate. Thus, Mrs Haynes-Kirkbright's decision to code all deceased patients herself could have accentuated the deviation from the norm. He felt, however, that this did not explain the reduction in palliative care coding at the time of the CHKS press release in December 2008.

5.228 He answered the point about the peer group by pointing out that it had been chosen by CHKS and the Trust for the purpose of the January 2007 report.

5.229 This brief summary of the points made by the Trust and by Professor Jarman cannot do full justice to the thorough summary of Counsel to the Inquiry, which has been considered with care. Assessment of the evidence has not been assisted by the fact that none of it has been

231 Jarman WS(2) WS0000065187, paras 31–32
232 Jarman WS(2) WS0000065187, para 32
233 Jarman WS(2) WS0000065176, para 10

given by witnesses who could be described as genuinely independent. The Trust witnesses were clearly seeking to defend its practices, and Professor Jarman was keen to demonstrate the efficacy of the analytical methods he has developed with such skill and effort. The result was that the evidence appeared to descend into partisanship and reference to a number of complex points which on analysis, and as demonstrated by Counsel to the Inquiry, turned out to be of limited relevance or were easily refuted. The suggestion by Professor Jarman that the changes were an attempt to manipulate the data to achieve improvements in the HSMR was bound to generate a degree of heat.

5.230 Professor Jarman suggested that, at a meeting with Mrs Haynes-Kirkbright, she had "[made] a remark that had the sense that one could do a lot with coding".[234]

5.231 Mrs Haynes-Kirkbright did not answer this allegation specifically in her statements and she was not called to give oral evidence. Professor Jarman may have taken away an impression, as he has described it, but without a more specific description of the words used and the context in which they were expressed it would be quite wrong to draw any adverse inference from this evidence against either Mrs Haynes-Kirkbright or the motivation of the Trust in its changes to its coding practice. Mrs Haynes-Kirkbright made it very clear, on repeated occasions, that she denied any suggestion that she was seeking to manipulate the data so as to procure a reduction in the HSMR. Her concern was to improve the accuracy of coding, particularly in relation to deaths.[235] Professor Jarman's description suggests that any comment made was informal, and not even heard by others in the room. The words would not necessarily carry a sinister implication any more than the commonplace observation that anything can be proved with statistics, a point proved by the intense debate over the effect of changes to the coding practice.

5.232 The principal issues raised in relation to the use of palliative care coding relevant to this Inquiry are:

- Was there a change in coding practice at the Trust that was disproportionate to the national average? The analyses produced by Professor Jarman demonstrate that there was, as addressed above and described in more detail in the graphs he exhibited;[236]
- Did such a change deviate significantly from the practice of comparable trusts? The comparison produced by Professor Jarman did demonstrate that there was a significant deviation against a group of trusts, which the Trust and CHKS had previously identified as a peer group for an associated purpose;
- Was there an increase in the use of particular codes at about the time of CHKS's advice about the positive effect of correct coding of palliative care? Again, the figures produced by

234 Jarman T98.115; Jarman WS0000042801, para 163
235 Haynes-Kirkbright WS0000069504; Haynes-Kirkbright WS(2) WS0000076974
236 BJ/91 WS0000065223, BJ/92 WS0000065225–33

Professor Jarman suggest there was, but the pattern is not such as to justify the conclusion that one led to the other;

- Was there evidence of a coordinated attempt by West Midlands trusts, including the Trust, to change their coding practices with regard to palliative care? There is evidence that, at about the same time, three trusts changed their practices, but, judging from the evidence of Walsall in particular, it is not likely that these trusts "put their heads together"; it is more likely that they all reacted to the adverse HSMRs in their trusts;
- Were the changes made by the Trust deliberate manipulation of the data with the intention of producing misleadingly positive results? Professor Jarman accepted that it was not possible to prove a reason for a change in practice from his analyses, although he was keen to draw attention to various coincidences in timing. It is unlikely that those working in the Trust on the issue of coding entered into a sophisticated plan to manipulate data dishonestly. It is much more likely that they were motivated by the known deficiencies in coding, and, in the case of Mrs Haynes-Kirkbright, by an enthusiasm to make her mark on a trust in great difficulties in this area. The evidence is sufficient, however, to draw a cloud of doubt over the confidence that the public can place in statistics of this sort. Professor Jarman's evidence demonstrates that changes in coding can reasonably be thought to cause factitious changes in the HSMR for individual diagnostic groups and for the overall rating. In short, it is impossible to rule out the possibility of "gaming" skewing the figures. This means that, while it is legitimate, and indeed mandatory, that apparently poor HSMR results should be taken as a serious indication of the need for a review of clinical standards in the relevant areas, little reassurance can be taken from "good" results, without some form of objective validation. This suggests that there is an urgent need to insist on independent and regular auditing of the data supplied by trusts which is intended for statistical purposes.

Overall conclusions

Use of mortality statistics

5.233 Mortality statistics may not be the best or only way of assessing the quality and effectiveness of care being provided, but during the relevant period these were, and even now there are, few other measured indicators available. Whatever methodology is adopted, mortality is bound to be a somewhat crude measure given the difficulties in obtaining reliable comparative factors. To the non-statistician, it appears that mortality rates for individual diagnoses or types of treatment are likely to be more informative than an overall figure. There is, however, a difficulty in some groups with small numbers of cases in obtaining a statistically significant result. Observers need to be alert to the distortion of results that may occur as a result of an unintended, or even dishonest, bias in coding, but equally should not automatically assume that correcting such a bias will produce a more reassuring result.

5.234 Whether a subdivided or overall SMR is reviewed, it is always important to keep in mind that a high rate of "unexpected" deaths cannot be translated into a number of "avoidable" deaths, any more than a low rate of such deaths means that all is well.

5.235 As is clear from the institutional reaction to the West Midlands HSMRs in 2007, high results have not instinctively been welcomed as useful information that informs consideration of the safety and effectiveness of service provision; in fact, such results have provoked defensive attempts to discredit the information. The WMSHA has submitted forcefully that its commissioning of the Lilford and Mohammed review was not a defensive step but was a genuine attempt to understand the relevance and significance of the HSMR.[237] It can be and is accepted that the SHA did genuinely wish to enhance understanding of these matters, but it is unlikely that so much effort would have been put into a challenging examination of the methodology of the HSMR had it not been for the obviously adverse inferences being drawn from the published results. The focus on work which had the potential for discrediting the figures distracted the WMSHA and others from giving equal weight to the concerning possibility that they were a useful indicator of a cause for concern as to patient safety. In that sense, the SHA's reaction was "defensive".

5.236 If the best use of available information is to be made in the interests of patient safety and welfare, healthcare leadership must resist the temptation to seek easy, "black and white" answers where a more sophisticated and thoughtful approach is demanded. The HSMR is a useful tool in an area where there are limited alternatives on offer.

5.237 In the first inquiry report, it was recommended that efforts be made to achieve a consensus with regard to mortality statistics, the appropriate methodology for them and their significance. Significant and appropriate steps have been taken in that regard, resulting in the creation of the SHMI.[238] There is no doubt that, without the work of the DFU and DFI, comparative mortality statistics would not have been published as quickly, or as fully, as they now are. There will always be a debate about the significance of such figures and the methodology, as illustrated by the large volume of evidence submitted to this Inquiry. It would serve no purpose to seek to come to conclusions here about the competing merits of the various forms of statistics now available, as conclusions are always likely to be superseded by new developments. As established in the first inquiry, as well as the present one, this debate was allowed to obscure the need to address risks to patients that the figures, from whatever source, might suggest, until such time as that implication had been investigated and addressed.

5.238 It is quite clear that scepticism about the DFI methodology, and to some extent resentment of the publicity given to its ratings, encouraged a focus on explanations such as problems with

237 CL0000000165 WMSHA closing submissions, section D, para 78
238 For a description, see Keogh WS0000065301–2, paras 148–150; BK/40 WS0000066059

coding, to the near exclusion of the more important possibility, for patients, of deficiences in quality of care.

5.239 The protracted debate conducted in evidence to this Inquiry about the use and effects of palliative care and other codes, failed to show that there had been dishonest manipulation. It did show persuasively, however, that "gaming" is possible, and that there is an urgent need for independent and regular auditing of data submitted by trusts for the purpose of any form of outcome measurement which may then be relied on by the public and regulators. This issue is considered further in *Chapter 26: Information*.

5.240 The NHS Information Centre now publishes SHMIs with a full explanation of the methodology and access to each trust's figures. It is important that its work is independently verified and capable of scrutiny by third parties. It should aspire to provide the gold standard of measurement of this sort of information.

5.241 Continued publication of statistics using alternative measures should not be discouraged, as these provide a useful reference point for the public and promote development and improvement of the techniques used. All involved in the provision of information to the public must take care to ensure that the permissible implications of figures and their limitations are fully explained.

5.242 All agree that mortality rates are, at present, a crude and not very effective measure of the quality of care, but can act as an indicator that quality of care issues should be examined. The converse is not true: positive results cannot be taken as confirmation of good quality care.

5.243 It is important that work continues in order to develop other measures of quality, not to replace the use of mortality rates entirely, but to provide a richer picture by which the quality of healthcare provision can be judged.

Dr Foster Intelligence

5.244 As noted above, DFI is not a regulator but a commercial organisation, whose purpose is to put information about the quality of hospital services into the public domain. It sought to convert complex information into a form that might be useful to the public. This was a valuable role: it was an independent organisation, it had the support of the distinguished and able statistical experts of the DFU, and it was seeking to broaden the information available to the public. This was at a time when what was being published by the state system was narrow in scope and often avoided the issues which were of legitimate interest to the public. Therefore, DFI was filling a gap.

5.245 There were, however, a number of problems, not all of which were of DFI's own making:

- In order to survive, DFI had to attract paid work from the very trusts that might be the subject of adverse HSMR ratings. They did this by offering the RTM system. Buying access to this system was the only way trusts could obtain advance warning of the annual results. While such a commercial relationship made no difference whatsoever to DFI's behaviour in publishing ratings, which it continued to do independently and fearlessly, it was objectively in DFI's commercial interests to demonstrate publicly that HSMR ratings identified poorly performing hospitals, so as to increase the incentive for trusts to purchase DFI's services and obtain a better opportunity to protect their reputations. These were not circumstances designed to enhance the trust between NHS organisations and DFI.
- Although DFI sought to explain its methodology, this was not understood sufficiently by those within the NHS system whose trusts were the subject of adverse published results. To attract credibility and consensus, statistical analysis has to be transparent and capable of repetition by others. This perception of a lack of transparency allowed some to reject the natural implications of the HSMR ratings.
- With hindsight, sufficient advance warning was not given in 2007, even to those buying DFI's services of the implications of their baseline change, leading the Trust, at least, to be taken by surprise at a sudden adverse change in its rating. This gave the Trust little time to understand its significance and take action to investigate it before being obliged to offer explanations to performance managers and others. The advance warning period had been agreed with the DH and when it was later realised that it was too short it was extended.[239] This short notice may have played some part in the rushed conclusion that coding was a factor and the subsequent reliance on that conclusion as effectively the whole explanation for the result. Once the Trust and SHA leadership had persuaded themselves of this, to the extent that they were both committed to it by statements made to others, it was always going to be difficult for them to exhibit a change of course.
- DFI was more diffident than it might have been in its advice to the Trust because of the genuine misunderstanding that had resulted from the failure to give sufficient warning of the change. While it had no intention of suggesting that the Trust "had no problem" with mortality, it could have been clearer that coding was not necessarily the entire explanation for the ratings and that there was a need for a review of possible clinical causes.
- In any event, DFI felt constrained by its position outside the system in terms of the nature of the advice it offered. As Roger Taylor put it when asked whether DFI should have

239 R Taylor T99-88

followed through the consequences of ratings at the meeting with the WMSHA in August 2007:

... having put the figures in the public domain, as it were, and raised the issue, I think ... if we had sat in that meeting and been asked to explain the issues around HSMR, we had then said, "We would like you to account to us for your actions in full", they would have said, not unreasonably, "Who are you to ask us these questions?" We have said publicly what we think organisations ought to do about a high HSMR ... on our survey this year, we are asking hospitals more about how they respond to information, but I – I don't think we are in a position to individually hold to account an SHA about their actions and – in the way that you're describing. I think if we had asked them to account to us in full for what they were doing, they would have said, "It's none of your business."[240]

West Midlands Strategic Health Authority

5.246 The WMSHA's reaction to the publication of Dr Foster's *Good Hospital Guide* in April 2007 was informed by the scepticism felt by at least some of its senior officials about the validity of the methodology, and their disapproval of the publication of ratings. This led to a focus on coding and other technical issues, and to a very limited amount of work being undertaken to review the quality of care provided to those who had died during the relevant period. Among other issues that do not appear to have been addressed in relation to coding, is that a correction in coding could merely result in "unexpected" deaths being moved from one category to another, leading to the Trust remaining an outlier, but in relation to different diagnostic groups. As observed by Chris Sherlaw-Johnson of the HCC in an email in December 2008:

The concern we have is that, despite coding variations or imprecision, these patients are dying of something, and if they are categorised correctly it is possible the alert may disappear from the "other" category only to re-emerge somewhere else.[241]

5.247 A case note review in relation to a very limited range of conditions bearing no necessary relationship to high mortality in particular trusts was unlikely to be helpful let alone definitive as to whether there was cause for concern. This exercise was highly unlikely to provide reliable information about the quality of care overall in the apparent "problem" diagnostic groups. In any event, the focus on technical issues was such that even this limited work relevant to quality was not completed. Unjustified and sweeping assurances were permitted to be drawn from this. Likewise, the assurances offered by the relevant trusts that there were no concerns about quality were accepted with little challenge and little was done to follow them up.

5.248 Quite simply, the figures reported by DFI were, if significant in the way it contended, "shocking", as stated at the time by Mr Allen. Instead of urgent and thorough steps being

240 R Taylor T99.112–113
241 BJ/32 WS0000043049

taken to investigate the most important hypothesis relevant to patients, most of the collective energy was devoted to issues that might discredit DFI's methodology. The scope of the work commissioned by the WMSHA could not have been criticised if, in addition, it had taken such steps. Unfortunately, it did not. Instead, its focus on technical data quality and coding issues bordered on an obsession. Even after the start of the HCC investigation, which was by no means exclusively initiated as a result of the HSMR, the WMSHA continued to devote its resources to challenging the validity of the HSMR. Anna Walker, Chief Executive of the HCC, observed to the Inquiry:

> *What I found odd, in relation to the strategic health authority, was that in spite of our repeated messages and organisation and my repeated personal messages to the acting chief executive, that the statistics didn't in any way condemn the trust, they raised questions and we needed answers to those questions, they continued to attack the statistics. That was what I thought was odd.*[242]

5.249 The clear view expressed to the Inquiry by the senior leadership of the DH was that the SHA's focus was wrong.

5.250 Sir David Nicholson NHS Chief Executive said:

> *... clearly with the benefit of hindsight we can see that the various regulatory and management bodies were too readily assured that the issues identified were not ones that indicated concerns about patient care at the trust. Whilst it is right that a high hospital mortality ratio does not of itself indicate poor or unsafe care, there was far too much focus on debating the validity of statistics and insufficient attention to addressing the issues of poor care which we now know to have been endemic in the A&E department and certain wards of the hospital ... The use of the data was innovative and was being developed and learned from all the time. It is too early to say if there was an approved way of interpreting the data.*[243]

5.251 While that criticism could be laid at the door of the Trust, it was the WMSHA which took on itself the lead not only in commissioning the Lilford and Mohammed study, but in overseeing the action plans of each affected trust.

5.252 In its closing submissions, the WMSHA accepted that there was an "organisational failure" to take account of the views of patients and their relatives by conducting a listening exercise. It also accepted that, while the HSMR did not enable an inference to be drawn as to the number of avoidable deaths, it did require serious investigation of the standards of care.[244]

242 Walker T83.109
243 Nicholson WS0000067699, paras 221–222
244 CL0000000133–4

The WMSHA pointed out correctly that the Trust was only one of six outliers in the West Midlands and that a consistent approach had to be taken with them all.[245] It is particularly concerning that such a widespread potential problem did not bring home to the WMSHA even more strongly the need to look at the standards of care being provided. While the WMSHA claims that it took a number of steps to obtain reassurance from the Trust that there were no quality of care issues, with the exception of the incomplete and less than exhaustive case note review, it did rely almost exclusively on accepting assurances in relation to action plans, and seems to have taken no account of the long history of governance issues.

5.253 Professor Jarman has made suggestions that the WMSHA discouraged trusts from contracting with DFI and, more seriously, coordinated a manipulation of data in relation to palliative care. There has clearly been an unfortunate cloud of mutual suspicion surrounding the relations between DFI and the WMSHA. However, on the evidence before the Inquiry, there was no concerted plan to coordinate the activities of trusts in either of these respects.

South Staffordshire Primary Care Trust

5.254 Stuart Poynor, SSPCT Chief Executive told the Inquiry:

> *In hindsight, the health economy could have taken a more precautionary approach to the statistics, and considered the possibility that these could be an indicator that highlighted poor care.*[246]

5.255 In its closing submissions, the PCT stated:

> *The PCT accepts that they should have asked more questions about whether the mortality data was actually illustrating quality of care issues ... The significance of mortality statistics and the way they should be used was not really appreciated.*[247]

5.256 It is easy to accept this self-criticism, but, as will be explored elsewhere, the PCT was not operating in a climate in which the assessment of the quality of the services it was commissioning was a priority. It did not have the appropriate resources for it to offer a truly effective voice on complex issues such as the significance of mortality statistics. It is difficult, therefore, to accept its assertion that receipt of the mortality alerts would have made a difference to its actions. It is highly likely that it would have relied on the lead of the SHA, as in fact occurred in any event.

245 CL00000000151
246 Poynor WS0000014314, para 137; Paynor T65.138
247 CL0000001465, para 214

Department of Health

5.257 The DH did not intentionally set out to "rubbish" the DFI report, but its officials were clearly uncomfortable with DFI's approach to mortality. The DH did not specifically encourage the WMSHA to act as it did, but, on the other hand, it did not discourage it either. The concern and issues around the interpretation of HSMRs have now been remedied in part by the work led by Professor Sir Bruce Keogh in setting up the working group which has produced the consensus around the SHMI methodology.

Healthcare Commission

5.258 The HCC was criticised by Mr Poynor, for not sharing information about its alerts with SSPCT:

> *My criticism is of the system. As a commissioner who has a role to commission for quality of care, if there is a risk that poor care is being delivered I believe we should have been informed about these alerts or complaints immediately rather than becoming aware when an investigation is announced. It is disappointing that the system was not more joined up in relation to this fundamental issue.*[248]

5.259 He rejected the argument that the alerts were too developmental to share: if they were important enough for the HCC to act on, then they ought to have been shared.[249] Others from the PCT claimed that knowledge of these alerts would have dissuaded the PCT from supporting the Trust's FT application and that they would have been helpful in triangulating other information.[250] It was argued that the alert information, for instance in jejunum operations, would have been a lot easier to understand than the HSMR. It is in fact open to doubt whether the PCT would have been persuaded to act differently. It took a sceptical view of the HSMR and it seems likely that it would have had as much difficulty in accepting the alerts more readily. The HCC was justified in proceeding cautiously with a new tool. The challenges experienced by organisations faced with suggestions of excessive mortality are such that a cautious approach was reasonable.

Recommendations

5.260 Recommendations arising out of the findings in this chapter are to be found in *Chapter 26: Information*.

5.261 For the future, it is clearly important that commissioners are able to understand and explore the significance of safety and quality indicators in relation to the providers from whom they commission services. This will be explored further in *Chapter 21: Values and standards*.

248 Poynor WS0000014330–1, PCT closing submissions para 205
249 Poynor T65.145
250 Fox WS0000013018, para 109; Sawbridge WS0000013425, para 121

Chapter 6
Patient and public local involvement and scrutiny

Key themes

- There have been a wide range of routes through which patients and members of the public can link into health services and hold them to account, but these have been largely ineffective and have received little proper support or guidance.
- The mechanisms for patient and public involvement (Public and Patient Involvement Forums (PPIFs), Local Involvement Networks (LINks)) had raised expectations about their role which proved impractical, relying on enthusiastic but uninformed and untrained volunteers and recruiting from a small, unrepresentative pool of the 'usual suspects'.
- The Overview and Scrutiny Committees (OSCs) in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement, and offered ineffective challenge.
- Local Members of Parliament (MPs) received feedback on concerns about the Trust, but largely just passed these on to others without following them up.
- Patient involvement structures have relied on goodwill and insight to make them work – in Stafford this meant they quickly broke down under dysfunctional relationships and in-fighting, whilst the lack of support led to a preoccupation with constitutional arrangements rather than patient concerns.
- The role of the local media in highlighting problems in quality should not be ignored as a warning sign.
- Foundation trust (FT) governors have great theoretical power without great accountability – they are reliant on the goodwill of the chair and board, and there is little consistency in their role between FTs.
- The community in Stafford was reticent in raising concerns and accepting of poor care; those who did make a complaint were not heard or given a voice.
- There is a danger that local scrutiny which is in fact ineffective may nevertheless appear to offer comfort to other regulators, which in reality it should not do, and this danger needs to be carefully considered under the new scheme.

Introduction

6.1 The Inquiry has heard considerable evidence about the interaction between patient and public representatives and the Trust. It might have been expected that concerns about the standards of service would have first become apparent through these channels. Such representatives and their organisations were intended to be accessible to patients and the general public and to have the means to identify concerns and communicate to those responsible for the management, oversight and regulation of providers. In practice, alarm bells were not rung by this route, or at least not sufficiently loudly to provoke any effective reaction. This chapter seeks to describe what happened and to explore the reasons why more concern was not generated by this route.

6.2 In this context, it is pertinent to examine:

- Patient and public involvement bodies;
- LINks;
- Local government health scrutiny committees;
- MPs;
- Local media outlets.

Patient and public involvement bodies

Community Health Councils

6.3 Community Health Councils (CHCs) were abolished in 2002, and therefore the examination of their activities fall outside the scope of this Inquiry. However, many witnesses suggested that the standard of representation of patient and public concerns had declined since then, and therefore it is apposite to include a brief description of how they operated.

6.4 CHCs were statutory bodies located largely within local authority areas with their own offices and staff. They had a membership drawn from the local community, elected councillors and appointees of the Secretary of State for Health. Individuals with particular expertise could be co-opted.

6.5 Their functions were:

- To support individual patients regarding information and complaints;
- To monitor local hospital and community (but not primary care) services;
- To provide a public perspective in relation to proposed changes in services.

6.6 They had a right to:

- Be consulted on service changes;
- Enter and inspect hospitals;
- Request and receive information from NHS bodies;
- Attend formal meetings with health authorities;
- Refer proposals for change to the Secretary of State.

6.7 It is not entirely clear why CHCs were abolished, but it was suggested that one reason was that their performance was not consistent around the country. There was also an issue over how much they cost to run. The Department of Health (DH) suggested in a paper supplied to the Inquiry, describing the history of public and patient involvement, that CHC membership had been unrepresentative:

> *The appointment of PPIF* [Patient and Public Involvement Forum] *members through CPPIH was a direct result of the concern that CHCs were unrepresentative and thus greater effort was needed to widen the involvement from all sections of the patient and local communities.*[1]

6.8 The Rt Hon Andy Burnham MP doubted in retrospect the wisdom of abolishing CHCs:

> *the abolition of Community Health Councils was not the Government's finest moment ... it seems we failed to come up with something to replace CHCs that did the job well.*[2]

6.9 As did Peter Walsh, Chief Executive of Action against Medical Accidents (AvMA):

> *Community Health Councils were responsible for monitoring the NHS and raising issues identified with the trusts concerned ... independent from the NHS ... enabled these bodies to effectively raise both individual and systemic concerns and press for appropriate changes to be made.*[3]

6.10 Malcolm Alexander, Chair of the National Association of LINks Members, supported the work of the CHCs:

> *Each CHC had complete freedom to determine its work programme, subject to the constraints of the legislation, and consequently there was some considerable variance in their focus. On the whole they tended to work very well and were generally seen as being vibrant and plugged into the local community and its issues.*[4]

1 CB/14 WS0000052297–298, para 40
2 Burnham WS0000063414, para 47
3 Walsh AVMA0001000017, para 33
4 Alexander WS0005000022, para 5

6.11 The proposal to abolish them was highly controversial at the time, and the Government failed at the first attempt to pass the relevant legislation in 2000.

6.12 The evidence was not entirely positive. Professor Sir Ian Kennedy, in his essay *Learning from Bristol – Are we?*, did not share this nostalgia, while not having much time for the successor to CHCs:

> *Community Health Councils and their recent replacement, Patients' Forums ... have historically provided the appearance of democratic engagement without in fact, being anything other than more or less effective talking shops. They certainly never enjoyed any power or capacity to make decisions.*[5]

Patient Forums

Legislation and guidance

6.13 Patient and Public Involvement Forums (PPIFs) derived from the National Health Service Reform and Healthcare Professions Act 2002. This abolished CHCs and imposed on the Secretary of State for Health a duty to create a forum for each NHS trust whose hospitals were in England. Members of forums were to be appointed by the Commission of Public and Patient Involvement Forums (CPPIF), also set up by the Act.

Commission of Public and Patient Involvement in Health

6.14 The CPPIH had duties to provide advice, staff and support to PPIFs, and to provide and assist providers of independent advocacy services. In addition, it was to set quality standards for forums, to monitor their performance and make recommendations regarding their future operation. It also had a duty to report concerns:

> *If the Commission—*
>
> *(a) becomes aware in the course of exercising its functions of any matter connected with the health service in England which in its opinion gives rise to concerns about the safety or welfare of patients, and*
>
> *(b) is not satisfied that the matter is being dealt with, or about the way it is being dealt with,*
>
> *the Commission must report the matter to whichever person or body it considers most appropriate (or, if it considers it appropriate to do so, to more than one person or body).*[6]

5 IK/2 WS0000026015
6 National Health Service Reform and Healthcare Professions Act 2002, section 20, www.legislation.gov.uk/ukpga/2002/17/contents

6.15 Such reports could be made to, among other bodies, the healthcare professions regulators, or the Commission for Health Improvement (CHI).

Functions and powers of forums

6.16 Section 15(3) of the NHS Reform and Healthcare Professions Act 2002 set out the general functions of PPIFs. These included:

- Monitoring and reviewing the range and operation of services of its provider trust;
- Obtaining the views of patients and their carers about services and reporting them to the trust;
- Providing advice, reports and recommendations about services to the trust, with regard to the views of patients and carers, or to any other body it thought fit to provide such a report.

6.17 CPPIH's guidance suggested that the purpose of PPIFs was to provide a "critical friend" to its trust:

> *... who works closely with it but represents the public's and the patients' views.*[7]

Power of referral to Overview and Scrutiny Committees

6.18 PPIFs had the power to refer to the relevant local government Overview and Scrutiny (OSC) or the CPPIH any matter it thought should be considered by them.

6.19 PPIFs were also empowered to refer matters to the local OSC where it considered the trust was not carrying out its statutory duty to consult[8] under section 11 of the Health and Social Care Act 2001.[9] Before making such a referral, the relevant forum was obliged to make reasonable efforts to resolve the matter with its trust.

Power of referral to follow up recommendations

6.20 Where a forum had made recommendations to its trust, it could require the trust to inform it whether it intended to take the recommended action, and if not, the reasons for this. In the event of a failure to respond or to take the appropriate action, the forum could refer the matter to the Strategic Health Authority (SHA) or the local OSC.[10]

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7 PPIF0001000034, *Handbook for PPI Forum Members* (December 2004), Commission for Patient and Public Involvement in Health, page 5

8 The areas in which a duty to consult was imposed under the 2001 Act were:
(a) the planning of the provision of *[health]* services *[for which the relevant Trust was responsible]*,
(b) the development and consideration of proposals for changes in the way those services are provided, and
(c) decisions to be made by that body affecting the operation of those services.

9 REG00010000001, The Patients' Forum (Functions) Regulations 2003, Reg 7

10 The Patients' Forum (Functions) Regulations 2003 [SI 2003/2124], Reg 8, www.legislation.gov.uk/uksi/2003/2124/made

Forum membership

6.21 Forums could appoint a Chairman and a Deputy Chairman from their number for any period they determined.[11]

6.22 The Patients' Forum (Functions) Regulations 2003 prescribed a formidable list of disqualifications from membership. These included having been a member of a forum for eight years or having ceased to be a member within the last four years. Employees of certain NHS bodies and local authorities were also disqualified, as were those who had been removed from their professional bodies under regulatory provisions. There was clearly intended to be a separation between the forum and the trust with which it was associated. The list of exclusions also precluded individuals who had worked for an NHS trust from membership of that same trust's forum.[12]

6.23 The CPPIH was obliged to ensure that the majority of members were patients past and present. Otherwise, members could be drawn from local voluntary organisations representing the interests of patients and carers.[13]

6.24 The guidance noted that there was power to co-opt members to the forum's committees and sub-committees but not to the forum itself. However, it suggested that "informal arrangements" could be made to "involve" non-members, although they would not have the formal responsibilities or powers as formally appointed members.[14]

Forum meetings

6.25 The Regulations also required meetings of the forum to be in public, but only in relation to specified business:[15]

> *agreeing annual and other reports;*
>
> *reviews to be carried out under section 15(3)(a) of the Act;*
>
> *agreeing the annual accounts;*
>
> *agreeing how expenditure of its annual budget is to be allocated; or*
>
> *making a referral to another body or person.*

11 The Patients' Forum (Membership and Procedure) Regulations 2003 [SI 2003/2123], Reg 3, www.legislation.gov.uk/uksi/2003/2123/contents/made
12 The Patients' Forum (Membership and Procedure) Regulations 2003 [SI 2003/2123], Reg 4, www.legislation.gov.uk/uksi/2003/2123/regulation/4/made
13 The Patients' Forum (Membership and Procedure) Regulations 2003 [SI 2003/2123], Reg 2, www.legislation.gov.uk/uksi/2003/2123/contents/made
14 PPIF0001000040, (December 2004), *Handbook for PPI Forum Members*, Commission for Patient and Public Involvement in Health, page 10
15 The Patients' Forum (Membership and Procedure) Regulations 2003 [SI 2003/2123], Reg 10(5)

6.26 At least seven days' notice of the business in those categories to be transacted was required. The CPPIH Handbook strongly recommended that forums hold other meetings in public and make minutes public.[16] This may have led to the requirement that any questions from the public had to be submitted at least seven days in advance.

Power of inspection

6.27 The Regulations gave forums a power to inspect:

> *(1) Subject to the following paragraphs of this regulation, persons authorised in writing by a Patients' Forum may at any reasonable time enter and inspect premises owned or controlled by—*
>
> *(a) in the case of a PCT Patients' Forum, those mentioned in paragraph (3);*
>
> *(b) in the case of a Patients' Forum established for an NHS trust, that NHS trust,*
>
> *and, except where, in the opinion of those persons or bodies, this would compromise the effective provision of health services or patients' safety, privacy or dignity, and without prejudice to paragraph (2), those persons and bodies shall comply with any request for entry.*
>
> *...*
>
> *(5) In exercising rights of entry and inspection under this regulation, a Patients' Forum shall have regard to the need to safeguard patients' safety, privacy and dignity, the need not to compromise the effective provision of health services, and to any advice given to it by the Commission.*[17]

6.28 The CPPIH's statutory guidance suggested that most visits would be formal, announced visits, but it was recognised that formal, unannounced visits might be required, for instance, where to announce a visit would render it meaningless, such as where cleanliness was to be inspected. However, the CPPIH did require that programmes for unannounced visits (not the visits themselves) be agreed beforehand with the trust. This agreement would extend to the general nature of the visits and the date by which they would end.[18]

Production of information

6.29 The Regulations granted the power to forums to require the production of information from trusts which appeared to the forum to be necessary for the effective performance of its functions, subject to exceptions including provisions designed to protect patient confidentiality.[19]

16 PPIF0001000044, *Handbook for PPI Forum Members* (December 2004), Commission for Patient and Public Involvement in Health, page 14
17 The Patients' Forum (Functions) Regulations 2003 [SI 2003/2124], Reg 3, REG00010000001
18 PPIF0001000065, *Handbook for PPI Forum Members* (December 2004), Commission for Patient and Public Involvement in Health, page 32
19 The Patients' Forum (Functions) Regulations 2003 [SI 2003/2124], Regs 5–6, www.legislation.gov.uk/uksi/2003/2124/made

Guidance on conduct of members

6.30 CPPIH gave guidance on contact with the press. It stated that members were free to give their own views to the media but must make it clear they were not speaking on behalf of the forum.[20]

6.31 So far as approaches from the public were concerned, CPPIH made it clear that it was not the job of a forum member to deal with individual complaints and that complainants should be referred to the relevant organisation.[21]

6.32 In the final section of the CPPIH Handbook, *Making a Difference*, a number of principles were set out as "*guides to success*":[22]

Listen to what patients and the public say

Remember some people do not get their views heard

Involve others

Don't duplicate

Build working relationships and partnerships

Work as a team

Work with the NHS not against it

Take a long view

Creation of the Mid Staffordshire Forum

6.33 In order to get forums set up around the country, CPPIH contracted with various service providers to offer support services in specified areas. For Staffordshire, the contractor was Age Concern South Staffordshire (now Age UK South Staffordshire when in 2009 Age Concern and Help the Aged merged). This is best known as a national charity but is in fact a federation of charitable associations, each responsible for the charity's activities in its own area. These are Age Scotland, Age Cymru and Age NI as well as Age International and its commercial services arm, Age UK enterprises. The three-yearly contract for South Staffordshire was funded by about £300,000 a year[23] and required Age Concern South Staffordshire to set up and support 14 forums,[24] one of which was that associated with the Trust. There was a separate forum for

20 PPIF0001000077, *Handbook for PPI Forum Members* (December 2004), Commission for Patient and Public Involvement in Health, page 42
21 PPIF0001000083, *Handbook for PPI Forum Members* (December 2004), Commission for Patient and Public Involvement in Health, page 48
22 PPIF0001000085–87, *Handbook for PPI Forum Members* (December 2004), Commission for Patient and Public Involvement in Health, pp49–51
23 Welch T21.93
24 Welch WS0000001996, para 6

the primary care trust (PCT). Staffing costs consumed about 80% of the budget.[25] Staffed offices were set up in Stafford and Stoke, as well as an unmanned office in Burton-on-Trent.

Support service

6.34 The role of the support service has been the subject of criticism among witnesses who considered that it dictated or restricted the PPIF's business rather than merely providing administrative support. The role envisaged by the CPPIF, and according to Mr Welch disseminated by the training he received, was to support and coordinate forums and administer business in accordance with the decisions of the forum, rather than to offer leadership. As set out below, this was not how certain forum members perceived the support service in reality.

Recruitment and selection of members

6.35 It appears that there were considerable difficulties recruiting sufficient members to the PPIF. Mr Welch said that some forums could only attract three or four members. It proved difficult to attract a diverse membership, and as may often be the way with voluntary and charitable activities, those applying tended to be retired. It also proved difficult to attract applications from minority ethnic groups in spite of specially focused advertisements.[26] Therefore, from the outset, the membership was hardly representative of the population.

6.36 According to Mr Welch, publicity was achieved through reporting in the media, as well as local workshops about the functions of PPIFs. Leaflets were produced in relevant languages; these were left in the Patient Advice and Liaison Service's office (PALS), reception desks at hospitals and other public venues such as libraries.[27]

6.37 Mr Welch told the Inquiry:

> *We couldn't afford to be too selective and generally accepted people whose interest in the PPI Forum was a worthy one. The calibre of recruits was of course variable ...*[28]

6.38 The Inquiry heard from a number of members of the PPIF. It appears that many members volunteered because of a personal interest in the Trust as a result of being a patient there, or a relative of a patient.

6.39 Rod Hammerton, Chair of the PPIF between October 2005 and 2007, was initially appointed a member of the Stafford forum, having previously been a member of the forum associated

25 Welch T21.99
26 Welch T21.108–110
27 Welch T21.111
28 Welch WS0000001997, para 10

with the local ambulance service.[29] He had been treated for serious illness at the Trust on three occasions. He stated that he owed his life to the hospital and its staff.[30] Somewhat hesitantly, he accepted that the potential conflict between a scrutiny role and his having been treated at the hospital did worry him a little, but he did not accept that this association affected his judgement.[31] He had been keen on promoting a constructive relationship, allowing for constructive criticism rather than a confrontational approach, but that view was independent of any regard he had for the hospital. In any event, his experience there had hardly been positive as he felt he had been mistreated on at least three occasions.

6.40 Robin Bastin, who became a member of the Stafford PPIF in March 2006, told the Inquiry that becoming a member was straightforward. He had wanted to join because of his personal interest following an adverse experience of the treatment given to his daughter. There was a short telephone interview, after which there was a Criminal Records Bureau check. He was then provided with a folder of induction material.[32]

6.41 Mr Bastin was less than complimentary about the make-up of the membership:[33]

> *I was quite amazed. The forum appeared to be made up of between eight to twelve elderly ladies and felt like something of a WI meeting.*

6.42 As will be seen, he did not hesitate to express his views in strong terms and in a manner which did not meet the approval of at least some other members.

6.43 Mrs Christine Woodward, who became Vice Chair of the PPIF, joined after being invited to do so. She felt she had something to contribute through her previous work with Diabetes UK.[34] Shortly after she joined, she had the sad experience of her son being treated at the hospital during what transpired to be a final illness. She was very impressed and grateful for the treatment he received,[35] but she did not believe that affected her judgement in relation to the business of the PPIF.

6.44 According to Mr Hammerton, the Stafford PPIF had about 10 members from a variety of backgrounds and an attempt was made to use their skills in its business. One such member was Terence Deighton, who was a retired electrical engineer with expertise in safety and risk management. His initial interest in joining the PPIF had been his objection to the Trust's policy

29 Hammerton WS0000001693
30 Hammerton WS0000001700–702, para 29–36
31 Hammerton T22.159; 174
32 Bastin WS0001000002, para 5–6
33 Bastin WS0001000003–4, para 9
34 Woodward WS0000002404, paras 2–3
35 Woodward T46.9–10

of prohibiting the use of mobile telephones. He found that fellow members, in particular the Chair (who preceded Mr Hammerton), lacked objectivity.[36]

6.45 From further afield, the Inquiry heard from Ken Lownds. He had no personal experience of the Stafford PPIF, but he had been a member and indeed, for a short time, Chair of the University Hospital of North Staffordshire PPIF. He found the process of being admitted as a member of the forum unimpressive. While he had to go to Birmingham for an interview, he was merely asked to confirm who he was and that he wanted to become a member.[37]

Training of Forum members

6.46 There was a difference of perception about the level of training offered between the provider, as represented by Mr Welch, and the recipients. Mr Welch described the training offered as including such topics as chairing meetings and conducting inspections. He believed that everyone seemed content with the level of training, although he noted that complaints had sometimes been received about the training provided by the CPPIH.[38]

6.47 Mr Hammerton, former Chair of the Stafford PPIF, told the Inquiry he received "very little formal training", and Mr Bastin was:

> *... quite frankly disgusted with the level of information and presentations being given to us, which seemed very beneath us.*[39]

6.48 Mr Deighton was also dissatisfied with what was provided, although it is apparent from his description that at least some level of briefing material was offered:

> *I do not recall ever being provided with really constructive training as to the function and role of the other external bodies within the Healthcare system. We were provided with lots of folders of information but I did not find this helpful in really understanding what function these organisations performed.*[40]

6.49 Mr Bastin found the induction day he attended unhelpful, basic and condescending.[41]

6.50 Mrs Woodward could remember little of any training before or at the time of becoming a member, but she noted that the PPIF often received talks on various aspects of the system.[42]

36 Deighton WS0001000201, para 11
37 Lownds T19.68–69
38 Welch WS0000001999, para 18
39 Bastin WS0001000003, para 7
40 Deighton WS0001000203, para 17
41 Bastin WS0001000003, para 7
42 Woodward T46.12–13

Trust Forum meetings

6.51 The Stafford PPIF met about once a month in Stafford. The meetings lasted between one and two hours and were open to the public.[43] According to Mr Deighton, members of the public never attended.[44]

Forum inspections of the Trust

General approach

6.52 The PPIF exercised its power to inspect the Trust on a fairly regular basis. It would give prior notice, but on occasions this was very short notice, of an hour or less.[45] Six members would visit, inspect the premises including clinical areas, and ask questions of staff and patients. A checklist would be drawn up in advance and specific roles allocated to each member of the team. Inspections would include physical examination of parts of the premises and conversations with patients. The results of inspections would be included in a report, to which all members of the team could contribute,[46] and shared with the Trust and the CPPIH along with any recommendations for action. If the Trust disagreed with the wording or conclusions of a report or some minutes, it would tell the PPIF, and the PPIF would reconsider and sometimes change the wording of reports.[47]

6.53 Mrs Woodward said that the PPIF members would "sometimes" talk to patients, but that to her knowledge they "never received negative comments" from them.[48]

Specific inspections

6.54 Mr Deighton became interested in the cleanliness of the Trust after a visit in connection with his initial interest about the use of mobile phones in hospitals. As a result of what he saw and from talking to patients, he was concerned about cleanliness and took this up with the then Chair of the forum without, he felt, succeeding in persuading him to take much interest.

6.55 Some time later, after Mr Hammerton had become Chair, Mr Deighton tried to persuade the forum to undertake a series of cleanliness inspections based on the national standards. Although there appears to have been a protracted debate about this and disagreement about the precise methods to be used, a series of three inspections did eventually take place on 15 November 2005, 24 January 2006 and 10 March 2006.

43 Hammerton WS0000001694, para 5; RB/1 WS0001000032
44 Deighton T15.21
45 Hammerton WS0000001693, para 3
46 Woodward WS0000002406, para 10
47 Hammerton WS0000001695, para 9
48 Woodward WS0000002405–406, para 8

Visit on 15 November 2005

6.56 The report of this visit concluded that a "favourable impression" had been obtained of the areas visited, which included the Accident and Emergency (A&E) Department, the Emergency Assessment Unit (EAU) and Wards 10 and 11 and that this had been a "good visit".[49] Areas of mildly expressed criticism included:

- Congested wards, particularly Ward 11 which was "seriously congested, very busy and appeared untidy";
- One rubbish bin in the main reception was "nearly full";
- Some criticism was made of the location and type of antibacterial gel dispensers and information about their use;
- A disabled toilet in Ward 10 was dirty;
- Not all incoming patients had been swabbed for MRSA.

6.57 The report was shared with the Trust, who responded by expressing pleasure that the overall impression of PPIF members had been favourable and describing various initiatives that were in train.[50]

Visit on 24 January 2006

6.58 This was the only one of the three inspections attended by Mr Deighton. His role was to participate in an inspection of A&E. He was appalled by what he found:[51]

- There was what he believed to be a quantity of blood at the entrance to A&E which was beginning to dry.
- About 90% of the chairs in the waiting area were ripped and dirty with blood, dust and debris in the tears.
- The floors were dirty and in poor condition.
- He met the mother of a patient who was crying at the state of cleanliness.
- The toilets were "completely disgusting" and had not been cleaned for a long time.
- He noticed that receptionists were triaging patients.
- The children's area was filthy.
- In the assessment area, washing facilities for staff were next to an overflowing bin, and the area was dirty.
- He noticed staff, including doctors, not cleaning their hands between seeing patients.

49 OTHER0001000017, Letter to Forum Coordinator and Action Plan following Monitoring visit of 15.11.2005 (9 January 2006)
50 OTHER0001000011, Letter to Forum Coordinator and Action Plan following Monitoring visit of 15.11.2005 (9 January 2006)
51 Deighton WS0001000209–212, paras 37–48; T15.70 *et seq*

6.59 He immediately drew his findings to the attention of his colleagues, and Mr Hammerton came to have a look. His interpretation of what he saw was different, because although he agreed that there was dirt present, it could, in his view, have been there a short time and was not therefore indicative of a systemic problem.[52]

6.60 Mr Deighton wanted the PPIF members to contact the Chief Executive and senior Trust management immediately, but Mr Hammerton and Mrs Woodward insisted that the concerns be channelled first through the forum's usual procedures, which involved consideration by the forum as a whole and a report drawn up by the Coordinator. This reaction caused Mr Deighton to submit his immediate resignation.[53]

6.61 Mrs Woodward told the Inquiry that she too had been concerned about the state of A&E, particularly in 2005.

> *The reception was in a very bad state. Seats were torn and toilets were abused. The children's area left a lot to be desired ... It was also clear that people were overworked and over-stretched in the reception area and not giving the service they should have been. Cubicle areas were dirty also.*[54]

6.62 The report of the visit reflected, albeit in milder language, the matters that had been observed by Mr Deighton.[55] Among other concerns raised were:

- Dust and dirt in various places in Wards 10 and 11;
- Full waste bins in Wards 7 and 11 and reception;
- Christmas decorations stored in a bathroom on Ward 10;
- Poor state of toilets in Wards 2, 7 and 11 as well as A&E and the main reception area.

6.63 A total of nine recommendations were made.

6.64 The report's conclusion went out of its way to emphasise positive aspects of the visit and to express understanding for the difficulties facing the Trust:

> *It is clear that reorganisation is continuing to take place in the Hospital and areas are improving ... although there remains work to be completed ...*

52 Hammerton WS0000001695, para 11
53 Deighton WS0001000212–213, para 49; Deighton T15.76
54 Woodward WS0000002407, para 13
55 CW/1 WS000000248

Overall we were pleased with the improvement in cleanliness since our last visit and whilst we have been critical of Ward 11 and the A&E we are aware of the difficulties and pressures that Ward 11 has experienced over the last two months with both staff shortages through sickness and also the pressure from full wards ... adding to the maintenance problems.

Whilst compiling this report on Accident and Emergency we note and acknowledge future plans for the refurbishment for this department ...

6.65 The reply from the Trust on 3 March 2006 expressed pleasure that:

... the Forum were pleased with the improvements in cleanliness since the last visit ...[56]

6.66 The letter did not address Mr Deighton's concerns.

Visit on 10 March 2006

6.67 On this occasion, the final visit in the programme planned by the PPIF, members visited A&E, EAU, and Wards 1, 2, 7, 10 and 11. A number of positive observations were made about the provision of information posters and other notices. But a series of critical comments were made about cleanliness. These included a dirty toilet on Ward 11, torn seats still being present in A&E and elsewhere (including one chair labelled as condemned by infection control), vomit on a window which had been pointed out to staff on an earlier occasion, and cobwebs on an air vent in a corridor.

6.68 The PPIF then produced a final report covering the three visits.[57] Its conclusion was that there had been a "significant improvement in cleanliness" since the previous visits and a "positive response" to its recommendations. The areas visited on the third occasion were described as clean and tidy "excepting a few discrepancies". It was noted that some areas merited further attention.

6.69 A further unannounced visit took place in November 2006.

56 OTHER0001000021 Letter from Trust to PPI Forum re Monitoring Visit – 24 January 2006 (3 March 2006)
57 CW/2 WS0000002417–424

Members's views on the effect of the visits

6.70 Mr Hammerton told the Inquiry that he had always felt that the PPIF was making progress with the Trust and that its concerns were listened to.[58] He considered that the forum had made an impact on cleanliness at the Trust:

> *In the early stages of the PPIF involvement with the hospital I would have to say that the state of the Hospital observed on some visits was appalling. The level of dirt, in particular, was a matter of concern ... This was one of the things that which* [sic] *we got improved.*[59]

6.71 However, an exception was A&E:

> *One exception was A&E, which was always a complete disaster.*[60]

6.72 Mrs Woodward told the Inquiry that the forum:

> *... tried to ensure that the reports reflected exactly what we found. There was never a question of saying between ourselves that the report could not state something as it sounded bad. We were not going into the hospital to cover things up which were wrong.*[61]

6.73 She agreed that A&E was an area where little progress was made:

> *Accident and Emergency (A&E) is an example of an area where problems were raised but immediate solutions were not provided. It took a long time for funding to be found to put the problems in accident and emergency right but this was constantly on our agenda.*[62]

Contact with the press

6.74 Mr Deighton's unhappiness with the approach of the Stafford PPIF was such that, as has been noted above, he resigned. He said that he had expected the forum to monitor the hospital and its culture rather than concentrating on what he regarded as trivial matters. He thought there was a reluctance to discuss important issues.[63]

6.75 Following his resignation, Mr Deighton communicated his concerns to the CPPIH which responded with the suggestion he was "out of step" with the forum. Dissatisfied with this, he went to the local press with his story, and articles were published. In one, published on 2 February 2006, Martin Yeates was quoted as saying in response to the complaints:

58 Hammerton WS0000001696, para 14
59 Hammerton WS0000001696, para 13,
60 Hammerton WS0000001695, para 10
61 Woodward WS0000002407, para 15,
62 Woodward WS0000002407, para 11
63 Deighton WS0001000201–202, para 11–16

If they are true then that is not acceptable. We will conduct a thorough investigation to get to the bottom of it. We consider ourselves to be a very clean hospital and independent reports have told us that.[64]

6.76 The PPIF's reaction to this publicity was unfavourable. Mrs Woodward in particular was recorded in the minutes as saying:

... the PPI Forum had no knowledge of this story being published, and in no way endorsed the remarks made. She said that the Trust had been open and accommodating towards the needs of the PPI Forum in undertaking inspections or visits to Trust premises, and had always been extremely cooperative ... significant improvements had been noted, and a high standard of cleanliness has been maintained.[65]

6.77 Mr Hammerton told the Inquiry that Mr Deighton's conduct had caused "great irritation" to forum members and the Trust.[66]

6.78 Another member who felt sufficiently frustrated to contact the press was Mr Bastin. He was concerned about the difficulty he had in obtaining from the PPIF sufficient information about infection rates. In due course, he received a copy of the minutes of a meeting of the Trust's Infection Control Committee.[67] These reported a total of 341 cases of infection during the period January to September 2006 and a monthly average of 36 compared with an average of 13 per month from 2002 to that date. It was alleged at a subsequent meeting of the PPIF that he had been sent the minutes at his request, but he told the Inquiry he had received them almost by accident as the PPIF observer on the Infection Control Committee, Christine Woodward, had been away. Mr Bastin felt no confidence that the leadership of the PPIF would take the matter seriously and decided, after consulting Mr Deighton, that he should make this document public by allowing a local reporter to take it. As a result, a report appeared in a local publication.[68]

6.79 The reaction of the PPIF was to accuse Mr Bastin of a breach of the CPPIH's code of conduct. Mrs Woodward was recorded as expressing distress that the trust and goodwill that she felt had been built up with the Trust had been put at risk.[69] Mr Bastin was not prepared to be prevented from contacting the Trust, and therefore resigned from the PPIF.[70]

64 www.staffordshirenewsletter.co.uk/News/Town-hospital-inbr145a-squalid-state146.htm
65 TD/13 WS0001000558
66 Hammerton WS0000001696, para 12
67 RB/2 WS0001000089
68 Bastin WS0001000006, paras 16–18
69 RB/3 WS0001000094
70 Bastin WS0001000007, para 21

Reaction to the Trust's workforce reduction programme

6.80 Mr Bastin, shortly after becoming a member of the PPIF, attended a Trust Board meeting on 6 April 2006 at which Martin Yeates put forward the workforce reduction programme for that year. The details of this are described in *Chapter 1: Warning signs* and *Chapter 2: The Trust*.

6.81 As recorded in the minutes, Mr Bastin registered his concerns:

> *Mr Robin Bastyn* [sic] *commented on the 150 job losses that had been announced in the early part of the meeting. He asked if the Board were aware of the deep concern that this had caused in the local community, and questioned the assurance from the Board that patient services in the hospital will not suffer. He referred to a belief that the majority of redundancies will be amongst clinical staff and expressed concern regarding MRSA issues within the Trust. He asked if there was sufficient realisation amongst the Board members that the talk of not affecting services was not correct?*[71]

6.82 Martin Yeates is recorded as having assured Mr Bastin his fears were unfounded.

6.83 Mr Bastin was asked whether the PPIF took any action on this matter:

> *No, what could they do? We had – I had expressed my concerns, perhaps it was a bit silly of me to think that I was talking for the PPI there, but I had let them know that the general public – hang the PPI, but the general public were seriously concerned about these cuts going ahead.*
>
> *Q. Did you think that the PPIF could have done more?*
>
> *A. No, not really. I mean, let's take the PPI in its true context. A little group of eight or ten people meeting on a monthly basis, nobody knows about their existence. How on earth could they have any impact on big decisions like that, that had already been made?*[72]

The Forum's observations on the Trust's Annual Health Check declarations

6.84 The PPIF was one of the bodies able to comment on the Trust's annual self-assessment of compliance with the core standards as part of the Healthcare Commision's (HCC's) Annual Health Check (AHC) process. The pattern of their commentary was similar to that seen in the inspection reports. Reservations in relation to the declaration were balanced by positive remarks.

71 TRU00010009819 Minutes of confidential Trust Board meeting of 6 July 2006
72 Bastin T16.45

2006–2007 commentary

6.85 In relation to the AHC core standard C15(b) (that the Trust should have systems in place to ensure that patients are properly nourished), the PPIF observed:

> *We are unable to confirm 'Compliance' with this core standard as we are familiar with cases during the year where patients with disabilities have been unable to feed themselves. With the patient's permission, the Forum will notify Pals of the cases referenced.*[73]

6.86 In spite of the concerns raised in the inspection reports described above, and Mr Deighton's more strongly expressed criticisms, no qualification in relation to hygiene issues or concerns about A&E was recorded.

2007–2008 commentary

6.87 The PPIF made the following remark about core standard C20(a) (provision of a safe environment for patients), stating:

> *EAU has been found all too frequently not to meet the appropriate standards as reported through previous PPI Formal Unannounced Inspections and visit reports.*[74]

6.88 This apparently concerning remark was balanced, if not overshadowed, by an effusive overall view:

> *It is important to report that our relationship with your Team at the Mid Staffs General Hospitals Trust has been further developed during the last twelve months and we have been very encouraged by Team members' willingness to note, discuss and make changes following our suggestions and comments ...*
>
> *Summing up, we perceive it to have been a good year for the Trust and, most particularly, its patients. Our congratulations are thus enthusiastically passed to you and your Team.*[75]

Other comments on the Forum's relations with the Trust

6.89 The PPIF sometimes had difficulty in getting the Trust to act.[76] Mr Hammerton said that generally, however, things did eventually get done in response to a request from the forum.[77]

73 HCC0000000015 Trust core standards assessment final declaration (April 2006)
74 SHA0024000315 Trust core and developmental standards declaration 2006/2007
75 SHA0024000316 Trust core and developmental standards declaration 2006/2007
76 Hammerton T22.109. It should be noted that although he was specifically critical of Colin Plant in this regard, Mr Deighton told the Inquiry he found him particularly helpful: Deighton T15.31
77 Hammerton WS0000001695, paras 9–10

6.90 Before the Trust became an FT, either Mr Hammerton as Chair or Christine Woodward as Vice Chair was able to attend Trust Board meetings. Mr Hammerton spoke positively about this opportunity, and believed that the PPIF's concerns were listened to by the Trust.[78] However, in retrospect, having read the press reports about the problems at the Trust, and after seeing them confirmed by an increasing volume of evidence, he had concluded that people within the Trust were blocking the flow of information to people, such as himself, whom, he accepted, lacked the relevant experience and training to challenge the Trust effectively.[79]

6.91 Christine Woodward's view of the Trust's reaction to the PPIF's concerns, as expressed to the Inquiry, was somewhat less positive than the impression given in the reports:

> *Sometimes we received constructive answers ... In general, however, the type of response which we would normally receive to issues raised would not be so much of a promise but a reassurance that things would be put right. However, timescales were often lengthy and we were repeatedly told that funds were not available.*[80]

6.92 Mr Bastin, like Mr Deighton, did not think that the PPIF was listened to by the Trust. Among his other concerns was a lack of reaction he received to questions about complaint handling:

> *... as they just appeared to be building up the backlog of complaints on the computer system and not providing us with any details of the complaints. It felt like we* [were] *being strung along. I found this to be the typical attitude of the people at the hospital who I dealt with via the forum.*[81]

The Forum's relations with the Overview and Scrutiny Committee

6.93 The PPIF had power under the regulations to refer matters to the local OSC.[82] This was something of which Mr Hammerton appeared to have been unaware.[83] In any event, he considered this committee to have been ineffective because he felt its members lacked any relevant knowledge.[84]

6.94 Mrs Woodward was aware of the power of referral and saw the OSC as a powerful body, but felt that in practice it was unable to effect change.[85]

6.95 Mr Welch thought that there had been no useful link between the two bodies.[86]

78 Hammerton WS0000001696, para 14
79 Hammerton T22.123–124
80 Woodward WS0000002409, para 20
81 Bastin WS0001000011, para 35
82 The Patients' Forum (Functions) Regulations 2003 [SI 2003/2124], Reg 7, www.legislation.gov.uk/uksi/2003/2124/made
83 Hammerton T22.137
84 Hammerton WS0000001697, para 17
85 Woodward WS0000002410, para 23
86 Welch T21.161–162

6.96 In fact, the Inquiry received evidence showing that there was liaison between the PPIF and the OSCs of both the Staffordshire County Council and Stafford Borough Council. For example, the Borough Council's committee received a presentation of the PPIF's annual report[87] in 2007. In November the same year, the PPIF presented a report on cleanliness at the Trust. So far as the County Council's committee was concerned, the PPIF also provided information about cleanliness.[88]

6.97 The only joint action between an OSC and the PPIF of which the Inquiry received evidence concerned the issue of healthcare acquired infections (HCAIs) in 2006 and 2007. This arose out of contact made with the Chair of the County Council's OSC, Councillor Muir, by Mr Deighton and Mr Bastin in the autumn of 2006 to express their concerns at the infection rates at the Trust.[89] As a result, Councillor Muir met Mr Hammerton and decided to instigate an "investigation" with the National Patient Safety Agency (NPSA) and the HCC.[90] By this, he meant that he would contact these bodies to obtain comparative data. It was agreed that the PPIF would continue to monitor the implementation of the Trust's action plan. Councillor Muir wrote to the Health Protection Agency (HPA) and the HCC, copied to the Trust and other Staffordshire provider trusts, on 2 November 2006 requesting this information, but was told by both that they did not hold such data.[91]

6.98 On 2 February 2007, the Trust belatedly replied through the Medical Director, Dr Suarez, having not understood previously that the request was directed to them in addition to the HPA and the HCC. She provided the following figures for the incidence of *Clostridium difficile* at the Trust for the previous five years:[92]

Table 6.1: *C. difficile* cases at the Trust 2002–2006

Year	Total cases	Identified on admission
2002	179	0
2003	172	0
2004	153	4
2005	203	33
2006	376	55

87 Edgeller WS0000003050, para 33; AE/10 WS0000003131
88 CLO000003191, *Counsel to the Inquiry's closing submissions,* Chapter 4 – PPIF, para 110
89 Muir WS0000034500, paras 98–99
90 JM/24 WS0000034829; JM/25 WS0000034832
91 JM/27 WS0000034845
92 JM/28 WS0000034855

6.99 Councillor Muir observed that there had been a significant increase in infections but did not consider that the figures stood out from those of other trusts and believed that the Trust was dealing with the problem adequately.[93] At the County Council OSC's meeting on 15 January 2007 it received a report on the PPIF's inspection of the Trust in the previous November (see above for a description).[94] The action plan included four pages of newly discovered matters requiring attention. Councillor Muir recalls taking a copy of this report to a meeting with Mr Yeates and asking him to appoint someone to take responsibility for dealing with the matter.[95] The matter was raised again at the meeting on 28 March 2007 when the figures obtained from provider trusts, including the Trust, were considered. The discussion centred around what the OSC could do to contribute to achieving a reduction in the number of cases, and the advice from the Trust was that it could assist by raising awareness of the issue generally and providing relevant health education. There was no recorded consideration of management issues for the Trust, except a suggestion that nurses should be prevented from wearing their uniforms outside the hospital.[96]

6.100 By this time, the PPIF had conducted two further inspection visits, in December 2006 and February 2007, and a further one was scheduled for May 2007, the conclusion of which was that cleanliness had "noticeably improved" "as reported previously".[97]

Abolition of Public and Patient Involvement Forums and the Commission of Public and Patient Involvement in Health

6.101 In 2005, the Government decided to abolish the CPPIH as part of a review of arm's length bodies. There was concern about its cost and a perceived lack of success in recruiting members for PPIFs and in steering the approach of forums to their work.[98] While consideration was given to retaining PPIFs, it was decided to replace them with a different means of involving patients and the public. An expert panel set up to review how best to incorporate patient and public views into the system recommended that an entirely new system should be created. In *A Stronger Local Voice*, the causes for dissatisfaction with PPIFs were identified as including:[99]

- Inconsistency in practice across the country;
- Lack of meaningful engagement in planning and commissioning services;
- Failure to recruit a numerous and diverse membership;
- Excessive bureaucracy;
- PPIFs tied to provider trusts when there was an increasing emphasis on community care;
- Potential for conflict between PPIFs and public involvement as members of FTs.

93 Muir WS0000034502, para 105
94 JM/30 WS0000034873
95 Muir WS0000034502, para 108
96 JM/33 WS000034916–917
97 PPIF annual report SBC0004000243
98 CB/14 WS0000052302–304, paras 60–67
99 *A Stronger Local Voice: A framework for creating a stronger local voice in the development of health and social care services* (July 2006) Department of Health, DH Gateway ref 6759, www.vision2020uk.org.uk/core_files/A%20stonger%20local%20voice.pdf

Overview of Public and Patient Involvement Forums as informed by the Stafford experience

6.102 Although the volunteer members of the Trust's PPIF did their conscientious best to fulfil a role of scrutiny of the Trust, and managed to raise at least some concern about cleanliness and infection rates (albeit in the latter case via two dissident members), the PPIF failed to identify the depth and breadth of the deficiencies present. It did not fail because of deficiencies on the part of any of its membership, or of its administrator, but because the forum appears to have been ill-equipped to fulfil this role.

6.103 Mr Hammerton, when asked to explain why he had not been aware of the state of affairs as revealed by the HCC investigation, said:

> *Well I suppose I'm just too trusting. I believed in what I was being told.*[100]

6.104 Mrs Woodward ascribed the failure to a lack of information and knowledge:

> *I think we, many of us ... did realise at the end that we'd not been kept fully informed about a lot of things that were going on, and it was that lack of knowledge that prevented us from asking some very vital questions that we could have asked.*[101]
>
> *... perhaps we should have asked more ...*[102]

6.105 One explanation for that was provided by Mr Bastin, who pointed to the absence of engagement with patients and the public:

> ... [it was] *one of the big failings of the PPI, one of the big failings of the LINk. But there you are. I mean, no, they didn't. How could they? They were such a small organisation, they could have gone around and beaten the drum or something like that, or tried to get television time, I don't know. But it wasn't that sort of organisation. It was a cosy little arrangement of people doing what – what they thought they ought to be doing. But I was amazed that I never did see an advertisement for a PPI meeting. Never.*[103]

100 Hammerton T22.189
101 Woodward T45.77
102 Woodward T45.90
103 Bastin T16.106

6.106 The experience of the Trust's PPIF exemplified many of the problems identified nationally by the Expert Panel in 2006,[104] which led to their abolition and the creation of LINks:

- It had a limited membership largely, through no fault of the individuals concerned, consisting of volunteers who had a reason to be indebted to, or critical of, the Trust because of a patient or family experience.
- The body had no democratic legitimacy, or authority derived from expertise or institutional status.
- As representatives of the public view, the forums were handicapped by a low public profile and lack of connection with representative interest groups. As a result, any views of the forums were no more or less significant or persuasive than the few individuals who were its members.
- The forum did little to reach out to the public to obtain wider views. There was a lack of effective engagement with the public. Public needs and experience are not to be obtained by consensus or a majority in a small committee, however well intentioned, but by the systematic collection of public views in a variety of ways.
- While it was provided with administrative support in the form of the service of Age UK, it lacked expertise to back up its work. While it made creditable attempts to monitor cleanliness, albeit without sufficiently emphasising the concerns identified, members did not have the expertise or the resources to draw the relevant inferences about competence of Trust management, or to consider the implications of matters such as staff cuts.
- It had the power of inspection, and members did receive guidance on how to exercise this power, but in practice there was little forums could do to ensure that any concerns identified were addressed effectively.
- There was no compulsory or optional template provided of the range of areas it should direct its attentions towards.
- There was, therefore, a demonstrable imbalance between the forums and the trusts they were supposed to scrutinise.

6.107 Mr Deighton and Mr Bastin were fiercely critical of the PPIF and the attitude of its other members. They, in turn, were resented by the other members. There was a conflict over the appropriate tone for approaching the Trust, with one side advocating and adopting a much more confrontational approach than the other. The prevailing majority sought to gain influence and to effect change by combining critical comment, contained in emollient language, with effusive praise of things seen to have been done well. Adopting such an approach was entirely understandable. The idea of a "critical friend" who draws attention in a "constructive" or "supportive" way to matters requiring improvement is deep rooted in the healthcare system. It is associated with a perceived need to balance criticism with praise.

104 CB/14 WS0000052289

6.108 The somewhat acrimonious disputes between the two points of view were the inevitable result of reliance on a forum consisting of a membership whose only qualification, other than one of a vague connection or interest in the Trust, was that they had expressed an interest in joining it. None of the members from whom the Inquiry has heard were anything other than genuinely and honestly seeking to make their contribution. It is perhaps not surprising that the forum's successes tended to be around matters with which members of the public might be expected to be more familiar, such as obtaining a better bus service and removing the prohibition on the use of mobile phones, than around more technical and clinical issues. But such a forum was never going to be able to resolve such differences of view, or more importantly, ensure all views were effectively represented to organisations with a responsibility for correcting or regulating deficiencies in the service.

6.109 While, as the 2006 review suggested, there may have been much good practice undertaken by forums – and in fairness it has not been part of the Inquiry's remit to examine evidence of other areas – the experience of Stafford shows that there was no system in place likely to ensure that all forums delivered, from the patient's point of view, representative and effective scrutiny of the service provided by the Trust. Mr Welch, who had helped to run 14 PPI forums thought that the Stafford PPIF was in the top three of those he managed in terms of its operation, and was complimentary about the contribution made by its members.[105] Given the evidence about the performance of the forum as described above, this was not reassuring evidence.

Local Involvement Networks

Policy

6.110 *A Stronger Local Voice* (see above) proposed the setting up of LINks to replace PPIFs. The purpose of LINks was said to be to:[106]

> *Provide a flexible way for local people and communities to engage with health and social care organisations;*
>
> *Support and strengthen open and transparent communication between people, commissioners and providers;*
>
> *Make sure organisations that commission services and provide health and social care services are more accountable to the public and build positive relationships with them.*

6.111 LINks were intended to obtain and analyse information from a wide range of people and sources, such as complaints, PALS, national surveys and focus groups. They were then to

105 Welch WS0000002000, para 20
106 *A Stronger Local Voice: A framework for creating a stonger local voice in the development of health and social care services*, Department of Health, page 14, www.vision2020uk.org.uk/core_files/A%20stonger%20local%20voice.pdf

decide what to pass on to commissioners and providers. In short, they were intended to be a means for commissioners, OSCs, and regulators to access the views of the local population.[107] Among the activities this was meant to assist was access by regulators to local information on the public's and users' needs and experiences.

Legislative framework

6.112 The policy was enacted by the Local Government and Public Involvement in Health Act 2007. This imposed on local authorities a duty to make arrangements, in effect by setting up a LINk:

> *for the purpose of ensuring that there are means by which certain activities could be carried out within the local authority's area.*[108]

6.113 Those activities included:

> *(a) promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;*
>
> *(b) enabling people to monitor for the purposes of their consideration of matters mentioned in subsection (3), and to review for those purposes, the commissioning and provision of local care services;*
>
> *(c) obtaining the views of people about their needs for, and their experiences of, local care services; ...*
>
> *(3) The matters referred to in subsection (2)(b) are –*
>
> *(a) the standard of provision of local care services;*
>
> *(b) whether, and how, local care services could be improved;*
>
> *(c) whether, and how, local care services ought to be improved.*

6.114 LINks were required to produce annual reports to be sent to their local PCTs, SHA, OSCs, the HCC and the Secretary of State for Health.

6.115 The key differences between LINks and PPIFs were that:

- They were set up and funded by local authorities rather than directly by the DH;
- Membership could include organisations such as charities, or patient interest groups as well as individuals;

107 *A Stronger Local Voice: A framework for creating a stonger local voice in the development of health and social care services*, Department of Health, page 14, www.vision2020uk.org.uk/core_files/A%20stonger%20local%20voice.pdf
108 Local government and Public Involvement in Health Act 2007, Section 221, www.legislation.gov.uk/ukpga/2007/28/contents

- There was no central support and advisory body;
- The make-up and constitution of each LINk was entirely a matter for local discretion.[109]

6.116 Different views were expressed at the time about this:

> *Ministers' decision not to prescribe size, shape and nature of LINks was designed to address many of the concerns that had been expressed by critics of PPIFs, and indeed of PPIF members themselves – that they should be flexible and locally designed. However, the lack of clarity as to what a 'good' LINk should look like and how it should operate was also criticised.*[110]

6.117 Malcolm Alexander, who had been Chair of the CPPIF and then Chair of the Association of LINks, told the Inquiry:

> *In setting up the LINks the Government failed to be prescriptive enough. The Government tried to be hands off in its approach and let individual LINks, once formed, decide how they wanted to run themselves. Without clear direction on governance ... LINks began to vary enormously in terms of their composition, what they perceived their role to be and the nature of the work they carried out ...*[111]

6.118 The experience of the Staffordshire LINk fully justified this view.

6.119 The 2007 Act came into force on 1 April 2008, creating the responsibility for creating LINks simultaneously with abolishing PPIFs. The gap in the availability of patient and public involvement until new arrangements were in place was required to be filled by "temporary arrangements" put in place by the local authority.[112]

The creation of the Staffordshire Local Involvement Network

6.120 The Inquiry received voluminous evidence containing a wide range of criticisms of individuals and their conduct in connection with the Staffordshire LINk, sometimes expressed in vitriolic terms. It is unnecessary in order to fulfil the Terms of Reference to consider each and every one, even where notionally the criticisms were relevant, and many were not. Still less has it been necessary to come to conclusions about the rights and wrongs of these criticisms. Where they are referred to in what follows, they are merely intended to describe the entirely dysfunctional nature of the LINk and for the sad light it throws on a community that became driven by the events played out in and around its local hospital.

109 CB/14 WS0000052306
110 CB/14 WS0000052307
111 Alexander WS0005000038, para 60
112 Local government and Public Involvement in Health Act 2007, section 228, www.legislation.gov.uk/ukpga/2007/28/contents

Outsourcing to Staffordshire University

6.121 The 2007 Act obliged local authorities to make contractual arrangements with a body which was not a local authority, or an NHS body as listed in the Act.[113] Staffordshire County Council, the local authority for the areas in which the Trust was situated, started a tendering process early in the year. Three organisations competed for the tender, including Age UK which had provided the support service for the PPIF. The successful tender was that of Staffordshire University, the only university in the country which applied for this work.[114]

6.122 The University considered itself equipped to undertake this role because, as was explained by Matt Snowden, Director of Business Development and Resources in the Faculty of Health:

> *Staffordshire University was the only university in the country which applied to act as a host for a LINk group. This surprised me. Our motivation was based upon the fact that as part of their all-round education we have to expose students to the views of patients. We have a track record with user involvement and engagement with the public. This is part of the education process, and we were well placed to support LINk because of our health and education experience. We felt this was a natural progression from what we were currently doing.*[115]
>
> *Our motivation wasn't to have the LINk to inform our educational provision, but rather that our experience of working with the public and patients and service users within our education gave us an impetus to want to expand that work. And certainly we'd done work around research with patients, and one of the things we felt that LINk – or where we could add some value to the LINk is empowering individuals to research their own communities, which is one of the things we've done, is a very similar activity to the LINk. It is empowering people to – to effectively research the issues in health and social care, both in terms of what services are commissioned and then how those services are delivered.*[116]

6.123 With Staffordshire University having been selected as preferred bidder, contractual negotiations were completed in May 2008. The resources made available to Staffordshire County Council for LINks was £300,000. Of this, the Council retained about £30,000 for its own costs. £110,000 was allocated to cover the host's operating costs and a university management fee, leaving £160,000 for the LINk Board.[117]

113 Local government and Public Involvement in Health Act 2007, section 222
114 Snowden WS0000002242, paras 1–6
115 Snowden WS0000002242, para 5
116 Snowden T25.97
117 Seru WS0004000004–5, paras 15–16

Local Involvement Networks constitution

6.124 A steering group consisting of the members of all LINks in Staffordshire was set up to devise a structure and a constitution. The structure decided upon was a countywide board, the membership of which would be two representatives from each of eight sub-committees covering a borough or district authority area. Each sub-committee would have 16 members who were to be elected by an "open and transparent" process.[118]

Local Involvement Networks administration and support

6.125 In September 2008, the University appointed Linda Seru as Director of the hosting service. She was employed for two days a week and was assisted by a coordinator and an administrator, each working 2.5 days a week. In other words, there were fewer than 1.5 whole-time equivalent staff to service the requirements of the LINks Board and eight sub-committees, including their communications with NHS organisations. Ms Seru said this was a "daunting prospect".[119]

6.126 An early challenge facing LINks was how to support the range of activities it was meant to be undertaking. Without going into the detail, there were endless arguments about resourcing sufficient support, for example to provide secretarial support for meetings and to arrange "enter and view" activities. The board, when appointed, could not agree whether expenditure of funds on support was justified. By the time the University's contract came to an end, this issue had still not been resolved.[120]

Membership of Local Involvement Networks

6.127 There was no central guidance or prescription with regard to the process for selecting LINks members. They could have been selected, for example, from representatives of local voluntary organisations, but in Staffordshire it was decided that members should be elected by an "open and transparent" process.[121]

6.128 The interest in becoming a member of LINks was insufficient to generate competitive elections. The procedure was that those who happened to attend a meeting were asked if they wanted to be considered and were then elected by a show of hands at the meeting.[122] Mr Snowden observed that most of those who wanted to be elected were retired, and Ms Seru told the Inquiry that most were over 60 and white British. Many were former PPIF members or involved with other community or voluntary organisations.[123] She was keen to

118 Seru WS0004000010, paras 43–45
119 Seru WS0004000014, para 61
120 Seru WS004000047–048, paras 220–225
121 LS/3 WS0004000095, para 21
122 Seru WS0004000010–011, para 45
123 Snowden WS0000002245, para 21; Seru WS0004000056, para 258; Seru T26.17

encourage strategies to increase the diversity of the membership. She was not particularly surprised at the lack of ethnic diversity given the make-up of the local community.

6.129 The lack of interest in LINk was such that by the time of the reorganisation in 2010 (see below), three of the eight districts did not attract sufficient membership to form a sub-committee.[124] Mr Bastin suggested the lack of interest was in part due to a failure to spend enough on publicity: as a result there was little awareness of or interest in LINks.[125] Mr Bastin was less than complimentary about his fellow members of the local LINk, as many of them had been members of the PPIF who had fallen out with him.[126]

Governance preoccupations

6.130 For virtually the entire time between 2008 and 2010, Staffordshire LINk was preoccupied with fractious disputes on governance issues, with no attention being paid to the actual business it was meant to be conducting.

6.131 An example of this was a dispute involving Mr Deighton, who was for a short time Chair of the Stafford sub-committee, about whether a Burton-on-Trent resident could legitimately be a member in Stafford. Mr Deighton and Mr Bastin sought advice from the DH on the subject, and the matter not having been resolved to their satisfaction, Mr Deighton resigned from the sub-committee before its first meeting.[127]

6.132 Another dispute arose over whether co-opted members should have voting rights.[128]

6.133 There were arguments about whether the Board was taking sufficiently into account the views of district sub-committees, and objection was taken to what were perceived to be instructions handed down by the Board in the minutes of its meetings.[129]

6.134 One area where no progress was made was in relation to exercising the power to "enter and view" premises. Ms Seru drafted a policy and presented it to the County Board in December 2008.[130] However, members were not prepared to undertake visits without having the benefit of indemnity insurance in spite of DH advice that this was unnecessary.[131] The board created a sub-group responsible for this area of activity and an acute services sub-group. There is no record that these groups ever met. No visits ever took place. Even after the change in arrangements in 2010, no visits were undertaken in the year that followed, in part because

124 Owen WS0004000229, para 5
125 Bastin T16.172–173
126 Bastin WS0001000014, para 49
127 Deighton WS0001000223, paras 82–83
128 Seru WS0004000022, paras 97–99
129 Seru WS0004000056, para 257
130 LS/1 WS0004000067, page 17
131 Seru T26.129–132

of a delay in Criminal Records Bureau checks and in part because no visits were requested of LINks.[132]

6.135 This experience was clearly not unique to Staffordshire. Malcolm Alexander, who had been Chair of the CPPIF and then Chair of the Association of LINks, told the Inquiry:

> *... some LINks focused* [sic] *their efforts on governance issues. LINks members did this because each LINk was required to set up its own governance arrangements ... Some LINks ended up with an absurdly bureaucratic style of governing as a result.*
>
> *I remember deliberately opening the meeting of one LINk group I attended by saying that I hoped they wouldn't mention the word 'governance'. I then discovered that it was on the agenda.*[133]

6.136 He also confirmed that the apparent reluctance to use "enter and view" powers was not uncommon:

> *There is a general hesitancy in relation to carrying out an 'enter, view and observe' visit. Some LINk members and Hosts seem to think that there has to be a really good reason to go into a hospital, rather than going regularly and getting to know the terrain.*[134]

Interaction with Cure the NHS

6.137 The first meeting of the Staffordshire LINk Board was held on 30 October 2008, six months after the passing of the 2007 Act and a similar period after the announced start of the HCC investigation into the Trust.[135]

6.138 A meeting of the Staffordshire LINk District Committee was held on 21 October 2008, six months after the start of the HCC investigation. It was attended by Julie Bailey and various members of Cure the NHS (CURE). Julie Bailey told the Inquiry that Mr Bastin had suggested that they attend. She said they were not made to feel welcome and were in fact asked to explain who they were and why they were there. She said that apart from Mr Bastin and one other, no member of the committee was aware that the Trust was being investigated.[136]

6.139 According to the minutes, after what appears to have been a protracted discussion about what arrangements should be made for elections, Julie Bailey proposed from the floor that the entire committee should stand down. This proposal was not adopted by any committee

132 Owen WS0004000249, paras 52–53
133 Alexander WSWS0005000035 para 51; WS0005000038, para 61
134 Alexander WS0005000039, para 65
135 Seru WS0004000011, para 46
136 Bailey T10.46–48

member, but Mr Bastin offered his place to Julie Bailey which she declined.[137] Julie Bailey told the Inquiry that CURE felt that the committee was "dysfunctional", and she left.

6.140 There was a discussion about the issues at the Trust in the context of matters for consideration by the County Board when considering its work plan for 2008/09. The minutes recorded that there was:

> *Perceived management incompetence which some members of the public and representatives of Cure the NHS identified as requiring "urgent attention to protect vulnerable patients of all ages whose care may be jeopardised by inadequate staffing/ skill shortages/poor staff attitudes".*[138]

6.141 It is clear that this view was not shared by all, as the minutes included a note:

> *Although several members of the public expressed concerns about services at Stafford hospital, comments were also made from the floor and by committee members about first hand experience of good quality care at the hospital. It was also acknowledged that the hospital is currently under investigation by the Healthcare Commission (HCC) which had been instigated in part by the Cure the NHS Group.*[139]

6.142 Some members expressed concern about the use of LINks for "campaigning". Linda Seru offered to meet CURE to explore how LINk could work with it, and Julie Bailey offered to share its evidence with LINk. Such an exchange did not in fact happen.[140] CURE formed the view after its experience of this meeting that LINk was not going to be an effective organisation from its point of view.

6.143 It does not appear that LINks either at Stafford or county level addressed the issues at the Trust again before the publication of the HCC report.

Reaction to the Healthcare Commission report

6.144 The LINks County Board met for the first time after the publication of the HCC report on 2 April 2009.[141] There appears to have been a lengthy discussion, the result of which was a decision

137 LS/10 WS0004000145–146; Bastin T16.174
138 LS/10 WS0004000146
139 LS/10 WS0004000146
140 Seru WS0004000032, paras 143–144
141 LS/2 WS0004000077

that a sub-group of the board should be appointed to consider the matter further. Among the views expressed as recorded in the minutes were the following:[142]

- A suggestion that the board await the outcome of further investigations before a discussion;
- "The LINk needs to consider whether this was a 'blip' in service provision or whether it was so out of the ordinary that it needs further consideration";
- Concern that "we don't rush into things but do nothing at the moment until LINk has had the opportunity to examine the emerging evidence in depth before commenting as a Board";
- "There will be a mass of information and someone needs to research it for the LINk, perhaps 2/3 people but the LINk does need to respond but not now";[143]
- Concern that information was going via the host and not directly to the board;
- There was an opportunity now to use the HCC report as a synopsis to form the basis of discussions within the board or a sub-group to agree a way forward;
- A member stated that he had been treated very well at the hospital;
- A concern "not to destroy the good things in the process";[144]
- At least some of the members of the sub-group should read the HCC report in full.

6.145 Some of the comments made appeared to show a lack of appreciation of just how serious the picture shown in the HCC report was and a general lack of clarity about what the role of LINks was in this situation.

6.146 On 6 May 2009, the appointed Chair of the sub-group sent a letter to board members and district committee chairs asking for representatives to be nominated for the group and requesting evidence from LINk members about the standards of care at the Trust.[145] Only one sub-group submitted comments, and the sub-group may only have met three times.[146]

6.147 Linda Seru proposed that the HCC be invited to give a presentation of the report to LINks membership to be attended by the Trust Director of Nursing, Dr Helen Moss, and the local MP, David Kidney. The County Board Chair did not agree with this proposal. Ms Seru thought the Chair had been reluctant to chair a joint meeting because attendance at a joint meeting of the nature proposed might be interpreted by some as giving support to the Trust. However, he and the Chair of the sub-group did meet Dr Moss to discuss the Trust's action plan.

142 LS/2 WS0004000081–082
143 LINK0000000029, Minutes of County Board meeting (2 April 2009)
144 LINK0000000030, Minutes of County Board meeting (2 April 2009)
145 LS/17 WS0004000178
146 Seru WS0004000040, paras 186–187

6.148 Ms Seru told the Inquiry that she experienced great difficulty in finding a way for LINks to address the issues raised in the HCC report because of its make-up:

> *Generally speaking the HCC Report seemed to overwhelm some of the subgroup and others gave the impression that they hadn't read it.*[147]

> *I found that it was very difficult to find an effective way to deal with the HCC Report. The LINk members were good as patient representatives but few had sufficient technical ability or breadth of understanding to analyse detailed reports of this type.*[148]

Distracting factors

6.149 It is clear that throughout its life LINks in Staffordshire was bedevilled by disputes over governance, personalities and other distractions which hindered it in getting on with its core task of representing the views of patients and the public at a time when this was urgently needed. Reference has already been made to the arguments about governance, but, in addition, a number of other issues took up a great deal of time at meetings and for the host.

6.150 A concern was raised by Linda Seru concerning Mr Bastin's handling of an approach made to him by an official of South Staffordshire PCT (SSPCT) concerning the development of working relations between LINks and the PCT. This was raised as a potential breach of the code of conduct and resulted in a breakdown of relationships between him and Ms Seru.

6.151 Simultaneously, Mr Bastin and some colleagues were complaining to the County Council's contract manager about the standard of administration and the approach to her role taken by Ms Seru.[149] She in turn alleged that certain LINk members had been guilty of unacceptable behaviour.[150]

6.152 In April 2009, a member of the LINk support team's staff lodged a formal complaint to her employer, the University, in which allegations were made about the conduct of three LINk members. The allegations were fiercely denied, and a counter allegation was made that the member of staff had been "put up" to making the complaint by Ms Seru. A university official investigated the matter and concluded that the members had not intentionally behaved in an objectionable fashion but that the effect of their conduct needed to be taken into account. He wrote to the three members asking them not to attend the host offices in person. The issue ended up being escalated to the Deputy Vice Chancellor of the University but without resolution.[151]

147 Seru WS0004000040, para 187
148 Seru WS0004000040, para 182
149 Bastin WS0001000017, paras 56–58
150 Seru WS0004000024, para 106
151 Seru WS0004000052–053, paras 236–242; Snowden WS0000002247–049, paras 32–7; Bastin WS0001000018, para 61

6.153 The LINk Annual General Meeting on 26 May 2009 saw a complete breakdown of relations to the extent that the meeting had to be suspended. A member made serious allegations about the financial propriety of the host and asked for the meeting to be suspended as her sub-committee had passed a vote of no confidence in the board. The meeting descended into chaos, as a result of which it was suspended, and the public were asked to leave.[152] A meeting of the Board was immediately convened where the discussion focused on the need for a review of the operation of LINk and enforcement of the code of conduct.[153]

6.154 By this time, various members had contacted Malcolm Alexander, Chair of the National Association of LINks Members. Mr Alexander organised a public meeting in Stafford to discuss the Trust on 5 May. He invited LINks members to attend. Although 200 members of the public came to the meeting, no delegation from LINk or the host attended.[154]

6.155 Also in May 2009, LINk members, including Mr Bastin, met the Minister of State for Health, the Rt Hon Ben Bradshaw MP, to voice their concerns about the organisation. As a result, the DH organised a meeting with the County Council, the LINk Chair and the OSC. The DH requested an urgent review of LINk.

6.156 The next meeting of the Board, in June 2009, focused on proposed disciplinary proceedings, governance and structural issues. No reference was made, at least in the eight pages of minutes, to members' or the public's views on any aspect of healthcare including the standard of service at the Trust.[155]

Review of the Local Involvement Network

6.157 Following the resolution of the Board in May to agree to an independent review, PPI Solutions was appointed by the DH to undertake it.[156] It reported in September 2009.[157] Among the concerns expressed by stakeholders were:

> *The LINk is not yet seen as a credible organisation as it is small and not well networked;*
>
> *The LINk has been hard to engage with and not responsive to approaches. It seems under resourced;*
>
> *There are concerns about conduct of some members which has affected credibility and willingness to engage with it;*
>
> *It is not clear how organisations can participate in the LINk.*[158]

152 Seru WS0004000041–043, paras 189–200
153 LS/19 WS0004000199
154 Alexander WS0005000040, paras 68–69
155 LS/20 WS0004000203
156 DH00860000087 Letter from Department of Health to West Midlands Public Health Group re Review of Staffordshire LINk (July 2009)
157 LINK00040000126 Interim Report of the review on the Staffordshire Local Involvement Network (7 Sept 2009) PPI Solutions Ltd
158 LINK00040000130 Interim Report of the review on the Staffordshire Local Involvement Network (7 Sept 2009) PPI Solutions Ltd

6.158 The report identified as substantial issues:

> *Roles are not understood and agreed with LINk members, host and LA* [local authority] *representative;*
>
> *The structure is not working effectively;*
>
> *Process of decision-making is not working well;*
>
> *Lack of defined role within the membership for both individuals and groups;*
>
> *Absence of outreach activities and wider engagement in the work of LINk;*
>
> *Limited progress with work plan;*
>
> *The staff resources to support the LINk have not been sufficient;*
>
> *Members have not had training;*
>
> *Communication is poor;*
>
> *Not enough people are aware of the LINk or involved in its work;*
>
> *Issues of conduct.*[159]

Reorganisation of the Local Involvement Network

6.159 In December 2009, Jackie Owen was appointed by the University to take over leadership of the host service. Within days of her appointment, the County Council terminated the University's contract, but she was retained as Interim Director of LINk.[160] Her view on taking over was generally in agreement with the findings of the review. She examined the organisation's minutes and concluded that:

> *... it was a total shambles, with no decisions ever made. That was the point it had reached at the time of the review.*[161]

6.160 From reviewing what was happening elsewhere, she did not believe the problems shown here were unique to Staffordshire:

> *I would say it is very much not unique to Staffordshire. I think Staffordshire just hit the headlines first with it.*[162]

159 LINK00040000131 Interim Report on the review of the Staffordshire Local Involvement Network (7 Sept 2009) PPI Solutions Ltd
160 Owen WS0004000228–229, paras 2–4
161 Owen WS0004000230, para 5
162 Owen T27.124

6.161 Ms Owen remodelled the organisation by removing the split between county and district level and forming a coordinating group instead of a board. She launched a recruitment campaign which succeeded in populating the group with 11 members, including some she regarded as high calibre.[163] She also set about engaging with local interest and representative groups. CURE declined to be involved because of its previous experience with LINk and a view that it had achieved what it had without assistance. In her view, LINk was becoming what it was intended to be: a "network of networks".[164]

Conclusions on Staffordshire Local Involvement Networks

6.162 The Staffordshire LINks were an unmitigated failure from the beginning through to the period of crisis at the Trust when they were most needed. The evidence shows that there were a number of contributory factors:

- The LINks concept was enacted and then implemented by the DH without any due regard to the need for a proper and orderly transition from the previous system of PPIFs and for coherent guidance with regard to the structures and resources required to ensure effective, consistent representation of the patient and public voice nationally. In essence, local authorities were provided with a sum of money and then told to outsource the setting up of a network to a contractor to do as they saw fit;
- There was no clear definition of the role of the host in terms of whether it was intended to be one of administrative support or of leadership. There was no guidance or other central support setting out any form of template for the structure and governance of LINks. This sowed the seeds for an unfortunate and unproductive conflict between largely self-appointed members and the host team, which fuelled mutual suspicions and loss of confidence.

6.163 The position cannot be expressed better than it was in AvMA's closing submissions:

> *The inherent weakness of hosting arrangements were demonstrated by the operation of LINKs in Stafford, which replaced the PPIF. The local authority commissioned hosting arrangements from Staffordshire University, who had little experience in this complex area. Linda Seru was provided with little handover and no guidance. She effectively started her role with 'blank sheets of paper'. By this time, funding for the national body* [CPPIH] *had been withdrawn, leaving both the Host and LINks members without any guidance or support.*[165]

6.164 The concept suffered a serious weakness in its ability to command authority as a truly representative voice of patients and the public. A small group of volunteer members of the

163 Owen WS0004000251, para 57
164 Owen WS0004000234, paras 16–20; Owen T27.15
165 CL0000000445–446, AvMA closing submissions, para 302

public, however well intentioned and dedicated, is unlikely to achieve that without recognition that the role of such a group is to collect and communicate local opinion rather than solely to express its own personal views. There may have been well functioning LINks elsewhere, but the experience of Stafford would suggest that this would have been in spite of the system adopted to create them, rather than because of it.

6.165 A further weakness was that no such group, even with professional organisational support, is likely to be equipped effectively to understand, analyse and address the complex issues of healthcare thrown up on a routine basis, let alone the crisis that developed at the Trust, without access to substantive healthcare professional support, independent of the organisations with which it was meant to interact.

6.166 A system could not have been designed more effectively to promote discord, tension and paralysis of decision-making among members than that set up in Staffordshire if it had been intended to do so. There seems to have been no effective means in place to resolve issues quickly. The result was a focus on frankly petty disputes between members, and between members and the host team, on governance and procedural matters, which reflected credit on no one; and a complete failure to represent the views of patients and the public in what has been termed the biggest scandal to have befallen the NHS.

6.167 It would be unjustified and unfair to single individuals out for criticism in spite of the multiple complaints made in the course of the Inquiry by participants in this sorry story. Not only would it have been a disproportionate use of the Inquiry's time to dig sufficiently deeply into the evidence to come to fair conclusions, but also it would not assist in the learning of lessons for the future. It must be remembered that all the members of LINks were volunteer members of the public, and all were genuinely trying their best to assist. It is not their fault that the system of selection failed to give them any authority, or that they received no training or proper understanding of their role, or that there were no means of swiftly resolving conflicts and disputes which were inevitable in the circumstances of Stafford at the time. No more can the personnel of the host service be personally subject to criticism. They were handed a difficult job, with no time to put anything in place before LINks was meant to be in business and with precious little guidance as to what to put in place.

6.168 However, the same cannot be said of Staffordshire County Council. It was handicapped by the concept presented to it because of the deficiencies in the introduction of the LINks concept referred to above. It had no choice but to outsource the support service. While it might be argued that the choice of Staffordshire University as host was unwise, it cannot be said this was an unreasonable decision: obviously no organisation had direct experience of supporting what was an entirely new way of approaching public involvement. Nonetheless, the Council retained the statutory responsibility for ensuring that there were means of ensuring public and patient involvement and representation in the county were working. It should have been obvious at the outset that close oversight would be required to ensure that what was being

put in place was working. A mere glance at almost any of the minutes which it has been the misfortune of this Inquiry to have to read would have given serious cause for concern whether the structure and membership of LINks as they were being set up were capable of delivering the statutory objectives. Sadly, the impression gained from the evidence is that it took the crisis at the Trust, and the direct intervention of the DH and Ministers, to galvanise the council into taking corrective action.

Local authority overview and scrutiny committees

Legislative framework

6.169 County Councils, Borough Councils, and District Councils for areas in which there is no County Council, and London Borough Councils, are required by statute to have an overview and scrutiny committee (OSC) with the power to:

> *... review and scrutinise, in accordance with regulations ... matters relating to the health service (within the meaning of that section) in the authority's area, and to make reports and recommendations on such matters in accordance with the regulations.*[166]

6.170 Such a committee has the power to:

> *Review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority;*[167]

- Make reports and recommendations to local NHS bodies, its local authority and Monitor on any matter reviewed or scrutinised;[168]
- Require a local NHS body to respond to its report or recommendation;[169]
- Require such a body to comply with reasonable requests for information about:

  the planning, provision and operation of health services ... in order to discharge its functions;[170]

- Require an officer of a local NHS body to attend before it:

  ... to answer such questions as appear to the committee to be necessary for discharging its functions.[171]

166 Local government Act 2000, section 21(2)(f) as inserted by the Health and Social Care Act 2001, section 7
167 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 2(1)
168 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 3(1); Health and Social Care (Community Health and Standards) Act 2003, Schedule 4, para 116 – "Local NHS bodies" are defined to include, SHAs, PCTs, NHS trusts and NHS foundation trusts.
169 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 3(3)
170 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 5
171 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 6(1)

6.171 Consequential duties of OSCs include:[172]

- Inviting interested persons to comment on the matters under consideration by it;
- Taking account of:

  ... relevant information available to it and in particular, relevant information provided by a patients' forum pursuant to a referral ...

6.172 With certain immaterial exceptions, local NHS bodies have a duty to consult the OSC if it:

> *... has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service.*[173]

6.173 Where the OSC is not satisfied that an adequate consultation in terms of content or time to comment has been provided, it may report this to the Secretary of State for Health who may require the NHS body to carry out such a consultation or further consultation as considered appropriate.[174]

6.174 Where the OSC considers that such a proposal:

> *... would not be in the interests of the health service in the area of the committee's local authority, it may report to the Secretary of State in writing who may make a final decision on the proposal and require the local NHS body to take such action or desist from taking such action, as he may direct.*[175]

6.175 The OSCs of one authority have the power to delegate functions to that of another where it considers the latter to be better placed to undertake it.[176]

172 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 2(2)(b)(c)
173 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 4(1)
174 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 4(5)
175 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 4(7)
176 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 8, www.legislation.gov.uk/uksi/2002/3048/made

Statutory Guidance

6.176 Statutory guidance, to which OSCs are obliged to have regard,[177] was published in 2003.[178]

General points

6.177 A number of points emerge from this:

- The primary aim of scrutiny was said to be:

  to act as a lever to improve the health of the local people, ensuring that the needs of local people are considered as an integral part of the delivery and development of health services.[179]

- OSC members were advised of the:

  need to take a constructive but challenging approach to the role, bringing together evidence and people's experience, to identify priority issues and drive forward improvement … It is important for elected councillors who are involved in overview and scrutiny of health to gain an understanding of the NHS and the provision of health services, as well as to understand local needs.[180]

- The powers of the OSC:

  enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. It is recommended that best use of these powers will depend on committees scrutinising a health issue, system or economy, not just the services provided.[181]

- Its work was to focus on an objective review of issues of local concern but:

  it is not the role of the committee to performance manage the NHS. Other organisations exist to perform this role. Committees are best places to concentrate on ensuring that health services address the needs of local communities.

177 Local government Act 2000, section 38; Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048, Reg 2(2)(a)] www.legislation.gov.uk/uksi/2002/3048/made
178 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003)
179 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 1.1
180 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 1.2
181 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 1.4

Approach to scrutiny

6.178 With regard to the manner of scrutiny involved, the guidance advised that:

> *A constructive approach based on mutual understanding between the committee, the local authority executive function and local NHS bodies will be a prerequisite for success … Scrutiny is sometimes challenging and will sometimes be uncomfortable for the organisation being scrutinised but if the process is aggressive, or relies on opinion rather than evidence, it is unlikely to lead to positive or sustainable improvement. Likewise health bodies will need to respond honestly to questioning and provide explanations if they are unable to implement overview and scrutiny committee recommendations …*[182]
>
> *The power to scrutinise the NHS needs to be applied both robustly and responsibly. Scrutiny should be probing and incisive, focusing on its primary aim of improving services for members of local communities. Asking the obvious question can be very revealing, but committees must also recognise that some of the problems facing the NHS have no simple or universally popular solution …*[183]

6.179 The OSCs were advised that they needed to:

> *develop a close working relationship with* [patients'] *forums relating to the health service within their area. This might include discussing the outline and process of a scrutiny review with members of forums prior to beginning the review, and also co-opting forum representatives onto the committee or inviting them to become expert witnesses or advisers. It will also be important for committees and forums to discuss appropriate responses to matters of concern to patient safety and welfare should such circumstances arise.*[184]

6.180 The guidance advised that OSCs had a choice of approach: of being reactive, for example by responding to referrals, or proactive in determining their own subject matter and terms of reference.[185]

6.181 To be effective, the guidance suggests:

> *committees must balance 'expert' opinion and public concerns where these conflict … To ensure credibility, committees should consider all views and evidence before finalising recommendations … To achieve this effectively … committees will need adequate support and advice from the local authority's officers.*[186]

182 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 1.7
183 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 1.10
184 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 4.5.3
185 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 5.1
186 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 5.4

Information and communication

6.182 The guidance emphasised that collated data from PALS and the Independent Complaints Advocacy Service (ICAS):

> *... will be a crucial input to the scrutiny process ...*[187]

6.183 The need for *"clear lines of communication and information exchange"* with patient's forums was emphasised. It was noted that:

> *... patients' forums will monitor trusts and PCTs at an operational level.*[188]

Discretion to delegate

6.184 Referring to the statutory power for scrutiny functions to be delegated from County Council to District Council level, it was suggested that for this to be effective:

> *... there must be clear terms of reference agreed between the local authorities and clarity about the scope and methods of scrutiny which might be used.*[189]

Terms of reference and understanding of responsibilities of Staffordshire County Council Overview and Scrutiny Committee

6.185 In 2002, Staffordshire County Council (SCC) set up a Health Policy Commission consisting of seven councillors to review NHS provision in Staffordshire in order to provide the Council with a:

> *... clear picture of the issues facing health providers in Staffordshire, the availability and type of information which is available to scrutinise and to make recommendations on how scrutiny may be carried out.*[190]

6.186 The commission devised a scheme whereby both the County Council and the eight Borough and District Councils in Staffordshire would have OSCs.[191] The proposal was that:

> *The County Council will concentrate on more general issues and the District Committees on more local issues particularly relating to individual PCTs.*[192]

187 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 4.1
188 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 1.6
189 SBC00010000257, *Overview and Scrutiny of Health – Guidance* (July 2003), para 7.3
190 AE/01 WS0000003060
191 Stoke-on-Trent, as a primary authority, was outside these arrangements and has its own committee.
192 AE/01 WS0000003063

6.187 Each of the borough and district committees was to have a representative on the county committee which is otherwise populated with county councillors appointed by their parties in proportion to the political make-up of the council. In the other direction, a county councillor was to sit on each of the local committees.

Terms of reference and allocation of responsibilities by County Council

6.188 Pursuant to what the Inquiry was told were the original terms of reference for County Council OSCs,[193] the County Council's Health Scrutiny Committee (HSC) was empowered to:

- Within the scope of its allocated roles and responsibilities, respond independently to health related consultations from Government and external agencies;[194]
- Assume responsibility for overview and scrutiny or matters relating to the planning provision and operation of health services, and make reports on such matters in accordance with the legislation.[195]

6.189 Borough and District Councils without a social care function are not obliged by statute to have a health scrutiny committee, but the Inquiry was told that most do so, and all in Staffordshire have such a committee. As mentioned above, the County Council had power to delegate functions to district committees. The extent to which it did so in the case of the Trust has been a matter of debate before the Inquiry.

6.190 In 2003, the County Council and the District and Borough councils agreed a scheme of joint working under which certain functions would be performed by the local bodies. The intention of this was that the county HSC would deal with matters having a countywide theme whereas the local committees would deal with local issues.[196] The county HSC could also appoint one local council to lead on a particular scrutiny activity. In such a case there would be terms of reference determined by the county HSC.[197] The matters which local OSCs could deal with included "local national health service bodies". Among the general working principles adopted was one on accessibility:

> *Scrutiny activity will, for each piece of work, actively seek to identify interested parties and to involve them where appropriate in the overview and scrutiny process.*[198]

6.191 The same principle was repeated in the county's Joint Code of Working of June 2008 and, substantively, in an amendment in June 2010.[199] However, the latter document expressly

193 SCC00030000079 Article 8 – Scrutiny Committees
194 SCC00030000080 Article 8 – Scrutiny Committees, para 8.3.xiii
195 SCC00030000081 Article 8 – Scrutiny Committees, para 8.5.a
196 SBC00010000087–SBC00010000094, *Report to the Health Scrutiny Committee* (24 June 2008)
197 SBC00010000095, *Report to the Health Scrutiny Committee* (24 June 2008)
198 SBC00010000098, *Report to the Health Scrutiny Committee* (24 June 2008)
199 SBC00010000093; SBC00030000091–94; SBC00010000234–237

provided that the scrutiny of the acute hospital trusts, including the Trust, would be retained by the county HSC. Therefore, objectively, on the evidence seen, there was a lack of clarity about what precise function in relation to the Trust the County Council HSC delegated to the Borough Council.

Terms of reference and understanding of responsibilities of the Borough Council

6.192 At its first meeting, the Stafford Borough Council's OSC noted its terms of reference and its function as being:

> *To review and scrutinise* [in accordance with legislation] *matters relating to the health service in the Council's area and to make reports and recommendations on such matters in accordance with the regulations.*[200]

6.193 The Chief Executive was empowered to call a meeting of the Borough Council's OSC if he or other officers thought there was an item requiring consideration and the Chairman failed to call such a meeting. Similarly, the officers, or any member on seven days' notice, could require a matter to be placed on the agenda.[201] It adopted as a method of working:

> *Selecting a single topic in the current year which it could examine in detail and come forward with meaningful conclusions.*[202]

6.194 Ian Thompson, Chief Executive of Stafford Borough Council, had been the lead officer responsible for the OSCs between October 2005 and May 2008. He told the Inquiry that the terms of reference had been unclear as to which of the County and the Borough Council's committees were responsible for the scrutiny of the three Staffordshire hospitals and pointed out that there was no joint code of working until June 2008.[203]

6.195 Councillor Philip Jones has been a long-standing member and was, between 2008 and 2009, Chair of the Borough's OSC, as well as a member of the County HSC (from 2009). He considered that the arrangements for delegation from county to district level had always been unclear. He pointed out that there had never been terms of reference as required by the DH guidance. Before the joint code of 2010, there had been no formal devolution of authority. Therefore, he contended that primary responsibility remained throughout with the County Council.[204]

200 SBC0001000024, Minutes from the Health Scrutiny Committee meeting (10 July 2003)
201 SBC000100000012, Minutes from the Health Scrutiny Committee meeting (10 July 2003), para 2.1.d
202 SBC0001000026, Minutes from the Health Scrutiny Committee meeting (10 July 2003)
203 Thompson WS0000002308, paras 8–10
204 Philip Jones WS0000001784, paras 6–7

6.196 County Councillor Jim Muir had not been involved when the County HSC was set up, but disagreed that there had ever been a lack of clarity, asserting that it was "abundantly clear throughout, until 2010, that it was for the Borough Council to scrutinise the Trust".[205] He said that the minutes made it clear that in practice the Borough Council OSC dealt with the issues relating to the Trust.

6.197 An examination of the subsequent conduct of business by the County and Stafford Borough Council committees suggested that it was implicitly accepted that scrutiny of the Trust was a matter which could be, and was, addressed by the Borough Council OSC. For example, at the Borough Council OSC's first meeting, it accepted an invitation from the Trust for members to attend a Board meeting and to inspect facilities at the two hospitals. The Borough Council OSC's minutes repeatedly refer to its use of delegated powers.

6.198 However, this does not mean that the County Council Committee had divested itself of its statutory responsibility; it retained a duty to oversee the scrutiny, to receive reports from the Borough OSC and to take any action it saw fit in relation to this trust.

6.199 It is right to conclude that there had been a lack of clarity in relation to the formal allocation of responsibility, which was clearly undesirable. However, there is no evidence that this uncertainty played any part in hindering scrutiny by either committee.

Resources of overview and scrutiny committees

6.200 There was, and remains, a significant disparity between the resources of the County and Borough Committees. The County HSC has the benefit of being supported by a large infrastructure. Staffordshire County Council has a budget of £1.5 billion, a staff of 30,000, and a cabinet member leading in health and social care who commands a budget of £270 million. The County HSC is supported by officers experienced in scrutiny. All members receive training.[206]

6.201 Stafford Borough Council, on the other hand, although one of the larger councils in the county, now has a staff of 400 whole time equivalent post, and has a budget of around £54 million. It also has one scrutiny officer, who serviced all its scrutiny committees.[207]

205 Muir WS0000034482, paras 33–34
206 Matthew Ellis T34.8–9
207 Thompson T35.3–7; T35.74

Activity of Stafford Borough Council Overview and Scrutiny Committee

Committee records

6.202 In order to see what scrutiny activity was carried out, it has been necessary to consider what the minutes and other evidence showed the committee knew about and what, if any, activity was carried out. It has been far from easy to determine this as the minutes, particularly those of the Borough Council, are brief to the point of being uninformative: they register that a topic was discussed and summarise presentations made by external bodies, or formal questions put, but there is no summary of the debate, merely a series of very short reports of any decision taken. In many cases, the decision was often merely to "note" a presentation. It was widely accepted by witnesses that this style of minute taking was inadequate as it gives little idea what members of the committee actually contributed. That it was possible for them to ask many detailed questions was shown by a clerk's note preserved from one meeting, but such notes have not been routinely kept. It was suggested that this form of minute was common local government practice.[208] If this is so, the practice needs reviewing. While a Hansard style transcript is not required, it is unfair to the councillors and obstructive to public involvement and engagement for there to be no record of the contributions made by committee members whether by way of observations or questions, and of responses given. The essence of public engagement is that their views are captured to inform the decision-making processes within the service. This requires the recording not only of an outcome but also of the range of views expressed.

6.203 Stafford Borough Council intends to review this practice, but if it is prevalent, a more widespread review is required. The proceedings of bodies performing a statutory scrutiny function should be more fully recorded than appears in many of the minutes considered by this Inquiry.

Information available to the committee

6.204 In theory, the Borough Council's OSC received information from the Trust through the Trust's Executive team, the PPIF, the PCT, the media and individual members of the public. Perusal of the minutes (see above), suggests that there were communications from all these sources from time to time, but that the principal source of information was the Trust itself. Councillor Edgeller could only recall three occasions on which members of the public had raised a concern, and only one of these related to the quality of the service. The OSC was therefore very dependent on the accuracy, completeness and insight of the information conveyed to it by the Trust.

208 Phillip Jones T36.93

6.205 As noted above, the DH guidance suggested that information from PALS and ICAS about complaints was "crucial". However, this was not made available to the OSC, and it did not ask for it.[209]

6.206 Likewise, the committee does not appear to have received information from the HCC, apart from AHC ratings, or Monitor.

Public participation

6.207 The public were allowed to attend committee meetings and ask questions, but these had to be tabled seven days in advance of the meeting. Councillor Edgeller said it was difficult to know if this procedure inhibited the raising of concerns because members of the public so rarely attended meetings, before the problems of the Trust became widely known. The procedure was relaxed after the publication of the HCC report.[210]

6.208 Roger Dobbing told the Inquiry that the rule had been far too restrictive:

> *because what it meant was that that incident that may have occurred over the weekend could not be addressed for another four weeks, minimum, by which time it had lost all relevance.*[211]

6.209 He considered that no attempt was made to elicit information from the public.[212]

Committee activity

2003

Liaison with the Trust

6.210 At its first meeting on 10 July 2003, the Borough Council's OSC agreed to accept an invitation for members to attend a board meeting at the Trust and to inspect facilities at the two hospital sites. The invitation from the Trust Chief Executive suggested that this would provide:

> *An opportunity to build a constructive relationship between our organisations and begin to have a more meaningful understanding of the way we work and major issues facing each of us.*[213]

6.211 On 16 October 2003, it was reported that the County Council's representative on the Borough Committee had been appointed to liaise with, and have responsibility for, relevant issues

209 Edgeller T36.41–42; Jones T36.164
210 Edgeller WS0000003043, paras 6–9
211 Dobbing T17.150
212 Dobbing T17.150–151
213 SBC00010000066

arising from the Trust. It was noted that members had attended part of a Trust Board meeting, which had lasted all day, and this had been found *"interesting"*. Members were able to attend the next Board meeting if they wished.[214]

2004

Consideration of first application for Foundation Trust status

6.212 On 23 March 2004, the committee received a presentation from an Executive Director of the Trust on its proposal to apply for FT status. The 32 page consultation document described the Trust as having already made "significant progress" and had achieved three star status. It claimed that the Trust had adopted a proactive approach to clinical governance:

> *... with clear structures and reporting lines through to the Trust Board identified and adopted.*

6.213 And that following the Commission for Healthcare Inspection's (CHI's) report of 2002, they had:

> *... identified plans to overcome identified areas of weakness.*[215]

6.214 The current programme of work was said to include continuing to meet CHI recommendations. The minutes record that during the oral presentation, the Trust Director recognised that the key risks of becoming an FT included:

> *... a diversion of management and clinical time away from delivering services to patients during the process of application as deadlines were extremely tight.*

6.215 Members raised issues about a number of matters, including the:

> *... staffing and resource implications of the proposals particularly if it leads to competition between Trusts.*[216]

6.216 At the conclusion of the presentation, the committee resolved to support the Trust's application in principle, although members had been invited to a further presentation at a County HSC meeting at the end of the month.[217]

6.217 This support appears to have been given immediately after the presentation, with no further opportunity for members to reflect on the matter. This contrasts with the later consideration

214 SBC0001000030–31
215 SBC00010000343, Health Scrutiny Committee (23 March 2004)
216 SBC0001000065, Minutes of the Health Scrutiny Committee (23 March 2004)
217 SBC0001000065, Minutes of the Health Scrutiny Committee (23 March 2004)

on 22 September 2005 of an application by the South Staffordshire Healthcare NHS Trust: on that occasion the committee did not offer support immediately after the presentation but resolved to develop a response at a further meeting.[218]

Withdrawal of foundation trust application

6.218 By the time of the meeting on 4 November 2004, the Trust's CHI star rating had collapsed from three to zero stars, and the FT application had been withdrawn. Mixed messages were sent to the committee about the reasons for the withdrawal. A letter from the then Trust Chief Executive, Mr O'Neill, in July 2004 claimed that the decision:

> *... was made following a recent Board meeting when it was felt that due to funding difficulties in the local health system, deferment makes the most sense at the present time.*[219]

6.219 Reference was made to:

> *... an underlying shortfall ... in the region of £15 million. Of this £6 million is the cost of hospital care, which is not currently covered ... As the financial issues are resolved the application process will be resumed.*

6.220 In contrast, the officer's report of a meeting of the County HSC suggested it had been informed that it was:

> ... [the Trust's] *performance against the Star Ratings system which ultimately led to the deferral of their Foundation Trust application.*

6.221 And that it had resolved to write to the [Health] Minister expressing its support for the Trust's efforts to regain their three star status, referring to the:

> *... unfairness of the Foundation Hospital Initiative.*[220]

6.222 Members were also given copies of the Trust's slide presentation on the star rating system. This also addressed the staffing and financial positions. It stated that a shortage of clinical staff had been addressed by increasing clinical staff from 179.86 WTE in 2001/02 to 223.92 WTE now, and nursing staff from 853.81 WTE to 1,044.83.[221] There was said to be a £7.34 million deficit. The Trust had agreed a £1.5 million "brokerage" and would be allowed to overspend by £1 million the following year.

218 SBC0004000161, *Report to the Health Scrutiny Committee* (22 September 2005)
219 SBC00010000354, *Report to the Health Scrutiny Committee* (4 November 2004)
220 SBC00010000366–367; SBC0001000071, *Stafford Borough Council Health Security Meeting* (4 November 2004), para 1.6
221 SBC00010000361, *Report to the Health Scrutiny Committee* (4 November 2004)

6.223 As it was stated these sums had to be repaid, it might be thought to result in an increased planned deficit of £8.84 million.[222] It is unclear from the evidence that the committee reacted to these apparent problems at the Trust in any way other than receiving the presentation.

2005

Consideration of proposed cost savings

6.224 On 14 January 2005, the Trust issued a press release detailing its financial recovery plan. On 22 February 2005, at the express request of a resolution of the full council, the Borough Council's OSC considered the service implications at the Trust arising from proposed financial cuts. It was reported[223] that the Trust Board had approved a financial recovery plan to address a £6 million recurring deficit. It was forecast that it would be necessary to remove 180 WTE posts to save £4 million. The hope was expressed that the number might be less if some senior posts could be identified to be cut, and by means of skill mix adjustments. The Borough Council's Chief Executive's report to the OSC stated:

> *The Trust is clearly concerned to ensure that the clinical quality of care provided is not adversely affected and the process adopted will look to minimise the impact specifically on patient care. It is possible that the Trust may have no choice but to lose some members of staff, but this will be only as a last resort and the Trust will be doing everything possible to avoid such measures.*[224]

6.225 No record survives of the questions asked at the meeting, which was attended by the Chair, Chief Executive and another Executive Director of the Trust, but the minutes record that:

> *Members particularly noted that the Trust had no plans to close wards or discontinue services.*[225]

6.226 The minutes recorded that the committee resolved to note the Trust's response and to thank the Trust's representatives for attending. In other words, the committee merely received the report and took no further action to delve into the problem or express a view about it.

6.227 On 21 April 2005, the OSC considered the "possible implications of the trust's recovery plan"[226] and resolved to invite the Trust to a special meeting to discuss the issue.

6.228 Trust representatives attended the committee meeting on 30 June 2005. Again, the minutes do not record the substance of any discussion, but it is recorded that among matters referred

222 SBC00010000362, *Report to the Health Scrutiny Committee* (4 November 2004)
223 SBC00010000012, *Report to the Health Scrutiny Committee* (25 February 2005)
224 SBC00010000013, *Report to the Health Scrutiny Committee* (25 February 2005)
225 SBC0001000093, Minutes from the Health Scrutiny Committee (25 February 2005)
226 SBC0002000010/11, Minutes from the Health Scrutiny Committee (21 April 2005)

to by the Trust was a "reduction in establishment".[227] It was resolved that the Trust be invited to attend the committee on a regular basis.

6.229 At the same meeting, a report was received from the PPIF for the Trust.[228] The health officers of the councils with scrutiny committees had met earlier (on 13 April) and noted that training in inspections was to be made available to Trust PPIF members. It was also agreed that "clarification" needed to be sought from the Trust about various proposed changes on which it was thought that consultation was required.

2006

Further issues about cost savings

6.230 The Trust approved its cost improvement plan for the coming year, involving the loss of about 150 posts, at a board meeting in April 2006.[229]

6.231 On 27 June 2006, the committee received a presentation from Mr Yeates on:

> *... the issues facing the Trust, including NHS configuration and a new Strategic direction that involved achievement of Foundation trust status in November 2007, workforce reductions and a new management structure.*[230]

6.232 The minutes do not record the content of the presentation or the discussion, and there is no other evidence to suggest that this plan was subjected to any level of scrutiny.

Annual report from the Public and Patient Involvement Forum

6.233 At the same meeting, the committee received the report of the Trust's PPIF for 2005/06.[231] This reported that the forum had noticed that general cleanliness at the hospital had improved. The report stated that the forum felt proud of the way in which the Trust had addressed its concerns arising out of its monitoring visits.[232] What those concerns might have been was not specified.

227 SBC0001000097, Minutes from the Health Scrutiny Committee (30 June 2005)
228 SBC0001000098, Minutes from the Health Scrutiny Committee (30 June 2005)
229 ESI00217868, Minutes of a Meeting of the Mid Staffordshire General Hospital's NHS Trust (6 April 2006)
230 SBC0001000190, Minutes of the Health Scrutiny Committee (27 June 2006)
231 SBC0004000200, *Report to the HSC* (27 June 2006)
232 SBC0004000204, *Report to the HSC* (27 June 2006)

Concern about children's services

6.234 On 7 September 2006, the committee resolved to contact the Trust:

> *... in order to clarify the reasons as to why the Trust attained such a low score following the Commission's recent assessment of Children's Services at the hospital.*[233]

6.235 The HCC had published a rating for children's services the previous month, awarding the Trust a score of one out of a maximum of four, largely because the Trust had failed to supply the relevant information.[234]

6.236 The Trust's response came from the interim Director of Nursing, Gill Landon, in a letter dated 26 September 2006. In near identical terms to a letter sent to the SSPCT, Ms Landon described the score as "disappointing" and that it had resulted from the failure to supply information in time. She offered reassurance:

> *I am sure you know that our hospitals and staff provide an excellent service to children and young people. Had we provided the information by the deadline, we believe that this may well have resulted in a higher score in this review ...*
>
> *... I assure you that you can continue to have confidence in the high quality services we provide for children and young people.*[235]

6.237 The committee was unaware of the West Midlands peer review expressing similar concerns and identifying immediate concerns.

2007

Consideration of Foundation Trust application

6.238 On 20 February 2007, the committee received a presentation from Mrs Brisby and Mr Yeates on the renewed application for FT status. From the slide presentation,[236] it appears that the committee was informed that it was being consulted on the Trust's proposals for governance, its priorities and a suggested new name. The slides on governance refer to the constitutional structure (members, governors, directors), but there is no explicit reference to clinical governance. The aims of the Trust included:

> *expanding and improving the range, nature and quality of services;*
>
> *further developing specific services into centres of excellence; and*

233 SBC0001000111/113, HSC Minutes (7 September 2006)
234 S Hawkins WS0000026347, para 45
235 AE/8 WS0000003101–02
236 SBC0001000119, HSC Minutes (20 Feb 2007)

aiming to be the cleanest place in town.

6.239 At the conclusion of the presentation, the committee resolved to support the proposals and to convey its best wishes for the application.[237] It proposed a different name for the FT to that proposed.[238] Thus, while there may have been some discussion at the meeting, which lasted about two hours, the committee did not take the opportunity to pause for reflection before offering its approval as it had done when considering the application of a neighbouring trust in the previous year. It is unclear what questioning or challenge took place.

6.240 Councillor Edgeller, who had attended this meeting, told the Inquiry that she could not recall what questions had been asked, but pointed out that the meeting lasted for two hours. As to the value of the consultation process, she had this to say:

THE CHAIRMAN: I mean, would it be fair to categorise what really happened on that day as your committee just rubber stamping the proposal, rather than there being any critical analysis of it?

A. I would say that, all right, the PowerPoint presentation was given and at the end of it there would be questions asked. But I can't recall what questions.

THE CHAIRMAN: But just as you say that as you had been told of no concerns on other matters, they wouldn't really be looked into by the committee, you would have had no basis at all to do anything other than accept what was being said to you by the trust which was that this application was, putting it broadly, a good idea; would that be fair?

A. Yes.

THE CHAIRMAN: Does that mean that the process of consultation in this particular instance therefore is meaningless?

A. Yes, I would say that. I would.[239]

Report from the Public and Patient Involvement Forum

6.241 The committee received a presentation of the PPIF's annual report in June 2007.[240] The report contained a reference to the three inspection visits which have been described above in the PPIF section. It also recorded that, following a meeting with the County HSC Chair, plus press articles and public concerns about *Clostridium difficile,* a second series of visits had been arranged. The outcome of the visits was:

237 SBC0001000116/117, HSC Minutes
238 In fact, neither the Trust's original proposal nor that of the committee were adopted.
239 Edgeller T37.38–39
240 AE/10 WS0000003131

As reported previously, general cleanliness of all areas of Stafford Hospital has noticeably improved. Additional funding has been released to increase the frequency of cleaning from two to three sessions a day. As a result of these visits named Champions within the Trust are leading by example and promoting all issues relating to cleaning and cleanliness.[241]

6.242 Councillor Edgeller confirmed that the issue of cleanliness was raised at this meeting.[242]

6.243 On 22 November 2007, the Borough Council's OSC received a presentation from the Chair of the PPIF in relation to its inspections of the cleanliness of the hospital and also heard from Mrs Perrin, the Trust's Head of Marketing. There is an implication that members were concerned at what they heard, as they resolved to receive regular reports on the monitoring of *C. Difficile* from the Trust and recommended that when LINks were set up, they should retain the power to inspect.[243]

Questions from Cure the NHS

6.244 On 19 February 2008, the OSC received an update report from the Trust. This included the news that the FT application had been successful following what it described as:

A lengthy, detailed and searching investigation by ... Monitor to make sure that the Trust is well managed and financially strong so that it can deliver excellent healthcare for patients.[244]

6.245 Details, including figures, were given on the progress being made to reduce hospital acquired infections.

6.246 For this meeting Councillors Edgeller and Tabernor submitted three questions received from Julie Bailey and other members of CURE and the public. These raised, for the first time so far as can be discerned from the documents seen by the Inquiry, the type of concern that has featured so largely in the HCC report and the report of the first inquiry. They are worth setting out in full:

1. We understand a review on staffing levels was taking place in December 2007. Could you please advise as to what levels the staffing has been increased to and, as from what date are the changes to take effect. We refer directly to the problems relating to wards 10, 11 and 12. SDGH as highlighted recently.

241 SBC0004000243, *Report to HSC* (26 June 2007)
242 Edgeller WS0000003050, para 33
243 SBC0003000028/29, HSC Minutes (22 Nov 2007)
244 SBC00010000072, *Mid Staffordshire General Hospitals Trust Progress Report* (19 February 2008)

2. Could you advise as to the level of competence/training staff are given to be able to deal with patients suffering from dementia. You will appreciate that this used to be a more specialised nursing aspect, but, with the demise of the specialist hospitals and the movement into general hospital wards, can you advise as to what specialist training the general staff nurses receive.

3. Can the Chief executive of the SDGH, confirm that when a patient is unable to feed themselves through illness that their needs are addressed and that they do not miss their nourishment.

6.247 These questions had been submitted slightly too late to comply with the committee's requirement of seven days' advance notice, but Councillor Edgeller considered they ought to be answered and submitted them as a members' item.[245]

6.248 While the questions are recorded in full in the minutes, all that is said about an answer is that Ms Dunne, the Trust's Deputy Director of Nursing and Governance, Ms Williams, Head of Governance, and Ms Perrin, Head of Marketing, provided what was described as a "comprehensive" response.[246] Quite what that was is not recorded.

6.249 The committee resolved to congratulate the Trust on its achievement of FT status. In addition, it resolved to receive a further report on infection control, as well as details of its uniform policy. Concern about nurses wearing their uniforms outside the hospital is known to have been expressed in the context of its impact on infection control.[247] Therefore, it would be wrong to infer that no concern was raised following on from the questions asked. However, it does not appear that any member thought that there was any incongruity in conveying their congratulations to the Trust and the concerns underlying Julie Bailey's questions.

6.250 However, whatever was discussed did not satisfy Julie Bailey. She had not been allowed to speak at the meeting, although Trust representatives were allowed to respond to her written questions. Those responses were not minuted.

6.251 Julie Bailey wrote a long letter to all members of the committee on 20 February 2008.[248] In it, she recounted what is now the well known, but appalling story of the care received by her late mother at the hospital and enclosed a list of 66 points of general concern, including lack of assistance with feeding, and bowel and bladder care.[249] Familiar as Julie Bailey's complaints now are, some of the more striking general observations are worth repeating here:

245 CLO000003241–42, *Counsel to the Inquiry Closing Submission*, Chapter 4
246 SBC0001000150–151, Minutes from the Health Scrutiny Committee (9 February 2008)
247 SCC00050000125, *Literature Search 'Nurses as a Possible Source of Infection'*; SCC00100000365 Letter to Jan Harry (Director of Nursing) from Mr Lindon (Deputy Corporate Director) (5 April 2005) attaching document *Literature Search 'Nurses as a Possible Source of Infection*
248 CURE0023000412, Letter from Julie Bailey (undated)
249 CURE0025000001, List of 66 complaints (undated)

We sadly lost my Mother, I believe to the culture of neglect and disregard for the vulnerable within that hospital.

On her ward (11) there was complete disregard for a patient's well-being, they were basically left to fend for themselves. I do believe that if it wasn't for me and another patient's relative, two other patients on my Mother's ward would not be alive today. We fed and toileted them and kept them going.

It seemed that very few of the staff actually cared.

We found the staff to be totally demoralised.

Vulnerable people deserve better. They are entitled to respect and dignity but even their basic rights were denied them.

Other families had relatives who like my mother have suffered due to the unacceptable standards that are practised ... once you spend any length of time within that institution you see and hear it.

Once you spend any length of time in that hospital you see and hear things that disturb you.

6.252 Julie Bailey received two contrasting responses. On behalf of the Borough Council, a letter sent out in the name of the Head of Law and Administration, but not written by him, replied in what can fairly be described as dismissive language.[250] It included advice "that it is not the role of the health scrutiny committee to pursue individual cases from members of the public" and referred to the services of PALS and the regulations under which OSCs worked. The letter concluded "However, your letter will have alerted Members of the Health Scrutiny Committee to your concerns and the general nature of these may be taken into account during any future discussions held with the ... Trust."

6.253 Councillor Philip Jones, on the other hand, was much more responsive. He replied in a letter of 5 March 2008 which included the following sentiments and statements of intent:

I am so deeply touched and sorry that you had to endure such a truly awful experience ...

You might remember that at the meeting I called for openness and the Governors to be given the right to make unannounced visits to the hospital. The Committee urged me to take this to the next Council of Governors. I have therefore put down an agenda item for the Governors' meeting on 20 March ...

I will do all I can to improve patient care and dignified treatment.[251]

250 CURE0023000415, Letter from A Welch (Stafford Borough Council) to Julie Bailey (6 March 2008)
251 CURE0023000414, Letter from Philip Jones (Stafford Borough Council) to Julie Bailey (5 March 2008)

6.254 Mr Thompson explained that he thought the committee had found it difficult to reconcile the knowledge that the Trust had just been authorised by Monitor as an FT with the complaints made in Julie Bailey's letter:

> *I think they would have found it difficult to come to terms, as indeed they had to face in 2008, the fact that Monitor could give the hospital foundation trust status and there could still be significant issues with the hospital. And, you know, I think I have to say the second letter which I think Julie sent to the scrutiny committee – this is the one that refers to the 66 points – did come as a real bombshell. And I said this morning I think members were genuinely confused by the award of foundation trust status, I think it was in the December 2007, and a letter from Julie relating to issues – to issues that took place at that time, the 66 points, and I think they found it very difficult to reconcile those issues. I think they were – the issues obviously were discussed at the February 20 meeting 2008, and in many ways that sort of reconciliation process, coming to terms with that, was taken out of their hands because I think less than a month later, or around a month later, the HCC inquiry was announced.*[252]

2008–2009

Interaction with the Healthcare Commission's investigation

6.255 By the time of its next meeting on 17 April 2008, the HCC had announced its investigation, and Mrs Brisby had written to Councillor Jones (in his capacity as an FT governor) informing him of this.[253] The Trust had issued a press release in which it was asserted that the hospital's services were "safe" and that the explanation of the mortality figures was coding.[254] The only reference to this in the minutes is that the committee resolved to add:

> *... the results of the Healthcare Commission's investigation into mortality rates* [at the Trust] *... to the work programme.*[255]

6.256 At the same meeting, a presentation from Dr Helen Moss was received on infection and prevention control. There is no record in that context of the HCC investigation. There is no reference in the minutes to any discussion of the letter from Julie Bailey, and it is to be assumed that there was none.

6.257 Councillor Jones told the Inquiry that he received no information about the progress of the HCC investigation apart from that offered by the Trust; as far as he was aware, the Trust was the OSC's only source of information about the investigation. It did not receive copies of the letters

252 Thompson T35.117–118
253 PJ/3 WS0000001812
254 PJ/6 WS0000001822
255 SBC0001000158, HSC Minutes (17 April 2008)

written by Dr Heather Wood the HCC's lead investigator, alerting the Trust and others to the concerns being uncovered.[256]

6.258 At the committee's meeting on 24 June 2008, it was reported that Trust representatives were unable to attend, and as a consequence, members had been invited to visit the hospital to meet directors. This took place on 13 August 2008, and members received a presentation from Mrs Brisby and Dr Moss. There were a number of concerning features about this presentation:

- The presentation suggested that under the previous management in 2005/06, the Trust had suffered from a major financial deficit, a lack of governance, questions over its future viability, an inward looking culture, a lack of leadership and quality issues.[257] The HCC report, and the report of the first inquiry, suggest that this frank, retrospective assessment was correct, but there is no indication in committee reports and minutes that this dire state of affairs had been detected by the committee or that any concern was now being expressed that these very serious concerns had passed unnoticed by those responsible for local health scrutiny;
- It was asserted that in 2006/07 the Trust had obtained a new senior team, governance structure, and that there had been a major skill mix review, a focus on quality, investment in capital and clarity on the future. It was claimed that the Trust now welcomed scrutiny.[258] The plan for 2008/09 included £2.47 million for 188 new and additional nurses (by September), a:

  ... focused review and development of A&E services (including recruitment of a new matron and two consultants and an extended triage service), investment in gaining immediate patient feedback, and enhancing and developing quality, safe services for local people.[259]

6.259 Even without the benefit of hindsight, the OSC might have been expected to ask how good quality care could have been provided with such an apparent shortage of staff and how such a rapid increase in numbers was to be achieved:

- Information designed to reassure about the reported mortality rates was given. The overall (ie not the acute admissions) Hospital Standardised Mortality Ratio (HSMR) for 2005 to 2009 were given, showing a decline from 127 to 99 in April 2008. Reference was made to "independent" reviews of the rates by the SHA and Birmingham University.[260] This

256 Jones T36.72–74
257 SBC00010000109, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)
258 SBC00010000109, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)
259 SBC00010000110–111, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)
260 SBC00010000117, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)

suggests, as confirmed by other evidence,[261] that the concerns about mortality were explained away by reference to the coding explanation. Councillor Jones recollected that:

both of them put a brave face on the matter and said that they – the hospital would emerge with a fairly clean bill of health and that really there was nothing wrong, underlying the operations and the performance of the hospital;[262]

He felt that the Borough Council's OSC received these assurances with a degree of scepticism.[263]

6.260 The committee was also told of results from the Ipsos MORI survey carried out by the Trust in May 2008. This had followed a concerning 2007 HCC inpatient survey result, also published in May. The latter had placed the Trust in the lowest 20% of trusts in the country for cleanliness, treatment of patients with privacy and dignity, and involvement of patients in their care. There is no record either in the presentation or in the minutes that these results were drawn to the committee's attention. If the presentation slide is a correct summary of what the committee was told, the results of the Ipsos MORI survey were presented in a manner calculated to put the best "spin" on them:

Overall 92% rated the care provided as "excellent", "very good" or "fairly good".

6.261 This left 7% saying care was "fairly poor" (4%), "very poor" (2%) or "terrible" (1%).

97% said they or the patient they were visiting – were treated with respect and dignity.[264]

6.262 As reported to the Trust's Hospital Management Board, the overall total of 97% reflected those who reported that patients were so treated "at least some of the time".[265] Only 74% said that patients received such treatment "all of the time", whereas 15% only accepted that this occurred "most of the time", and 5% "some of the time" or "rarely". A scrutineer might reasonably have expected dignity and respect to be accorded to everyone at all times.

89% rated the hospitals as "very clean" or "fairly clean".

6.263 The Trust's Hospital Management Board heard that, of the overall total of 89%, only 44% thought the hospital "very clean", whereas 45% thought it "fairly clean", 5% "neither clean nor dirty", 4% "fairly dirty" and 1% "very dirty", ie a majority of 55% thought it was less than excellent, and 11% thought it was not clean.[266] The survey report noted that there were

261 Jones T36.81
262 Jones T36.76
263 Jones T36.77
264 SBC00010000126, *Delivering the difference* (12 August 2008), Toni Brisby and Helen Moss
265 ESI00047139, Agenda of Trust meeting (6 December 2007); ESI00047142–143 *Report to Hospital Management Board re Final Ipsos MORI Poll Report* (6 December 2007), Deputy Director of Nursing
266 PCT0010000326 Mid Staffordshire NHS FT, Patient Visitor and Carer Survey (May 2009), Ipsos MORI

significant differences in perception between inpatients and others, male and female respondents, social classes B–D and A, those aged over 75 and those younger. In each case, the first mentioned group were more likely to perceive cleanliness favourably.[267]

6.264 The committee does not appear to have been totally persuaded by the presentation. Councillor Jones, who by this time had not only received Julie Bailey's letter but also had been present at the governor's meeting which had been addressed by CURE members, told the Inquiry:

> *The general feeling was that maybe they weren't telling us the whole story here.*[268]

6.265 Possibly as a result of the scepticism generated by the presentation at its meeting on 4 September, the committee agreed that a letter should be sent to the Trust raising, among other issues:[269]

- Staffing cover and its effect on staff morale;
- Inconsistency of approach in different areas of the hospital;
- Waiting times in A&E.

6.266 It asked for clarification or assurances for its next meeting.

6.267 Councillor Jones explained that the reference to staff morale had been intended to refer to A&E, where committee members had observed problems.[270] He thought the terms of his letter were fairly clear and explained that he was keeping to himself at that stage the true extent of his unfavourable views about the leadership of the Trust, which had been informed through his observation of Trust meetings.[271]

6.268 Responses to the matters raised were given by Mrs Perrin in a report prepared for the meeting of 20 November 2008.[272] With regard to staffing issues, she said that over £1.5 million had been invested in additional nurses and that various other steps had been taken. It was said that sick leave had improved since this additional recruitment. This does not seem to be entirely consistent with information given to the Joint Negotiation and Consultation Committee (JNCC) on 27 November to the effect that there had been an "in-month rise" to a monthly average of 4.67% and a moving annual average of 5.21%.[273] Care pathways were being introduced for specific conditions to reduce inconsistency of approach, and the Trust was

267 PCT0010000320 Mid Staffordshire NHS FT, Patient Visitor and Carer Survey (May 2009), Ipsos MORI
268 Jones T36.76–77
269 Jones WS0000001783 and WS0000001811, Letter dated 8 September 2008
270 Jones T36.91–92
271 Jones T36.87
272 SBC00010000140 *Report to the Health Scrutiny Committee re the Trust's campaign to reduce healthcare associated infection* (20 November 2008), Helen Perrin, Marketing and Business Development
273 TRU00010003344, Minutes of JNCC Meeting (27 November 2008)

working on plans to improve A&E, but had not achieved the target of 98% patients seen, treated and admitted within four hours. Steps were being taken to improve this.

6.269 At the 20 November meeting, the Borough Council OSC received a question from Mr Lownds about North Staffordshire Hospital's proposal to apply for FT status in which he protested about the possible restriction on public access to directors' meetings. The OSC resolved to request that the Trust hold board meetings in public if it became an FT.[274]

6.270 The meeting also received AHC ratings for 2007/08; those for the Trust were said to be "good" for both quality of service and use of resources, and core standards were said to be "almost met". There appears to have been no consideration of the potential inconsistency between such a rating and the ongoing HCC investigation.[275]

6.271 The committee's meeting on 12 March 2009 took place five days before the publication of the HCC report. A progress report was received from Mrs Perrin, focusing on HCAI figures. The meeting was attended by Mr Morton, the new interim Chief Executive of the Trust.

6.272 By the committee's meeting of 30 April, the HCC report had been published, and this was addressed in the Trust's regular report. The meeting was attended by Mr Stone, Interim Chair of the Trust, and Mr Court, Director of Strategy, Planning and Performance. The minutes record that there was a "detailed and frank" discussion in which a number of issues were examined, including infection control, mortality, governance, the improvement plan and recruitment.[276]

6.273 On 23 June 2009, the OSC received a report from the Trust on its transformation programme, HCAIs, mortality statistics and the case note reviews.[277]

6.274 On 27 August 2009, the committee discussed the Trust's report with Dr Obhrai, the Trust's Medical Director, who was newly in post. As in the previous report, detailed figures were given for mortality as well as HCAIs.[278]

6.275 Thus, the pattern was established of each meeting being addressed by senior management of the Trust with an update of the Trust's progress. Detailed information was presented.

274 SBC0001000214–215, Minutes of the Health Scrutiny Committee Meeting (20 November 2008)
275 CURE00330012796, Health Scrutiny Committee Agenda and Minutes (20 November 2008)
276 SBC0001000232, Minutes of the Health Scrutiny Committee (30 April 2009)
277 SBC00010000167, code of joint working arrangements; SBC0001000240, Minutes of the Health Scrutiny Committee (23 June 2009)
278 SBC00010000176, Minutes of the Health Scrutiny Committee (24 June 2009); SBC0001000249, Minutes of the Health Scrutiny Committee (27 August 2009)

Conclusions on Stafford Borough Council's Overview and Scrutiny Committee

6.276 The legislation and guidance make it very clear that OSCs have an important role to play in looking at safety and quality issues affecting their community.

6.277 Mr Thompson, Stafford Borough Council's Chief Executive, initially took the position that the committee had undertaken an "effective and robust" scrutiny of the hospital.[279] Any deficiencies which were known about were pursued by questioning of the Trust officers, and any lack of awareness regarding matters of concern was due to the committee not having been informed about them. It was not the role of the committee to performance manage the Trust, and it was not equipped to do so. The committee had many areas of health service activity to scrutinise, and the hospital was not near the top of subjects of interest until Julie Bailey communicated her concerns in late 2007 and the HCC started its investigation.[280] Thereafter, the focus on questioning the Trust was more intense. He accepted that the minutes do not give this impression because they are formalistic and do not give details of the discussion and questioning that took place.[281] Whether that impression of the scrutiny activity of the Borough Council is justified must be considered against the evidence. Mr Thompson's position was that, essentially, the council was given no cause for concern until Julie Bailey's intervention.

6.278 In his oral evidence, he was more circumspect:

> *I think there's going to be very few heroes come out of this Inquiry. We're certainly not going to be acclaimed with that. So ... I think looking back and in hindsight, then clearly, at various times, with the benefit of hindsight we could have done more. And I'm not seeking to argue – argue differently. I think we did in our own way the – you know, what we felt was the most appropriate level of ... scrutiny.*[282]

6.279 He accepted that the committee had a role to play in looking at the quality of the service delivered, as well as more strategic matters, while emphasising that there were limits to what a small committee with limited resources could achieve.[283]

279 Thompson T35.172
280 Thompson T35.37
281 Thompson T35.107
282 Thompson T35.156
283 Thompson T35.156

6.280 Councillor Edgeller accepted that the committee:

> *... did not get underneath what the representatives from the Hospital were telling it ... Chief Executives usually talk up an organisation and put on a positive gloss. If the same happened again, then I would look deeper and ask questions to the people below ... e.g. the nurses, doctors and consultants.*[284]

6.281 Councillor Jones told the Inquiry that the reaction of committee members to the HCC report when it was published was that they "felt vindicated" because they had been asking the right questions.[285]

6.282 Whatever lack of clarity there was in the committee's terms of reference, examination of the activity of the committee confirms that there was some level of scrutiny directed at the Trust. When concerns were raised in 2005, about its cost cutting proposals, the Trust's executive team was requested to attend and explain themselves. However, neither the committee itself nor the Borough Council had the expertise to mount any effective challenge to the proposals. They were bound to accept the assurances of the Trust that services would not be affected in the absence of an informed understanding of the effect of staff reductions. There was no easily accessible guidance or benchmarks to refer to, which might have assisted them in this task.

6.283 Likewise, in relation to the concerns raised about children's services, an attempt was made at scrutiny by asking the Trust for an explanation. The committee was not to know that there were grounds for challenging the explanation and reassurance offered, because it was left unaware of the West Midlands peer review findings which had been made almost simultaneously.

6.284 The scrutiny of the Trust's FT application was similarly unchallenging. The evidence does not show what, if any, questions were asked of the Trust following its presentation, but no steps were taken to seek to confirm what it was being told before resolving to support the application. Once again it had little choice but to accept what it was being told. Councillor Edgeller was therefore right to accept that this process was meaningless.

6.285 It is clear that concerns about cleanliness at the Trust came to the attention of the committee in the course of 2007 if not before. Not only did it receive the PPIF annual report referring to this but also officers would have been aware of the contact between the Stafford County Council HSC Chair, Councillor Muir and the PPIF through the regular officers' meetings. For example, its notes of a meeting on 21 April 2006 refer to a presentation by the PPIF about its work on cleanliness. Scrutiny committees had to rely on the PPIF to inspect, as they had no

284 Edgeller W0000003055, para 50
285 Jones WS0000001789, para 26

power of their own. However, sufficient concern was raised in the mind of Councillor Muir to intervene and trigger further activity by the PPIF. Nonetheless, the Borough Council OSC appears to have remained a mere spectator to these events, receiving reports without comment or suggestions for action.

6.286 The official response of the Borough Council to Julie Bailey's questions and her letter of 20 February 2008 was quite unacceptably dismissive. Mr Thompson told the Inquiry that the OSC had not detected cause for concern about the issues she raised before because it relied on the public and other bodies to raise such matters, and none had.[286] From then on, he claimed:

> *HSC members began to ask further questions relating to basic patient care ... Therefore, the Borough HSC was already aware of, and dealing with the issues at the Hospital by the time the Healthcare Commission ... started its investigation in March 2008.*[287]

6.287 Unfortunately, the letter he wrote at the time suggests that the official position he adopted was that it was not for his committee to take any action but for Julie Bailey to approach others. He appears to have confused the duties of others to process individual complaints with the task of his committee to scrutinise the Trust. It should have been quite clear that Julie Bailey and her group had raised serious cause for concern about the general standard of service and management at the Trust, albeit understandably based on their own experiences. That is surely the most likely way in which such concerns will come to light. If ever there was an issue on which local politicians were entitled to involve themselves and make demands of the authorities for information and action, this was surely it.

6.288 Fortunately for the public interest, Julie Bailey was not lightly deterred from pursuing what she knew was right, but there is a considerable danger that less robust individuals would have been discouraged from taking further action by this formalistic and unhelpful letter.

6.289 In contrast, Councillor Jones' response was sympathetic and encouraging, as one would expect of a conscientious councillor. As it happens, any contribution he and like-minded colleagues might have made was overtaken in the event by the announcement of the HCC investigation.

6.290 Councillor Jones made it clear that once he became aware of serious concerns, he and the committee decided that they could make a contribution to scrutiny by pursuing issues about mortality rates, and HCAIs. However, prior to that date, there is an almost complete absence of evidence of scrutiny, in the sense of any challenge, to what they were being told by the Trust. The absence of clarity in what was delegated and terms of reference to govern the scope of scrutiny might have contributed to this state of affairs, but it is not the whole

286 Thompson WS0000002314, para 30
287 Thompson WS0000002313–314, paras 28–29

explanation. As pointed out by several witnesses, scrutiny committees have many areas for scrutiny and have to prioritise between them. There is certainly evidence that insufficient significance was given to information coming from the public. In any event, there may have been a lack of understanding about what scrutiny of an acute hospital actually entailed.

6.291 There are clearly limits on what a committee of elected councillors can be expected to do in scrutinising a hospital. As Councillor Edgeller put it when pointing out that the committee had no power to enter and inspect premises:

> *... the HSC can only do so much and though it continues to ask questions, it ultimately has to trust that the picture portrayed of the Hospital by its representatives is honest and accurate unless there is evidence to the contrary. It has no mechanism to make sure the representatives do this nor does it have any authority to investigate the situation at the Hospital itself.*[288]

6.292 Mr Thompson made a similar point:

> *... clearly ... we have not got the resources, our members don't have the background and training to do the ... in-depth scrutiny in the same way as, say, the HCC can do.*[289]

6.293 Councillor Shelton-Baron said:

> *... there was nothing that – because we don't have the power as a district council, there was nothing the council did which we couldn't have – that you know, any different that, you know, than we've – than we've done, because we don't have the power to do it.*
>
> *THE CHAIRMAN: So your answer is that faced with the same situation again, the same thing would happen?*
>
> *A. It would if we had the same people there.*[290]

6.294 Nonetheless, there was more that they could have done. The committee had the ability to seek information about the Trust and its activities from PALS, the PCT, the PPIF or constituents, among others. Instead it waited for such bodies and individuals to come forward. It received annual reports from the PPIF but appears to have been unaware of how ineffective it was in general, likewise its successor, LINks. The committee never considered exercising or asking the County Council HSC to exercise the power to submit a report and recommendations to any NHS body, or the Secretary of State.

288 Edgeller WS0000003053, paras 42–43
289 Thompson T35.156
290 Shelton-Baron T37.166–167

6.295 An increase in the amount of consideration given to the Trust is evident from the date of the publication of the HCC report. There were regular reports from the Trust, and these contained more detail and were more wide ranging than those seen before. The minutes continued to be uninformative as to the content of any discussions about issues raised, in contrast to the County Council's HSC minutes which give a fair idea of what points were made by councillors. While the level of questioning after the start of the HCC investigation increased, no attempt was made to contact the HCC or to offer assistance. It relied on the HCC approaching it, which did not happen.

Staffordshire County Council Overview and Scrutiny Committee

Delegation

6.296 Councillor Muir was adamant that it was the Borough Council's committee which carried out all scrutiny of the Trust.[291] While, as already observed, that committee did in practice undertake a degree of scrutiny, it does not necessarily follow that the County Council had divested itself of its responsibility. Until 2010 there was no formal delegation, and as will be seen, on occasion Mr Muir himself intervened in relation to the Trust.

6.297 Councillor Eagland, who succeeded Councillor Muir as Chair of the HSC, accepted that as Borough Council Committee members were uncertain about this, there was at least a failure of communication between the two councils.[292]

Training

6.298 Councillor Muir received one day's training for his role in addition to other opportunities to attend seminars. He felt that he was constantly reading medical material to improve his understanding of issues being discussed, and he brought to bear his previous experience as a board member of a health authority. However, he was of the view that the whole point of a scrutiny committee was that members were elected to represent their communities, and there was no need for them to have expertise or experience in health matters.[293]

Scope of committee's remit

6.299 The County Council HSC had a responsibility to provide an overview of the health service throughout the county, in which there were eight trusts, as well as trusts outside the county which took patients from within it.[294] While the committee would scrutinise matters relating to the Trust, where it had potential to affect the area as a whole, such as the application for FT

291 Muir WS0000034482, para 33
292 Eagland WS0000003548–549, para 31
293 Muir WS0000034476, paras 10–15
294 Muir WS0000034478, para 17

status, it was not its role to "micro-manage the Trust" or any other health service organisation in the county.[295]

6.300 Unusually for a County Council committee, from 2007 the HSC was authorised by the council to issue its own reports and correspond with third parties in its own right and without the authorisation of the Leader or Chief Executive of the Council.

6.301 Councillor Muir also persuaded the Council to pay the Chair and Vice Chair of the HSC at a higher level than the officers of other scrutiny committees to reflect the additional work and responsibility involved.[296]

The committee's approach

6.302 Councillor Muir supported the approach to the role of a scrutiny committee as indicated in the DH guidance of being a "critical friend". He felt that attempts at scrutiny would be ineffective unless there was a relationship of trust between the committee and providers as opposed to antagonism. It was more likely that providers would be open and honest in providing information:

> *I felt that if I couldn't go into a hospital and speak to the senior management in a friendly way, in order to draw out problems I would not be doing my job properly.*[297]

6.303 Councillor Ellis, who became Cabinet Member for Health after the publication of the HCC report, took a different view of how such a committee should operate:

> *... I believe that the HSC thought its role was to show an interest in the Hospital and encourage it, rather than to challenge. I fundamentally disagree with this approach ... known as "scrutiny as the critical friend" ... which ... sends out the wrong message.*[298]

6.304 Councillor Jones, who became Vice Chair of the County Council's HSC in 2009 after a period as a member, also disagreed with Councillor Muir and refused to participate in relationship management meetings with the Trust, which he characterised as having:

> *... a cup of tea and a chat.*[299]

295 Muir WS0000034481, para 28
296 Muir WS0000034477, para 15
297 Muir WS000003479–480, paras 22–23
298 Matthew Ellis WS0000002763–764, paras 5–6
299 Jones WS16; WS0000001787

6.305 He thought such meetings gave the impression that there had been scrutiny when in fact none had taken place. Councillor Muir disputed this characterisation and insisted that while meetings might have been informal, they were effective.[300]

6.306 It appears to have been a deliberate policy of the committee under the leadership of Councillor Muir not to proactively seek the views of the public. He thought this would not be a worthwhile exercise:

> *I do not think it was the County Committee's responsibility to go and find out what the views of people were. In a sense it would have been pointless to do this given the vast and frequently diametrically opposed range of views amongst different members of the public.*[301]

6.307 If a member of the public had come to him with concerns, he would have looked into them, but if he had been told to canvass views:

> *I would have gone home.*[302]

6.308 He considered it was not the role of the County Council's committee to voice the views of others as opposed to "respond to the interests of the community" in an objective manner. He felt the DH guidance was incorrect in this regard.

6.309 There was no provision in the committee's procedure for members of the public to ask questions, and therefore it was not surprising to hear from Councillor Eagland that she could not recall a member of the public attempting to ask a question at a meeting.[303]

6.310 The principal source of information for the committee was trusts' management teams. On occasions, expert assistance was sought.[304]

6.311 The HSC worked to a programme set annually and focused on regional matters, such as the merger of the local ambulance trusts. If it looked at the affairs of a particular trust, it was because of the relevance to the region as a whole.

300 Muir WS0000034495, para 84
301 Muir WS0000034480, paras 25–26
302 Muir WS0000034480, para 26
303 Eagland WS0000003544, para 14
304 Muir WS0000034487, para 53

Staffordshire County Council Health Scrutiny Committee's scrutiny of the Trust

Proposed service changes at Cannock Hospital

6.312 In September 2005, a special meeting was held to consider the Trust's proposals for service changes at Cannock. The HSC was concerned that the Trust had not complied with its obligation to consult the committee about significant changes as required by statute. Consideration was given to reporting the concerns to the Secretary of State, but it was decided that formal questioning of the Trust leadership would be a preferable course to take. At this meeting, Mr Yeates was allowed to give a presentation, during which he apologised for not having contacted the committee earlier about developments and promised to do so in the future. Members made numerous criticisms of the Trust's approach and asked challenging questions. For example, the view was expressed that the Trust would have to communicate a great deal better if it was to obtain the committee's support for a renewed application for FT status, and Mr Yeates was questioned about concerns over the Trust's ability to deal with an increase in emergency admissions.

6.313 After the Trust representatives withdrew, following deliberation between members, the committee resolved to require the Trust to provide a number of specific items, including: an undertaking that clear lines of communication be maintained with the committee; reassurance that robust systems for patient, carer and public involvement were being developed; and details of the services being currently provided.[305]

Clinical floors project

6.314 The clinical floors project was mentioned in the presentation given in September 2005. At the HSC's meeting on 16 November 2005, Councillor Wilkinson expressed his concerns about the service reconfiguration and the consequent part closure of the gynaecological ward. He was concerned at the effect on patients' recovery. It was resolved to write to the Trust to seek clarification.[306] At the next meeting, it was reported that Mr Yeates had accepted all points raised in a response described in the minutes as "very positive".[307]

6.315 In passing, there was reference in the minutes to issues of a personal nature raised by a member of the public, presumably not in connection with the Trust, but another one. It was reported that the Health Scrutiny Manager had taken up the matter with the Chief Executive concerned.

6.316 The floors project was referred to again during a further presentation by the Trust on its strategic direction to the committee at a meeting on 16 January 2006.[308] Councillor Wilkinson,

305 SCC00060000032, Staffordshire HSC minutes and presentation
306 SC00060000096, SCC HSC minutes (September 2005)
307 SCC00060000112, SCC HSC minutes (16 November 2005)
308 SCC00070000003, SCC HSC Minutes (16 January 2006)

the Borough Council representative on the committee, expressed concern at the effect on services of the closure of certain wards involved in the project and on training capacity.

6.317 The Trust was also challenged on whether it had contingency plans for the possibility of a failure of its financial strategy. The Trust representative assured the committee that there were such plans.

6.318 Another councillor expressed concern that the strategy was cost not patient led. He was assured that the plan was clinically led, although due regard had to be paid to financial considerations.

6.319 Councillor Eagland asked about the process of quality of service benchmarking and was assured that the Trust had employed specialist assistance to provide information on a "patient basis" and that an improvement team was "to take the findings forward".

6.320 The committee resolved to note the presentation.

6.321 Councillor Muir did not consider it his committee's role to confirm whether a project such as this was supported by the clinical staff or whether an appropriate risk assessment had been carried out.[309]

Concern about cleanliness and infections

6.322 The liaison between the County Council HSC, Messrs Deighton and Bastin and the Borough Council OSC has been noted above. Additionally, at the County HSC's meeting on 15 November 2006,[310] concerns were raised about the increased rate of *Clostridium difficile* at the Trust. Councillor Muir was aware this was an issue at other trusts as well, and he felt a comparison exercise was necessary. He sought information and received the letter from the Trust referred to above. He felt its figures were not notably different from the other trusts, and as a result he felt no need to delve deeper.

Contribution to Annual Health Check declarations

6.323 The committee considered what comment it should make for the HCC's AHC for 2005/06 at a meeting on 24 April 2006. It was aware that the Trust's score had slipped but understood that this was due to a failure to submit information. Councillor Muir regarded this as a matter for disciplinary action not scrutiny.[311]

309 Muir WS0000034494, paras 78–80
310 ESI00015194, Minutes of the Stafford Health Scrutiny Committee (15 November 2006)
311 Muir WS0000034496, para 87; JM/19 SCC0007000077

6.324 The committee commented as follows:

> *The Staffordshire Health Scrutiny Committee welcomes the opportunity to discuss with the trust the areas where they are non-compliant with the final declaration and proposes that a meeting be set up with the Trust to discuss how to take these matters forward.*[312]

6.325 The committee's comments for the 2006/07 declaration was a positively expressed description of the process of consultation in connection with the Trust's application for FT status, its work in relation to cleanliness and infection (see above) and general liaison.[313]

6.326 In retrospect, Councillor Muir did not believe that the AHC had "any real purpose", nor did he believe that it had addressed the issues brought to light by the HCC investigation.[314]

Observation on the Trust's Foundation Trust application

6.327 In connection with the Trust's application for FT status, Martin Yeates gave a presentation to the County Council HSC on 14 February 2007, at one point in the meeting reading out the email from Helen Jenkinson of the HCC making approving comments about cleanliness at the Trust. Members asked questions and made observations about the constitutional structure of the FT, its name, the future of PALS and financial freedom. The committee agreed to set up a sub-group to prepare its observations.[315]

6.328 The formal response, submitted to the Chair of the Trust on 4 April 2007, expressed the HSC's support for the application and congratulated the Trust on the presentation of its application.[316]

6.329 Councillor Muir explained that the committee did not see this consultation process as an occasion for asking fundamental questions:

> *... members were primarily concerned about how the Trust Board would be structured if the application was successful and whether or not there would be representatives from both South Staffordshire and Cannock on the board. Those were the sort of issues ... rather than any more fundamental questions as to whether or not the Trust was sufficiently equipped to be a Foundation Trust.*[317]

312 JM/19 WS0000034781
313 CURE0023000149–150, Trust core and developmental standards declaration 2006/2007
314 Muir WS0000034497, para 89
315 SCC00080000063–066, Committee minutes, 14 February 2007
316 TRU0005000276, Letter from Councillor Muir to Toni Brisby on the FT application, 4 April 2007
317 Muir WS0000034504, para 114

I don't think you could say that it was the role of the County Committee to specifically test whether the Trust was performing to the highest standards in order to achieve Foundation Trust status. They had to provide us (and others) with the presentation as part of the consultation.[318]

6.330 He believed that by this stage the previous concerns at the Trust's reluctance to engage with the community had been resolved, and he had been impressed at the care with which it engaged local organisations in the consultation process.[319] He could not recall the issue of the mortality statistics having any impact at the time on the issue of the application.

6.331 Councillor Eagland gave evidence to like effect: she believed the committee had relied on Monitor's assessment process. In hindsight, she accepted that the committee should have sought the views of others. She also told the Inquiry that the Trust's success in gaining FT status led it to believe it was justified in accepting the Trust's responses to its questions.[320]

Reaction to mortality statistics, the Healthcare Commission investigation and public concerns

6.332 Councillor Muir said he had asked Martin Yeates about the HSMR ratings at one of their meetings, and had been advised that it was a coding issue. He understood that the Trust was looking into the issue, and therefore he waited for the outcome of that process.[321]

6.333 During the course of 2008, Councillor Muir had relationship meetings with Martin Yeates, but the subject of the HCC investigation was not raised at any of them.[322] He told the Inquiry he would have been loath to take action during the investigation as the HCC had much more information than the committee and greater powers and resources.[323]

6.334 There was also little reaction to the approach that had been made by Julie Bailey and her colleagues to the Borough Council OSC in February 2008. At the County Committee's next meeting, on 31 March, there is a record of the county councillor who sat on the Borough Council OSC having earlier raised a question to the Council's cabinet/health trusts regarding mortality rates:

In view of the concerns raised by residents of the Borough, I would like clarification from the relevant authorities over the apparent confusion vis a vis mortality rates at the Staffordshire General Hospitals in Stafford.[324]

318 Muir WS0000034504, para 118
319 Muir WS0000034504, para 115
320 Eagland WS0000003545–546, paras 19–22
321 Muir WS0000034505, paras 121–122
322 Muir WS0000054508, para 135
323 Muir WS0000034508, para 134
324 SHA0003000236, Minutes of the Staffordshire Health Scrutiny Committee, 31 March 2008

6.335 A response from Martin Yeates was circulated at a meeting on 28 April 2008.[325] The reply stated that it was aware that Dr Foster's report had given the Trust a Standardised Mortality Rate (SMR) for 2005–2006 of 127, higher than the national standard of 100.[326] It explained that this had been investigated, and the Trust had concluded that the high rate was due to:

> *... problems in the way we were recording and coding information about patients.*

6.336 It asserted that this view was supported by independent analysis and a detailed review of individual patient case notes, and that further the Trust had worked closely with the SHA which had also researched SMR statistics for four trusts in the West Midlands. The reply stated that Dr Foster had confirmed the Trust's overall mortality was within national norms. The reply went on to say that more clinical coding experts had been employed and, as a result, the SMR had dropped to 100.4 between May and October 2007 for emergency admissions and 101 for all admissions. It concluded with the assertion that the Trust believed its mortality rates to be normal in light of the Trust's size, type and locality and that it would "continue the drive to improve the range and quality of their services".

6.337 Councillor Muir did not consider this was a matter requiring scrutiny by the committee during the HCC investigation as he relied on the assurance he had been given by Mr Yeates, and felt that the HCC had access to information and powers beyond its remit.[327]

6.338 Members were informed of the announcement of the HCC investigation, but the report from the committee is not recorded as containing any mention of this. No discussion of the issue seems to have occurred.

Reaction to the Healthcare Commission report

6.339 The report "horrified" Councillor Muir:

> *The things that were reported in relation to poor clinical care I would never have expected to have happened.*[328]

6.340 On 9 April 2009, a short time after publication of the report, the HSC held a meeting at which it received a presentation from the Interim Chief Executive of the Trust, Eric Morton. Members were recorded as asking questions about many aspects of the care and service at the Trust and the future role of the committee. Some members expressed concern at the ability of lay people to interpret information without expert assistance. A series of joint meetings with other scrutiny committees was agreed to.[329]

325 ESI00016197 Minutes of the Staffordshire Health Scrutiny Committee, 28 April 2008
326 ESI00016119–120, Question and answer from Councillor Amyas, 23 March 2008
327 Muir WS0000034508, para 134; JM/41 WS0000035001
328 Muir WS0000034511, para 145
329 JM/45 WS0000035035

6.341 Members of CURE attended this meeting and were approached by Councillors Muir and Eagland but did not want to engage. Councillor Eagland understood this reaction:

> *... more could have been done to get them to engage* [in the past].[330]

6.342 At its meeting on 9 July 2009, the first chaired by Councillor Eagland, a presentation was given by the Interim Chair of the Trust, David Stone. Members raised issues about the number of complaints received, the impact of the serious nature of some complaints, staff morale, the quality of information provided by the Trust in the past, the need to restore public confidence and calls for a public inquiry.[331]

6.343 Thereafter, joint accountability sessions were arranged with the Borough Council's OSC. A draft joint code of working explicitly made the scrutiny of the Trust the responsibility of the County Committee.[332] The code had just been agreed at the time relevant witnesses gave evidence, though the first meeting had not yet taken place.[333]

Conclusions on the Staffordshire County Council Scrutiny Committee

6.344 Councillor Ellis accepted that the overview and scrutiny committees had failed to uncover the deficiencies at the Trust. He attributed this principally to three factors:

- An adoption of the role of "critical friend" rather than a more robustly challenging attitude of the type he was used to in the scrutiny of his own work as health and social care lead within the council. He felt, looking back at the minutes, that while the right questions may have been asked, the reassuring answers given were accepted too readily. His sense was that committee members showed:

  > *... overt and uber respect ... to individuals and an assumption was made that they were being entirely accurate, but I don't think* [they were] *tested.*[334]

  > *... I believe that the HSC thought its role was to show an interest in the Hospital and encourage it, rather than to challenge. I fundamentally disagree with this approach ... known as "scrutiny as the critical friend" ... which ... sends out the wrong message.*[335]

- A lack of clarity of the role of scrutiny: he was critical of the guidance referred to above. He interpreted it as steering committees away from safety and quality issues and towards more strategic issues;

330 Eagland WS0000003544, para 15
331 ESI00016921, Minutes, 9 July 2009
332 WS0000002325 IT/2, para 2.3
333 Edgeller WS0000003054, para 45; Eagland T41.21
334 Matthew Ellis T34.19; WS0000002763, para 4
335 Matthew Ellis WS0000002763–766

- The committee received no information which would have led it to suspect the depth of problems at the Trust.

6.345 His view was necessarily a remote one: he had not been personally involved in health oversight and scrutiny, and the events now under review occurred under a previous administration run by a different party.

6.346 His criticism of the guidance was not well grounded on a close reading of it. Indeed, it was apparent in the course of his evidence that he had not read it. However, it would be fair to comment that the guidance tends to emphasise the need for constructive dialogue and does not make it entirely clear that the committee can examine a specific issue of safety and quality at one provider, although there is nothing to suggest this cannot be done either. The guidance does not offer a committee any excuse not to launch a scrutiny of a serious concern of which it becomes aware concerning the safety and quality of a service being provided in its community. Indeed, it will have been failing in its duty if it did not do so.

6.347 Councillor Muir rejected the suggestion that his committee could have found out what was happening at the Trust:

> *I think that this would have been impossible. You would have needed to be a god to be able to monitor in such detail across the breadth of service providers which fell within our remit.*[336]

6.348 He pointed out that it had no power to undertake unannounced visits, and the issues raised in the HCC report were never raised by members. They could not see what nurses saw on wards. He felt that it would not be appropriate to give scrutiny committees more powers as he saw their role as being to deliver a "slap" or a "punch", by which he presumably meant a public rebuke.[337]

6.349 Councillor Eagland thought that more could have been done:

> *In relation to the criticism that the Committee failed to respond to patient concerns in relation to the Trust, I would have to agree. What became extremely apparent after reading the HCC report is that we, along with other agencies, could have been more involved with what was going on at the Trust at the time ... I wish that we had dug deeper ... there should have been more scepticism of what we were told by the Trust.*[338]

336 Muir WS0000034511–512, para 150
337 Muir WS0000034512, paras 151–153
338 Eagland WS0000003551, para 35

6.350 Although some attempts were made to downplay the responsibility of scrutiny, as well as taking an overview a health overview and scrutiny committee has clear statutory responsibility to scrutinise the provider trusts in its area. Scrutiny ought to involve more than the passive and unchallenging receipt of reports from the organisations scrutinised. That this is possible is demonstrated to some extent by the approach taken by the County Council HSC since the publication of the HCC report. It has required regular meetings and reports, as before, but the members clearly ask more challenging questions, often based on concerns that they perceive are shared by the public. Previously, the scrutiny performed by this committee was deficient in a number of respects:

- It failed to make clear where the responsibility lay for scrutinising the Trust, a major provider of healthcare in the county. In spite of claims to the contrary, it did not divest itself of its responsibility to involve itself in the scrutiny, either in theory or practice.
- Having maintained such a role, it confined itself to the passive receipt of reports.
- It made no attempt to solicit the views of the public. It had no procedure which would have encouraged members of the public to come forward with their concerns.
- It made little use of other sources of information to which it could have gained access, such as complaints data or even press reports.
- It showed a remarkable lack of concern or even interest in the HSMR data. Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee, with challenge being offered to the coding explanation.
- It showed little reaction to the concerns expressed by CURE to the Borough Council OSC, even though they were at least in general terms brought to its attention.
- It took no steps to consider the implications of the announcement of an investigation by the HCC or to follow its progress.

6.351 In short, this committee appears to have been wholly ineffective as a scrutineer of the Trust. Councillors are not and cannot be expected to be experts in healthcare. They can, however, be expected to make themselves aware of, and pursue, the concerns of the public who have elected them. That is surely the intended purpose of giving a local scrutiny role to councillors.

6.352 It has been suggested that they could not have done more because they lacked the power of entry and inspection. This did not prevent Councillor Muir, very properly, coordinating inspections by the PPIF in response to concerns communicated to him by Messrs Deighton and Bastin. In any event, the power of summoning the leaders of provider trusts to give an account of their actions in public is a powerful tool, which, if used properly, proportionately and after preparation, could act as an incentive towards improvement and as a challenge to the public being offered inaccurate or superficial information.

6.353 These criticisms must be levelled collectively at a committee membership with a changing membership rather than at individuals.

Local Members of Parliament

6.354 The Inquiry heard from four former or current local MPs:

- David Kidney, MP for Stafford (Labour) May 1997 to May 2010;[339]
- Dr Tony Wright, MP for Cannock (Labour) 1992 to 2010;[340] Dr Wright had also been Chair of the House of Commons Public Administration Select Committee and a prominent campaigner for the protection of whistleblowers;
- William Cash, MP for Stafford 1984 to 1997 and for Stone (Conservative) since 1997;[341]
- Jeremy Lefroy, MP for Stafford (Conservative) since 2010.[342]

6.355 It is right to place on record that all gave evidence willingly and were conspicuous in being obviously keen to assist the Inquiry with their experience and not to make party political points. All three who were sitting MPs at the time of the first inquiry had provided considerable assistance in disclosing to it the complaints they had received from constituents and in obtaining permission for this step from the complainants.

The role of Members of Parliament

6.356 It is necessary to make clear at the outset that MPs are not regulators or healthcare experts, but represent their constituencies and constituents in Parliament. Therefore, while they necessarily have to develop an understanding of local affairs and will represent the expression of concern or requests for assistance when asked to do so by a constituent, they have no direct responsibility for the performance of healthcare organisations in their constituency. However, because of their position, they might be expected to become aware of concerns about a hospital from their constituents. Further, as more than usually well informed local figures, they can offer a helpful perspective on the significance that was attached at the time to various developments of which they were aware.

6.357 A code of conduct for members, approved by the House in 2012, provides that:

> *Members have a general duty to act in the interests of the nation as a whole, and a special duty to their constituents.*[343]

339 Kidney WS0000002771, para 1
340 Wright WS0000003640, para 1
341 Cash WS0000003385, paras 1–2
342 Lefroy WS0000002600, para 1
343 *The Code of Conduct* and *The Guide to the Rules relating to the Conduct of Members 2012*, www.publications.parliament.uk./pa/cm201012/cmcode/1885/1885.pdf

6.358 Parliamentary etiquette requires that it is the MP for the constituency in which a person lives who should take up concerns of a constituent, even if the cause for concern arises in another constituency. If the "wrong" MP is contacted, he is expected to pass the matter on to the "correct" one to deal with it.[344]

Loss of star rating

6.359 David Kidney initially understood CHI's star rating system as an indicator of performance. When he saw the Trust's rating increase to three stars in 2003, he saw that as an encouraging improvement in performance.[345] When it dropped to zero stars in 2004, he found this alarming and took a number of steps:

> *I think the word ... used by you is the right one, it was bewildering. I walked in the hospital one day and it was a three-star hospital, and I walked in another day and it looked exactly the same but it was now a no-star hospital. How could this be? Is it safe if it has no stars? And I asked a lot of people from the – the commissioners who provide the star system, to the hospital management, to the primary care trust, the strategic health authority "How can this be? What's wrong with our hospital?"*[346]

6.360 Those he approached included the DH, the SHA and the HCC. He says he was assured by all these bodies that:

> *... the hospital was safe.*[347]

6.361 He met David O'Neill, the then Trust Chief Executive, who communicated not only his anger at the loss of stars but also the view that it did not measure the quality of care. He also contended that the Trust was receiving insufficient financial support.[348]

6.362 Mr Kidney was advised by the HCC that the Trust had done well on the "balanced scorecard" in some areas. This led him to be confused about what the rating system meant, and he felt from then on that the hospital had something to prove. However, the essential message he received from the Trust and others was that it was safe and could address the issues which had led to the loss of stars.[349]

6.363 As a result of his concerns, he and Dr Tony Wright MP went to see the then Minister of State for Health, The Rt Hon John Hutton MP (now Lord Hutton of Furness), principally to seek

344 *Members and Constituency Etiquette,* House of Commons Library, 9 January 2009
345 Kidney WS0000002772, para 6
346 Kidney T39.7
347 Kidney WS0000002772, paras 11–12
348 Kidney T39.17–20
349 Kidney WS0000002774, para 13

assurances that the Trust would receive the necessary support to recover its rating. According to Mr Kidney, the Minister dispensed "tea and sympathy" but little else.[350]

6.364 The episode left him confused about the significance of the ratings.

Significance of the Primary Care Trust

6.365 Mr Kidney raised with the PCT relevant matters of concern brought to him by constituents and often met its Chair and Chief Executive. The PCT did not raise with him concerns about quality and appeared to him to focus on commissioning and funding issues. He also met the Chair of the PCT's Professional Executive Committee (PEC), Dr Roger Beal, on frequent occasions, but he never raised concerns with him.[351]

6.366 Dr Wright felt that the PCT's engagement with issues locally had reduced after the 2006 reorganisation; he suspected that its staff had been preoccupied with preserving their jobs and that this may have led to a loss of focus on what was happening in hospitals.[352]

General impressions of the Trust

6.367 Mr Kidney initially formed a favourable impression of Martin Yeates, having met him several times after he arrived in 2006:

> *He* [Martin Yeates] *seemed to me to have an open style, always replying to my letters personally and promptly, and it appeared as though the Hospital was returning to an even keel.*[353]

6.368 However, he went on to state that despite Mr Yeates's management style being well received, and despite Martin Yeates having a sizeable number of staff members express support for him upon his resignation, he felt that Mr Yeates had been over-promoted in the NHS. He further stated that he had been disappointed that Mr Yeates did not accept responsibility and resign after the release of the HCC report.[354]

350 Kidney T39.36–37
351 Kidney WS0000002776, para 26; Kidney T39.40
352 Wright WS0000003644, para 21
353 Kidney WS0000002777, para 30,
354 Kidney WS0000002788, paras 73–74

6.369 Dr Wright had never harboured a favourable view of the Trust:

> *My impressions of the Trust, and particularly of Stafford Hospital, were unfavourable, for a number of reasons. Even as far back as the mid to late 1990s I felt that there were serious leadership issues, at both executive and non-executive level. I remember wondering who was actually running Stafford Hospital at one point, when I was told that the Trust was unable to get consultants to travel to Cannock Hospital.*[355]

6.370 He recalled, even when he was a Parliamentary candidate, being told by an ambulance man that they frequently bypassed Stafford to go to Stoke.[356]

6.371 He also had a general concern about quality of care at the Trust:

> *I have always had a keen interest in consumer issues, particularly those in relation to the public sector. Quality of care is my background and soon after being elected I wrote a book on how to complain about services effectively. Because of this interest I was particularly attuned to quality of care issues and was becoming increasingly concerned that the service offered by the Hospitals was lacking ...*[357]
>
> *... I had an underlying sense that there was a danger that the powers that be were taking their eye off the ball in relation to the basics; the essential quality of what they were there to do. I began to think that the issues at Stafford Hospital were just the local manifestation of a national problem.*[358]

6.372 However, he saw this as part of a national issue rather than specifically as a local problem:

> *I felt at a national level we were – we were not paying sufficient attention to the quality of patient experience and I wanted to do it better. In every case I saw, whether it was the ones coming from Stafford Hospital or Cannock hospital or in some cases from Good Hope Hospital, or from Manor Hospital in Walsall or from North Staffs hospital in Stoke, or my father-in-law's experience in Wales, or my mother and father's experience in Northamptonshire, all seemed to point to the fact that there was this issue about basic care standards in the health service and, what should we do about it?*[359]

355 Wright WS0000003641, para 5
356 Wright WS0000003649, para 44
357 Wright WS0000003642, para 10
358 Wright WS0000003642, para 12
359 Wright T38.70–71

6.373 Mr Cash felt unable to make a comparison between Stafford and other hospitals as he lacked the expertise and the information on which to do so.[360] His constituents would have used University Hospital North Stafford as much as the Trust, but he could not recall whether he had visited the Trust between 2003 and 2008 or since.[361] Likewise, he could not recall any conversation with fellow local MPs comparing the state of their hospitals.

Workforce reductions

6.374 Mr Kidney was not concerned about the proposals to cut the work force at the Trust in 2005/06 of which he was aware. His impression was this development was consistent with the national picture of financial pressures. He did not connect this with any threat to the quality of the service and received little indication from constituents that there was cause for concern about quality:

> *The focus on finances and jobs was also prevalent among the public. As a Member of Parliament holding regular advice surgeries and being easily contactable at my constituency office, by telephone and by email, I received very few complaints about the quality of services and care at the Hospital during this period. Those I did receive, I raised with the Hospital and they appeared to be individual and appropriately dealt with.*[362]

6.375 He could not recall hearing of any healthcare body raising concerns that staff cuts risked affecting the quality of service at the Trust.[363] He did have discussions with the unions about the proposed cuts. Kath Fox, the Convenor at the Trust, came to see him and complained about not getting enough information from the Trust. She was expecting him to take up the union's case at a high level, but her concern appears to have focused on the effect on the employees and through them the effect it would have on patients rather than patients themselves.[364]

6.376 Dr Wright was aware of the 2006 redundancies, but this did not result in complaints to him. He received and was satisfied by assurances offered by Martin Yeates that patient care would not be affected.[365]

6.377 Mr Lefroy was only a prospective Parliamentary candidate at this time, but he did meet Mr Yeates and Mrs Brisby in November 2006 to discuss the proposed financial cuts. He received assurances that the deficit could be dealt with. In retrospect, he saw that this should

360 Cash T40.106
361 Cash T40.107–108
362 Kidney WS0000002778, para 33
363 Kidney WS0000002779, para 36
364 Kath Fox T43.114
365 Wright WS0000003645, para 25

have raised questions about what the consequences were, and he now regretted not having pursued the issue further. At the time, however, he was satisfied with what he was told.[366]

The Foundation Trust application

6.378 Mr Kidney was not an enthusiast for the concept of FTs, but he did believe that the process of application involved a thorough examination of the management and governance of the Trust:

> *To me, on the outside looking in, the process of applying for Foundation Trust status looked to be testing and exhaustive. When the regulator of Foundation Trusts, Monitor, approved the Hospital's application early in 2008, it was said that there had been a rigorous examination of the Hospital's leadership, management and governance arrangements and that they were all in order. Anyone reading the HCC's report a year later, with its trenchant criticisms of managers, management, financial control and weak overview by the Board must think how hollow this sounds; not just the findings but the very process itself.*[367]

6.379 He told the Inquiry that he neither opposed the Trust's application nor supported it. Martin Yeates had described the process to him on several occasions and his reaction was one of encouragement:

> *Personally I thought with the history we'd just been through, I couldn't see how they were going to be granted their application.*
>
> *Q. And you did not support it?*
>
> *A. I did not give my support to their application but neither did I oppose it.*
>
> *Q. Did you ever give any indication to Martin Yeates that you might support it?*
>
> *A. Well, I met him several times when he was describing to me the process they were going through. So certainly I heard the reports and they sounded positive – you know, I said to him "Well done for your – what you're going through". Obviously if they got the status, and it meant that after a rigorous assessment they were good managers, that's good for our hospital.*[368]

366 Lefroy WS0000002601, paras 5–6
367 Kidney WS0000002780–781 44
368 Kidney T39.87–88

6.380 He felt that if the application were successful, it would be a pleasant surprise:

> *To me, it was a question that I didn't think it was going to succeed with the application because of this history. If it did succeed and if the system tested them rigorously, then it was a pleasant surprise to me that they were better than I thought they were at leadership, management and controlling their finances and that would be a good, pleasant surprise.*[369]

6.381 As noted in *Chapter 4: The foundation trust authorisation process*, the Trust quoted Mr Kidney as being "very positive and supportive of the application". Mr Kidney made it clear he did not accept these were his words and that if he had been asked to approve their use, he would not have done so.[370]

6.382 Dr Wright did not question the direction of travel towards FT status as this was what all trusts were doing; he perceived that Martin Yeates had been brought in to achieve this end. It did not occur to him that the process carried a risk he should be concerned about, as:

> *I think this actually was wrong in retrospect but you could say that its ability to secure foundation trust status might be emblematic of its ability to have got to grips with its difficulties. Otherwise, how would it have been allowed to have foundation trust status, one might have asked.*[371]

Reaction to the Hospital Standardised Mortality Ratio rating

6.383 Mr Kidney became aware of the Dr Foster report of April 2007 and was very concerned by it. He told the Inquiry that he approached the Trust, the PCT, the SHA, the HCC and the DH to ask what they intended to do to ensure that the Trust was safe.[372] He received the explanation of coding from Martin Yeates. The SHA and the HCC told him they were investigating the matter, and the PCT said it was aware of the Trust's explanations. He told the Inquiry he was in no position to judge the explanation the Trust had given.[373]

6.384 Dr Wright was aware of the Trust's poor ranking in the HSMR results but like others was assured this was because of inaccurate input. However, he believed that the FT application process would be bound to take into account this sort of data.[374]

6.385 Mr Cash had no firm recollection of when he became aware of the mortality rates but in any event felt diffidence in interpreting the results:

369 Kidney T39.94
370 Kidney T39.91
371 Wright T38.90
372 Kidney WS0000002781, para 47
373 Kidney WS0000002782, para 49
374 Wright WS0000003646, para 29; Wright T38.95

... it is difficult to me to judge a story like this at the time it broke. I recall there were disputes over the interpretation and mortality rates and whether these were an accurate indicator, and I couldn't second-guess the mortality figures or their significance. But if it was a matter of concern in the local news, and attention was drawn to it nationally, I would be likely to conclude that something was wrong.[375]

Mr Kidney's work experience visit to Stafford Hospital

6.386 It was Mr Kidney's custom to spend part of the Parliamentary summer recess working alongside workers in his constituency to demonstrate his interest and to learn more about what was happening there. In the summer of 2008, he chose to work in the Trust on five separate days because he was aware the HCC investigation had been proceeding for some time and that staff morale was low.[376] His impression of the staff he met, mainly kitchen staff, porters and cleaners, was that they were very dedicated, hard working, and fiercely loyal to the hospital and its work, with ideas of how it could be better run. It is important to note that he was not allowed by hospital management to work alongside nurses in the wards because he lacked the relevant training.[377]

6.387 Following this experience, Mr Kidney wrote an article for a local newspaper in complimentary terms about the staff he had met. He told the Inquiry that he had not gone to the hospital as an inspector but in effect to meet constituents and understand their concerns.[378]

6.388 Julie Bailey was critical of Mr Kidney's actions, feeling that he was not listening to what she and others were saying. She also felt that an invitation he extended to her to attend a Labour Party open forum on health policy was an insult because he wanted them to discuss broader issues of health when there was appalling treatment being given locally.[379]

6.389 This incident demonstrates the difficult position in which MPs can find themselves in balancing the often conflicting demands of their constituents. It is clear that Mr Kidney was not attempting to mount a defence of the Trust or to assess the merit of the complaints made against it. On the one hand, he had constituents who were justifiably furious at the standard of care at the Trust; on the other, a group of constituents who worked at the hospital under conditions which were increasingly challenging to their morale. Mr Kidney's experience also demonstrates how deep were the feelings of antipathy on the part of those who had suffered at the hands of the Trust towards the institution and all those who worked there.

375 Cash T40.120; Cash WS0000003389, para 17
376 Kidney WS0000002786, paras 69–70
377 Kidney T39.136–137
378 Kidney WS0000002786–787, para 71
379 Bailey T9.177–178

Approaches from constituents

Dr Wright's impressions from complaints

6.390 Although, as noted above, Dr Wright had a poor view of the quality of care derived in part from complaints received, they did not cause him to believe there was a particular issue at the Trust as opposed to a national need to improve standards:

> *I must stress that at this time, my concerns were no more than a general negative impression I had formed, with no hard evidence to back them up. As an MP there is always a steady stream of complaints about local health services, as there is about other services, but although there was no particular volume of complaints about the Hospitals I was concerned about the serious care issues raised in some of them.*
>
> *At no point in these years was there a spike in complaints about the Hospitals; this only happened later when the HCC investigation was announced. Of course, it was impossible at the time to tell whether these complaints were one-off incidents, reflecting a national problem, or an indication that there were systemic failures at the Trust.*[380]

6.391 This may be in part because the role of an MP in relation to complaints is principally to pursue them on an individual basis. When asked what he saw his function to be in this regard, Dr Wright said:

> *I think it's to help the complainant to pursue the complaint and get a proper answer and then, secondly, to tell the organisation that these – these kind of things should not happen again, which is effectively what I did say to them.*[381]

6.392 He described what he did with complaints when he received them:

> *As and when I received complaints from constituents, which as I have said were not large in total number, I would write to the Trust. The letters were responded to and often accompanied by action plans, some of which were very elaborate. I now know that these action plans were not being monitored, or, in some cases, even implemented, however it was impossible to know that at the time.*[382]

6.393 It would have required what he described as a "generalised representation" to cause him to deal with concerns as raising a generic issue.[383] Additionally, he was unaware of the volume of complaints being received by the Trust or of the inadequacy of the system for dealing with them.

380 Wright WS0000003643, paras 14–15
381 Wright T38.12
382 Wright WS00000036456, para 27
383 Wright T38.68

6.394 Dr Wright was at a loss to know how he could have found out the gravity of the problems:

> *Everyone connected in any way with this matter should ask themselves if they could have done more to prevent it. It is certainly something I have asked myself. As the record shows, I did flag up my concerns in relation to individual cases, often in very robust terms, but had no way of knowing the depth or extent of the cultural and staffing problem at the Trust, or that it was not being tackled. I do not see, even in retrospect, how I could have known this, but I obviously wish I had.*[384]

Mr Cash's approach to processing complaints

6.395 Mr Cash told the Inquiry that he encouraged constituents to put complaints in writing to him. When he received a complaint about the Trust, he would forward it to the Secretary of State for Health. In each case seen by the Inquiry, the complaint was accompanied by a short standard form letter, drawing the letter enclosed to the Minister's attention. In none did Mr Cash express a reaction of his own. He would not generally send them direct to the Trust itself. He explained his reason for this:

> *In my experience the effectiveness of the system functions top-down; writing to the Trust I would get a lot of excuses and perhaps a plea of confidentiality rather than answers for my constituent. Whereas if I wrote to the Department of Health, they would pass the letter on to the next tier down, ultimately reaching the Trust which would have no choice but to properly consider the complaint.*[385]

6.396 He believed that this would have the effect of alerting the DH to problems and ensuring that there was knowledge of the matter throughout the system, leading to appropriate action being taken by the Trust when the letter reached it.[386] He assumed that the DH would be aware of any cumulative pattern and be concerned by it. He did not, however, draw any conclusions of his own from the complaints he received:

> *Q. Can you give us any idea leading up to, say, 2006 of how many complaints about Stafford Hospital you had been receiving?*
>
> *A. Not really, because as you can appreciate – I mean, this is stuff which just comes in, important as they are, on an individual basis, but they come in week by week or by month or by whatever. You're not actually accumulating a body of aggregated information in the absence of the – an extreme increase in complaints. So as far as I was concerned, they were coming in and they were being passed on and action was being taken by the Department in passing them down to the respective hospital or hospitals.*[387]

384 Wright WS0000003650–651, para 53,
385 Cash WS0000003387–388, para 11
386 Cash T40.98–99
387 Cash T40.85–86

6.397 Generally, Mr Cash would hear no more about the matter other than an acknowledgement from the Secretary of State.[388]

6.398 Mr Cash's letters ought to have been dealt with under the framework of the Prime Ministerial/ Cabinet Office guidelines published in July 2005.[389] Pertinently, the guidelines provided (inter alia) that:

- Correspondence from MPs and members of the public should be given the highest priority;
- Individual department targets for routine correspondence with MPs should be a maximum of 20 working days, and on occasions where this was not possible MPs should be kept informed of progress;
- MPs should receive considered and prompt responses, and every effort should be made to provide MPs with a substantive reply in good time;
- All correspondence to Ministers from MPs should be signed off at an appropriate ministerial level.

6.399 It is apparent that these guidelines were not effective during the period under scrutiny. Despite the fact that this should have been apparent to Mr Cash, it appears that he continued applying the same procedure. According to Ms Una O'Brien (the DH's Permanent Secretary), the system now in place for addressing MPs' letters when they are received is more effective than it was.[390]

6.400 Analysis of complaints dealt with by Mr Cash suggested that he received infrequently, if ever, a substantive answer to the complaint. He told the Inquiry that he would have assumed in such cases that his constituent had received an answer which satisfied them:

> *I think from experience when a complaint is made, more often than not the constituent will come back to you if they are – find that they're not getting what they wanted. So if the complaint had been passed through the system and there was no further follow-up, then it might reasonably be thought that in fact the matter was being dealt with, was being looked into, and if they came back to me, as I think happens on a number – has happened on a number of occasions, some ... turn into, what I would call individual campaign issues relating to a specific constituent who has not been getting the response that they expected.*[391]

388 Cash T40.103
389 http://webarchive.nationalarchives.gov.uk/+/www.cabinetoffice.gov.uk/media/cabinetoffice/propriety_and_ethics/assets/handlingcorrespondencefrommps%20guidance.pdf
390 T125.119–120. For DH perspective on this issue,
391 Cash T40.103–104

Julie Bailey's complaint to David Kidney

6.401 Julie Bailey wrote to Mr Kidney in December 2007 in detail about the appalling treatment of her mother and the response she had received from the Trust. Mr Kidney replied on 3 January 2008 offering his condolences. He informed her he had written to the Chief Executive and implicitly advised her to contact PALS and the PPIF. He told her of his involvement with the hospital and offered to discuss matters with her.[392]

6.402 Mr Kidney agreed to the suggestion that the tone of the letter should have been different.[393] It certainly conveyed none of the sense of shock that might have been expected on receipt of such a dreadful history of deficient care, not only of Julie Bailey's mother but also other patients. Julie Bailey was horrified at his response, prompting her to write to the Secretary of State for Health at the time, the Rt Hon Alan Johnson MP, and the *Staffordshire Newsletter*. She felt that Mr Kidney's reply effectively denied the low standard of care evidenced by her and other constituents's experiences at the hospital.[394]

6.403 In fact, the letter did cause Mr Kidney more concern than he had indicated in his reply to Julie Bailey. He told the Inquiry that:

> *I thought this was the kind of letter that meant I would need to leap into action.*[395]

6.404 He agreed that the letter suggested that there was something seriously wrong on at least one ward.[396]

6.405 The action he took was to write on the same day to Martin Yeates asking him to continue to deal with Julie Bailey's complaint. He added:

> [I] *feel that recently I have received several complaints from constituents along similar lines as regards low staffing levels and inadequate attention to the quality of care for patients. Have you noticed a similar trend? Does it worry you? Are there actions in place to break out of this particular cycle of complaints?*[397]

Cure the NHS attendance at Mr Kidney's constituency surgery

6.406 Julie Bailey and some 30 Cure the NHS (CURE) members visited Mr Kidney's advice surgery in February 2008 and told him their individual stories of substandard care.

392 JB/10 CURE0064000102
393 Kidney T39.126
394 CURE0023000331, Letter from Julie Bailey to Alan Johnson, 5 January 2008
395 Kidney T39.125
396 Kidney T39.126
397 ESI00226088, Letter from Mr Kidney MP to Martin Yeates, 3 January 2008

6.407 He took from the meeting a suggestion apparently made by a CURE member of "peer monitoring", by which he meant opportunities for CURE to visit the hospital and talk to staff and patients, possibly tied to membership of the FT.[398] He approached the hospital management to get this arranged, but it emerged that Julie Bailey and her group were unwilling to participate.[399]

CURE approach to Mr Lefroy

6.408 Mr Lefroy was contacted by Julie Bailey in early 2008 and through CURE became aware of the serious concerns about the standard of care at the Trust. He kept in contact with them throughout 2008 through Julie Bailey and Castell Davis. He wrote to Martin Yeates at the Trust to raise issues and offered CURE the use of the party association hall, which was not taken up.[400] He remained concerned by how these issues were handled:

> *I would say this irrespective of the party in office at the time. Where there are serious concerns being raised, there is a need to keep on top of the situation; to monitor, investigate and even take informal soundings on the position. To me, it felt, as a citizen, that there was a dereliction of duty somewhere in the Department of Health.*[401]

Julie Bailey's approach to Mr Cash

6.409 Julie Bailey and Debra Hazeldine visited Mr Cash at his surgery around December 2008 as they felt they and CURE were not getting anywhere with their complaints. He offered them advice about running a campaign and assisted in preparing a briefing for the HCC and the then Secretary of State for Health.[402] As a result, he wrote to Anna Walker, the Chief Executive of the HCC, on 13 January 2009. The letter enclosed a list of questions which were those which CURE wanted answered at the time. Mr Cash's short covering letter stated that:

> *I have been gravely concerned about matters at Stafford District Hospital for some time.*[403]

6.410 It is not clear what would have been the basis of that concern, apart from his involvement in a previous public inquiry in the 1980s about an outbreak of legionnaires disease at the hospital. There is, in any event, no evidence that he took any action in respect of any concern, except the forwarding of complaints to the DH, until this letter. He told people who complained to him to put their accounts in writing to which he would attach his own pro forma letter. This was the same format each time.[404] He "could not recall the individual cases" when looking back at the knowledge he had of the Trust's issues at the time.[405]

398 Kidney T39.129–130
399 Kidney WS0000002784, para 62
400 Lefroy WS0000002610, paras 10–20
401 Lefroy WS0000002610, para 37
402 Cash WS0000003390, para 20
403 WC/3 WS0000003485
404 Cash T40.88–89
405 Cash WS0000003391–392, paras 10–11

Reaction to the Healthcare Commission report

6.411 Before the HCC report was published, Dr Wright was told by Martin Yeates that he was confident that any issues raised by the report would be explicable and that his own position would be unaffected as he was remedying the problems. Dr Wright told Mr Yeates that if this was the case and he was seen to be addressing issues vigorously, he, Dr Wright, would support him, but if that was not the case, he would not.[406]

6.412 When he saw the report, Dr Wright said his reaction was that:

> *... it was a shocking and shaming report, but not a surprising one in the sense that it confirmed the quality of care issues I had raised with the Trust and that these were indeed systemic.*[407]

6.413 Among other actions taken, he wrote to Dr William Moyes, the Executive Chairman of Monitor, to seek an explanation of how the Trust could have been approved as an FT. He told the Inquiry he now realised that the regulators had not "got under the skin" of the Trust as he assumed had been the case.[408]

6.414 Dr Wright was not in favour of a public inquiry and had abstained in the vote on the issue in the House of Commons.[409]

6.415 Mr Cash thought that the report was "damning" and resulted in him losing faith in Monitor. He thought the report had failed to consider the failings in relation to the self-assessment system which he felt was "futile" and a significant contributory factor. He was among those who campaigned successfully for a public inquiry on behalf of his constituents.[410]

6.416 Mr Kidney was first shown the HCC report by Alan Johnson, then Secretary of State for Health. His reaction was one of shock:

> *The HCC's report was a tremendous shock for us all locally. We were bewildered, furious and in no mood for anything other than the quickest and strongest action to repair the terrible damage that had been done. Patients who trusted the NHS were tragically failed and let down. The Hospital's leadership, management and governance were shown up as inadequate.*[411]

406 Wright WS0000003646, para 31
407 Wright WS0000003646, para 33
408 Wright WS0000003647, para 38
409 Wright T.38.79
410 Cash WS0000003391–392, paras 24–25
411 Kidney WS0000002790, para 84

The most important consideration should be the patients and the effects that these broken systems had on them, their families and their carers. We all have an expectation that we may safely go to a hospital when we are injured or sick to receive good quality care and treatment, perhaps a cure, our health restored and even, in some cases, our lives saved. Instead, for some patients, their families and carers during the period under Investigation, there were delays, avoidable pain and suffering and what the report calls "poor outcomes" which in some tragic cases meant death. This is shocking and heart-breaking.[412]

6.417 His overall summary of the appalling situation revealed in the report was:

Stafford Hospital is our Hospital, the hospital that my family and I, like hundreds of thousands of other residents of Stafford constituency and surrounding constituencies in Staffordshire, go to for care and treatment. We were horrified by the HCC's report and confused that so many NHS organisations were involved but none of them had made a difference for the better. We were angry that assurances given to us, given to me, by our health professionals over the past few years were completely misleading, and heart-broken for those who suffered when they should have been comforted and for those who died when they should have lived.[413]

6.418 He felt that the HCC should have been more critical of its own failure to detect the problems at the Trust sooner.

6.419 After its publication, he took a number of steps:

- He approached Dr Moyes of Monitor to ask him to explain how Monitor came to authorise the Trust as an FT. Dr Moyes complained to him that the HCC had failed to tell him it was about to launch an investigation. Mr Kidney's reaction was to point out that Monitor had failed to uncover the Trust's failings in a year long investigation.[414]
- Mr Kidney raised the issue of communication failures with Ministers and obtained the impression that Government had not appreciated that there was a gap in this respect;
- He called for a public inquiry.[415]
- He was critical of the appointment of an Interim Chair and Chief Executive and sought to persuade Ministers that full-time appointments were essential.[416]
- He secured a debate in the House of Commons on the Trust and its issues.[417]

412 Kidney WS0000002791, para 88,
413 Kidney WS0000002797, para 119
414 Kidney T39.143
415 Kidney T39.168
416 Kidney WS0000002792, para 94
417 Kidney T39.196; Kidney WS0000002795, para 105

6.420 Following his success at the general election, Mr Lefroy saw his duty as being to demand a public inquiry and to support the hospital. He recognised the conflict inherent in what he felt he had to do:

> *Morale is low at the Hospital and I have tried to give encouragement where I can. I know that Julie Bailey has a slightly different perspective on where we are and I respect that; but there is a real need to restore public confidence in the Hospital. I am aware that the Hospital has already taken steps to improve the standard of care but it still has a long way to go as the leadership recognises.*[418]

Conclusions

6.421 As commented above, MPs have to represent as best they can the diverse and often conflicting demands of their constituents while pursuing multiple matters of policy. They are emphatically not regulators and are not usually experts in healthcare matters. As such, they are, in general, more likely to respond to crises and causes for concern brought to their attention, rather than to go looking for issues. How they respond to concerns of which they are made aware of will vary according to the judgement, priorities and interests of individual members. How they do so will in part inform the electorate's verdict on their candidacy at the following election.

6.422 Accordingly, the local MPs could not have been expected to become aware of the gravity of the situation at the Trust when those with actual responsibility had not appreciated the true position and when they had not been alerted by their constituents.

6.423 The source from which an MP was most likely to have become aware of concerns about the quality of care at the Trust was through the complaints they received. MPs can have a considerable effect by endorsing complainants and ensuring they are kept informed about any response and remedial action.

6.424 However, as the evidence to this Inquiry shows, if complaints are dealt with on an individual basis and are not looked at collectively, patterns will not be revealed, such as the repetition of previous deficiencies. Such complaints as were received were forwarded to recipients believed to have responsibility for responding.

6.425 While the usual channel adopted by MPs in the area was to forward letters to the Trust Chief Executive, Mr Cash adopted the procedure of sending them with a pro forma covering letter to the Secretary of State for Health, but no copy to the Chief Executive. This meant that Mr Cash did not receive any information subsequent to the complaint unless the complainant returned to report this to him. The other MPs will have received a copy of the Trust's response to

418 Lefroy WS0000002606, para 24

individual complaints but will not have taken any further action unless requested to do so by the complainant. None of them either put together the complaints received to detect any emerging pattern, or considered whether some individual complaints in themselves indicated systemic issues.

6.426 MPs will very properly have an individual approach to the manner in which they offer support to constituents, and it would be quite wrong to suggest prescriptive requirements as to how they should go about their work. However, they might wish to consider, based on the Stafford experience, whether they would be helped in alerting themselves to systemic concerns by adopting some simple system for identifying trends in the complaints and information they received from constituents. They could also pause to consider whether individual complaints implied concerns of wider significance than the impact on one individual patient.

Local news reports

Prevalence of reports about the Trust

6.427 It would be reasonable to anticipate that local news media would be a fruitful source of information, indicating concerns about the provision of healthcare in an area. The Inquiry asked Shaun Lintern, at the relevant time a reporter for the *Express & Star* newspaper, to research his newspaper's files for stories about the Trust in order to establish what could have been found out from this source.

6.428 The PCT produced an analysis of the number of articles published each year from the information produced by Mr Lintern as summarised in the following tables.[419]

Table 6.2: Mid Staffordshire NHS Foundation Trust and four comparable sized hospitals newspaper's analysis

Trusts of a similar size to the Trust. Number of articles extrapolated from six months' analysis for the year 2011.

Comparable sized hospitals	Full year (FY)	Per month average (PM)
George Eliot Hospital NHS Trust	172	**14**
Walsall Hospitals NHS Trust	108	**8**
South Warwickshire General Hospitals NHS Foundation Trust	148	**12**
Hereford Hospitals NHS Trust	86	**9**

419 CL0000001506, Closing submission from the PCT, appendix 4

Table 6.3: Number of articles per month, by year, supplied by Mr Lintern's exhibits to his witness statement from 2005 to 2009

Mid Staffordshire NHS Foundation Trust									
2005		2006		2007		2008		2009	
FY	PM	FY	PM	FY	PM	FY	PM	FY	PM
100	**8**	81	**7**	72	**6**	175	**14**	520	**43**

6.429 Mr Lintern made the point that the number of reports published does not indicate the totality of concerns that are communicated to a newspaper because of the risks of reporting serious allegations:

> *... there were many cases of poor care at the Trust that were brought to our attention but which we could not report simply because we did not have the facts to support the allegations. The Express and Star would not report a story unless there was some foundation to it ... In order to report such a story, we would need some basis of evidence, either a formal statement or a comment from the Trust.*[420]

6.430 Therefore, in part the large increase in stories following the HCC report was due to the fact that there was now a factual basis on which to base stories and a claim to public interest that had been absent before.

6.431 It can be seen that there was a significant increase in the number of reports in 2008 and an even larger rise in 2009. This increase is probably attributable to the announcement of the HCC investigation in 2008 and then the crisis resulting from the publication of the HCC report in 2009. Mr Lintern told the Inquiry that one reason for the increase was the newspaper's contact with CURE.[421]

6.432 Three complaints that were reported in 2007, however, were those of Julie Bailey, Barbara Townsend and June Locke. The inquest into the death of Jane Locke caused by infection, e-coli and MRSA was reported on 10 August.[422] There was a follow-up article, published in October, which included an interview with her sister Julie Langford who told the paper that:

> *They are trying to hide the truth of the numbers of these cases.*[423]

6.433 On 23 October 2007, an article was published concerning the death of Barbara Townsend from *C. difficile* having been admitted to hospital with a broken ankle. Her husband reported that

420 Lintern WS0000072817, para 10
421 Lintern WS0000072819, para 15
422 SL/3 WS0000073057
423 SL/3 WS0000073069

she had been treated with "complete indifference".[424] In December 2007, articles were published reporting Julie Bailey's experiences with the Trust and the creation of CURE.[425]

6.434 Not all the reports included in those produced by Mr Lintern related to quality of care. For example, some concerned the Trust's financial problems and the proposals for staff cuts. Others involved inquests into deaths where the standard of care may not have been an issue.

6.435 Healthcare organisations which commented on the significance of press reports generally suggested that there was nothing to set the coverage of the Trust apart from that of any other provider trust. As West Midlands Strategic Health Authority (WMSHA) put it, hospitals are frequently the subject of local comment.[426] SSPCT submitted that the reports would not necessarily have been different in tone to those on other trusts.[427]

Use of information from news media

6.436 The evidence of HCC witnesses varied about the extent to which the HCC made much of news media as a source of information. Shelagh Hawkins told the Inquiry that there was no method available to do so. Numbers of reports were unlikely to be helpful as a busy trust might well have more reports than a smaller one. Further, it was often difficult to verify press reports. She said that local officers were instructed not to fill out engagement forms based on press reports.[428] However, Marcia Fry of the HCC did not accept that the use of such reports was discouraged, and Nigel Ellis of the HCC saw value in reports, although he would have wanted to know the sources of the report.

6.437 Martin Bardsley of the HCC added that the submission of an engagement form based on a newspaper report was not encouraged, because:

> *... what we needed in engagement forms was not necessarily the press report itself, but the thing that triggered the press report in the first place. So we would be looking for engagement forms to be based on – on that piece of evidence that had led to that particular story ... a lot of the time it would be fairly obvious the source of these stories.*[429]

6.438 On the basis of this evidence it seems unlikely that much use was made of news media reports, in part because it would have been believed that the information would be known through other, more reliable sources.

424 SL/3 WS0000073067
425 SL/3 WS0000073086–7
426 CL00000000081, *WMSHA closing submissions*, Chapter C – The quality of care at Mid Staffs, para 23(v)
427 CL00000001441, *SSPCT closing submissions*, *Chapter 12 – The PCT's relationship with patients and the public*
428 Hawkins T78.95–96
429 Bardsley T82.129

Conclusions on the use of information from news media

6.439 It does not appear that the regulator, at least, attached great significance to media reports. There would be a number of considerations to bear in mind when having regard to such a source of information:

- A report may not be a reliable or complete account of a matter.
- The frequency of reporting may not be a reliable guide to the presence of a genuine concern.
- Positive reports may be easier for a newspaper to come by as they will be promoted by the organisation.
- Comparison between trusts may be impracticable.

6.440 Nonetheless, scrutiny of reports about a healthcare organisation may reveal concerns that are not otherwise known of, or if known, have a significance which has not been understood. Reports may also disclose a depth of public concern which has not been detected by other means. They may disclose a need either for investigation of an issue or for reassurance of the public in relation to a matter for which there is a ready explanation. As officials of the HCC made clear, it would be unwise to rely exclusively on a media report for the facts, but a report is likely to point the way to sources of information able to supply appropriate details. Therefore, it would be reasonable to expect those charged with oversight and regulatory roles in healthcare to monitor media reports about the organisations for which they have responsibility.

Conclusions

Patients and carers as partners in care

6.441 It is a significant part of the Stafford story that patients and relatives felt excluded from effective participation in the patients' care.

6.442 Much lip service is paid to the concept of a partnership with the patient in planning and providing care. The concept of involvement of patients in the healthcare system must start at the front line where treatment is provided. Such a partnership is achieved not only by involving individual patients in decisions about the care and treatment to be provided but also in a continuing dialogue about their needs, expectations and conditions. All too often in a busy, pressurised ward these are ignored to the detriment of the patient's well-being. In addition to patients, their families, close friends and visitors are often experts in the patients' needs, and able and willing to assist both the patient and the healthcare provider in many different ways. These can include:

- Speaking on behalf of patients unable to speak for themselves;

- Acting as advocates for any patient by drawing problems and concerns to the staff's attention;
- Acting as intermediaries by assisting in conveying explanations and information to both patients and staff;
- Assisting where wanting to do so, in the provision of care;
- Providing reassurance to patients.

6.443 As is argued in *Delivering Dignity*:

> *There is an imbalance of power in the relationship between a person receiving care and the staff delivering it. Those staff who provide dignified care constantly seek to redress this imbalance by involving the individual in decisions wherever possible, explaining what is happening and why, listening to and addressing concerns, and above all treating each person as someone deserving respect, understanding, empathy and kindness. In short, they recognise care as a partnership instead of treating older people as passive recipients.*[430]

6.444 On admission to hospital, patients with family and other social connections do not abandon them when they walk through the door. There is absolutely no reason why, if they wish to do so, patients should not be enabled to continue to avail themselves of the benefits of such connections, or why family members should not be encouraged to play one or more of the roles described. This can and should all be done in a manner consistent with patients' rights to make decisions for themselves and to control the degree of confidentiality they wish to preserve over medical information. Where, as is sadly so often the case with elderly, confused and vulnerable patients, they have no family or other close social connections available and willing to undertake this protective advocacy role, it is important that it is provided in another way, if desired by the patient.

6.445 Their position in this partnership means that patients, those who care for them, and, as potential patients and carers, the wider public have a singular and vital contribution to make in the maintenance of the standards of care, in monitoring outcomes and experience, and in informing decisions about allocation of resources and improvements in quality, among other things. As the challenges of involving patients and the public in the healthcare issues of Stafford show, it is not easy to identify and implement effective methods to enable this to happen.

6.446 Patient and public involvement in health service provision starts and should be at its most effective at the front line.

430 *Delivering Dignity*, Draft report of Commission on Dignity in Care for Older People, February 2012, page 11

Patients and carers's involvement at the front line of care

6.447 Patients and those who visit and care for them are an invaluable resource of information about the standards of care actually being delivered and as supporters in the delivery of such care. Any service which ignores this is failing to exploit a valuable asset for the benefit of their patients. They are informed eyes and ears whose knowledge and opinions matter. They are likely to be the first to detect that something is of concern in the care being delivered not only to their relative or loved one but also to others in the ward. They are likely to be a necessary part of any discharge arrangements. It should be the responsibility of all staff who come into contact with patients and those with them to listen to what they have to say and ensure that appropriate action is taken on it. Such action ought to include drawing matters to the attention of an appropriate nurse and ensuring that a record has been made of what has been communicated. Where a concern is raised it should be recorded and addressed as such, even if no formal complaint has been lodged or intended. Where what is passed on amounts to a suggestion of an adverse incident, it should be treated as such in accordance with the relevant policy.

6.448 Further, where relatives and others want to provide help, and the patient is willing to receive it from them, such assistance should be welcomed. Therefore, providers need to review unnecessary restrictions on visiting hours and ensure that a constructive exchange of information is possible with families and others close to the patient. Hospital wards should, subject to health protection requirements, be as open to visitors as would be a patient's home.

6.449 The need for this sort of approach has been recognised in *Delivering Dignity,* which has recommended:

> *Hospitals should see older people's families, friends and carers as partners in care rather than as a nuisance or interference. Hospitals should encourage family, friends and carers to come in and augment care if the older person wishes it, while retaining responsibility for ensuring care is delivered.*
>
> *Hospital boards must understand how people experience care in their hospital, and view dignity as a key measure of performance. All boards and management teams must have robust processes in place to collate feedback and complaints from older people, their families and staff so they can identify emerging trends and respond to them.*
>
> *Feedback from patients and their families should be discussed and responded to on the ward every day. Hospitals should give staff the time to reflect on the care they provide and how they could improve; this is an essential part of giving good care.*[431]

431 *Delivering Dignity*, Draft report of Commission on Dignity in Care for Older People, February 2012, page 5

Patient and carer feedback

6.450 Some recognition of the value of patient and carer observations are given in attempts to involve them in patient surveys and real time feedback.

6.451 In *Chapter 2: The Trust*, analysis of the patient surveys of the Trust conducted by the HCC and the Picker Institute shows that they contained disturbing indicators that all was not well from long before the intervention of the HCC. Yet, it appears that the reaction was to look at the results as numbers to be improved if possible, rather than to examine the underlying causes for the Trust's poor performance. It is possible undue comfort was taken from improvements in numbers which signified that an unacceptable number of patients were not being treated acceptably. An approach to this sort of survey which accepts average as acceptable or takes comfort from a majority of positive responses when the proportion of negative ones indicates a significant number of substandard episodes of treatment is likely to leave large numbers of patients being cared for badly.

Community health councils

6.452 Those who have spoken of these at the Inquiry have almost invariably praised their effectiveness compared with the structures which succeeded them. Whatever the force of Sir Ian's condemnation of the lack of real democratic authority, cited earlier in this chapter, it is an oversimplification to suggest that CHCs and PPIFs were comparable:

- Unlike PPIFs, CHCs had features which enabled the best led to be effective advocates of patient and public views in ways unachievable by PPFIs and LINks;
- They had a recognisable identity, were independent of the rest of the local health system and were accessible to the public;
- They could derive at least a degree of authority from a membership including democratically elected councillors, representatives of patient groups and healthcare professionals;
- The combination of powers, such as entry and inspection, and making reports to health bodies, ensured a hearing for their views;
- They had an infrastructure which enabled them to make informed judgements and interventions;
- They had a role to play with regard to patient complaints.

6.453 CHCs also had disadvantages:

- They were probably resource hungry;
- They were as effective as their leadership, which was of an inconsistent standard throughout the country;

- They may have had a tendency to overuse their powers, resulting in protracted consultation processes.

General developments after the demise of community health councils

6.454 Whatever the faults of CHCs, it is now quite clear that what replaced them, at two attempts in 10 years, did not produce an improved voice for patients and the public but achieved the opposite. The functions that CHCs joined together under one roof were dispersed among a number of disparate organisations which failed to replicate the potential that CHCs possessed, even if they did not always succeed in exploiting it. The relatively representative and professional nature of CHCs was replaced by a system of small, virtually self-selected groups which were free to represent their own views without having to harvest and communicate the views of others. Neither of the systems which followed were likely to develop the means, or the authority, to provide an effective channel of communication through which the healthcare system could benefit from the enormous resource of patient and public experience waiting there to be exploited.

6.455 Councillor Muir, drawing on his contacts over the years with CHCs, PPIF and LINks, said that while he felt that CHCs had "done a decent job":

> *Public and patient involvement groups tended to sound better in theory than they functioned in practice.*[432]

Public and Patient Involvement Forums

6.456 PPIFs relied on a variably effective, locally provided infrastructure. The system, as envisaged under the enabling legislation, gave rise to an inherent conflict between the host, which was intended to provide a support service but in practice was required to lead with proposals and initiatives offered to lay members, and members of the forum, who were likely to have no prior relevant experience and to be qualified only by reason of previous contact with the hospital to be scrutinised. Understandably, many will have volunteered for the role because of a feeling of debt owed to a hospital for effective care given to themselves or a loved one. Others might have been motivated by bad experiences at the hospital. Neither group was likely to be objective in its views or to be willing to agree with those having different experiences.

6.457 In the case of the Trust's PPIF, the evidence shows quite clearly the failure of this form of patient and public involvement to achieve anything but mutual acrimony between members and between members and the host. A preoccupation with constitutional and procedural matters prevented much progress. The forum's one achievement was a series of hygiene inspections which did at least result in some reaction from the Trust and the scrutiny

432 Muir WS0000034499, para 98

committees. However, differing perceptions of what was observed and a diffidence toward the Trust muffled any real consideration being given to what its findings signified about the general running of the hospital. As indicated above, this is not the fault of any of the conscientious volunteers who gave up their time to help others, or the host staff who were expected to create a working organisation with little background structure or guidance from which to work.

Local Involvement Networks

6.458 If anything, LINks were an even greater failure. The, albeit unrealised, potential for consistency represented by the CPPIH was removed, leaving each local authority to devise its own working arrangements. Not surprisingly in Stafford, the squabbling that had been such a feature of the previous system continued, and no constructive work was achieved at all. Thus the public of Stafford were left with no effective voice – other than CURE – throughout the worst crisis any district hospital in the NHS can ever have known.

Local authority scrutiny committees

6.459 The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be:

- The combination of responsibility for scrutiny of performance and for representation of the public view on strategic health issues is a demanding one for lay councillors with limited or no expert support;
- Councillors are by the nature of their position more likely to respond to concerns raised with them by constituents than to feel able to make proactive inquiries;
- As politicians dependent on local votes, councillors will be subject to a conflict between the duty to offer criticism and challenge and the need to be seen to support important local institutions. It is a conflict which will reinforce the tendency to receive and accept assurances from organisations such committees are meant to scrutinise;
- The distribution of powers necessary for scrutiny is at best confusing and at worst an inhibition on effective performance of these duties.

Local Healthwatch

6.460 The DH provided the Inquiry with a briefing paper on Healthwatch in October 2011.[433] It has not been informed of any developments since. Under the new reforms, Local Healthwatch is intended to be the "local consumer voice" with a "key role" in influencing local commissioning

433 DH00000004590

decisions through representation on the local health and well-being board. They will be expected to "build on existing LINKs functions" including monitoring scrutiny and providing information about patients' experiences in reports to commissioners and providers. It will be able to support individual choice by the provision of information and by "providing or signposting to NHS complaints advocacy services". The DH says this distinguishes the new from the old system because:

- Local Healthwatch will be participating directly in the commissioning decision-making process as opposed to merely presenting views;
- It will be able to support individuals as well as provide a voice for the community;
- It will have a national as well as a local voice by its association with Healthwatch England.

6.461 The responsibility for establishing Local Healthwatch will rest with the local authorities in the same way as they had for LINks.

6.462 The DH attaches importance to Local Healthwatch being independent and is working on means to ensure this.

6.463 The briefing paper ended with a helpful list of organisational behaviours the DH would expect Local Healthwatch to display:

- Presenting views, shaping and monitoring health and care services
  - Provide the strong, independent, local, consumer voice on views and experiences to help bring about better health and social care outcomes;
  - Monitor local health and care services and make recommendations to commissioners and providers about things that could or should be improved;
  - Be authoritative, credible and influential with commissioners and providers of services, to help shape those services and help them to improve;
  - Contribute its information about local health, care and public health services to the Joint Strategic Needs Assessment process and the health and well-being strategy.
- Supporting Individuals
  - Be highly visible and accountable in the local community, and be known about, understood and trusted by local people as a source of information and support;
  - Signpost people or help them to access information, thus helping them exercise choice;
  - Empower and facilitate people to speak out, including through NHS complaints advocacy services.
- Organisational behaviour
  - Operate in a way that encourages and facilitates participation from all who want to be involved, including acting in a transparent way;
  - Actively engage and involve people who need help to be able to contribute, underpinned by principles of equality and diversity;

- Have a good understanding of local voluntary and community groups, other patient and public groups, such as patient participation groups and foundation trust membership, and how they complement each other. This will enable Local Healthwatch groups to work through and with local organisations to understand and present the views of local people and effectively signpost people to information and advice;
- Have excellent relationships with commissioners and providers, acting as a critical friend, informed about the experiences, needs and aspirations of local communities;
- Have the capacity to use health, social care and public health information and to help others to do so;
- Have an in-depth understanding of the issues facing the local community, and apply this as a member of the local health and well-being board;
- Be a well-led and well-managed organisation, including being open to scrutiny (for example, through self-assessment and peer review), seeking continuous improvement;
- Have a high level of knowledge and expertise in health and social care policy and implementation, including keeping up to date with developments, for example, in personalisation.

6.464 The DH does not intend to ring-fence the grant given to local authorities for the purpose of establishing Local Healthwatch. Mr Alexander expressed fears that this would result in the fund being diverted to other purposes in times of need.[434] As was the position with LINks, the DH does not intend to prescribe an operational model, leaving this to local discretion. Mr Alexander objects to this on the grounds that it is likely to replicate the weaknesses experienced with LINks.[435]

6.465 The experience of LINks in Stafford provided, sadly, a test of what is required to enable patient and public views to receive proper consideration at the time when there is the greatest need, namely, when there are serious concerns about the standard of available healthcare. The failure of Stafford LINks to provide such a channel may well have exacerbated the suffering of those who had cause for complaint and the divisions in the community that have been all too apparent during the course of this Inquiry.

6.466 Local opinion is not most effectively collected, analysed and deployed by untrained members of the public without professional resources available to them, but the means used should always be informed by the needs of the public and patients. Most areas will have many health interest groups with a wealth of experience and expertise available to them, and it is necessary that any body seeking to collect and deploy local opinion should avail itself of, but not be led by, what groups offer. Additionally, however, the complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.

434 Alexander WS0000077920, paras 29–30; WS0000077920–921, paras 31–35
435 Alexander WS(2).38

6.467 It does not prejudice local involvement in the development and maintenance of the local healthcare system for there to be consistency throughout the country in the basic structure of the organisation designed to promote and provide the channel for local involvement. Without such a framework there is a danger of repetition of the arguments which so debilitated Staffordshire LINks.

6.468 While the CPPIH was not entirely effective in supporting PPIFs, the absence of any central support mechanism was a serious weakness for LINks. Local Healthwatch should have the benefit of a central resource of guidance and support. This could most conveniently be provided by Healthwatch England.

6.469 If Local Healthwatch is subjected to the vagaries of the health of local authority finances, its independence will be prejudiced. Whether justified or not, the fear that views inconsistent with a stance taken by the local authority could result in a reduction of funding will have a chilling effect on its approach to its functions. Local authorities should be required to pass over the centrally provided funds allocated for this purpose to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening if it has become incapable of performing its function. It is only in this way that a repetition of the failure of Staffordshire LINks can be avoided.

6.470 The resources supplied to Local Healthwatch must be sufficient to reflect what is needed for its duties. These include proper provision for:

- Initial set-up costs;
- Publicity;
- Induction and training;
- Collection of local opinion, collective and individual;
- Expert advice on technical and clinical issues;
- Costs of membership and other forms of involvement.

Lessons for the future

6.471 Patients and those who love and care for them are likely to be the first to raise the alarm about the quality of care at a hospital or other provider if only they are listened to and the significance of what they are saying is properly appreciated. There is no one way in which this can be achieved, and, indeed, it is likely that there should be many ways in which the patient voice can be heard effectively. Experience in this, as in so many other areas, is that reorganisation by abolishing one body to create another can be distracting and disguise a weakening of public protection behind unwise claims of improvement. Therefore, it is

important that the new structure of Healthwatch England and Local Healthwatch is used to make patient experience and views easier to obtain and use.

6.472 It is suggested that the following principles and approaches should be adopted:

- It is important that patients', relatives' and carers' voices are heard, and that they are consulted and listened to while recognising that they are perhaps not necessarily best equipped to run the organisations charged with that task, or at least to do so unaided in terms of leadership. They can be involved in the organisation and in the task and thereby make a valuable contribution. They may not be best equipped to identify the lessons to be learned or the methods of obtaining relevant views. In other words, public involvement organisations need professional leadership and support to be effective. As in every other aspect of the provision of healthcare there needs to be a partnership between patients and healthcare professionals. Effective membership of such an organisation cannot be achieved by direct elections, but some form of representative authority is of value. Therefore, it would be appropriate to have a membership which includes local government elected representatives, representatives of local patient interest groups, healthcare professionals not directly employed by providers in the locality, and some members of the public selected by the group as a whole.
- The experiences and opinions of individual members of the public are very important and will often indicate important lessons to be learned, but such an individual is not necessarily representative of a wider group. That does not mean that their voice should be ignored or that what they have to say is not acted upon. Indeed, information from one such source may be sufficient to justify drawing adverse conclusions about a provider's system and leadership. However, decisions about strategic issues, such as the allocation of resources between primary and secondary care or different forms of treatment, are more likely to require collective and representative input rather than an individual contribution.
- Patients and the public need to be involved in decisions taken in all healthcare organisations, whether providers, commissioners, oversight bodies or regulators. How they are involved and what their role is may depend on the role of the body in question, and this aspect will be considered elsewhere in this report.
- If a more universal acceptance of the priority of patient needs is achieved in this way the function of a separate forum or scrutiny body can be clear. It is:
  - To provide a channel for the experiences of patients and lessons to be learnt from those experiences to be received by the local healthcare system, their managers and regulators;
  - To provide a means of coordinating the activities of individuals and patient interest groups in supporting, scrutinising and contributing to the improvement of the healthcare system locally;
  - To be the vehicle for obtaining collective opinions about proposals for change.

- Such a body needs to have authority and a means of exerting it. This requires independence and a clear right to have its findings taken into account by the healthcare system. This can best be achieved by:
  - Accountability to a national independent body or the healthcare regulator;
  - A separate constitutional structure ensuring its independence of judgement and action;
  - Ring-fenced financial resources to ensure parity of the patient and public involvement throughout the country, the stewardship of which is accountable to the local authority (if that is the route through which the funding is channelled);
  - Powers to require information from all parts of the system, including access to complaints information;
  - Powers enabling it to verify what it is told by patients and the public which may include questioning of relevant officials, and inspections of premises;
  - An entitlement to report to the regulator and have its findings and recommendations examined by the regulator, in particular where direct communication with providers or commissioners has failed to have that effect.
- Being a body for involving the public, its business must be conducted with transparency; its meetings should be open to the public, who should be entitled to contribute and also have access to the organisation's working documents.

Summary of recommendations

Recommendation 43

Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

Recommendation 145

There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in *Chapter 6: Patient and public local involvement and scrutiny*.

Recommendation 146

Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.

Recommendation 147

Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

Recommendation 148

The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.

Recommendation 149

Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

Recommendation 150

Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.

Recommendation 151

MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.

Chapter 7
Commissioning and the primary care trusts

Key themes

- The evolution of commissioning was characterised by an aspiration to improve the quality of service without immediate provision of the tools with which to deliver this. The result was that primary care trusts (PCTs) did not develop means of effectively monitoring quality performance. The rhetoric was not necessarily reflected on the ground.
- PCTs were also hampered in their role by the reorganisation to which they were subjected.
- Local general practitioners did not raise with the commissioners concerns of which they were aware until specifically asked, following the announcement of the Healthcare Commission (HCC) investigation. They need to recognise their continuing obligations to their patients after referral to hospital.
- The PCT approach to quality monitoring was passive rather than proactive, and it did not have the expertise or resource to respond independently to the concerning mortality results.
- There was little patient or public involvement in commissioning processes.
- The PCT was inhibited in its approach to intervention by the practical difficulties in taking radical steps to close or move services.

Policy background[1]

7.1 Primary care trusts (PCTs) were born out of the development in the 1990s of the concept of splitting NHS functions between "purchasers" and "providers". The purpose was to introduce a more commercial and competitive attitude within the NHS as a means of controlling costs and improving the quality of service. Following the 1989 White Paper, *Working for Patients*, the idea was that the then district health authorities and GPs acting as fundholders would arrange to "purchase" services from self-governing provider NHS trusts which could compete with each other for the business in what was termed "an internal market".

1 For a more complete history of the development of the structure and management of the NHS, see the expert report of Professor Newdick and Dr Judith Smith, *The Structure and Organisation of the NHS* [EXP0000000001]

7.2 These ideas were enacted in the National Health Service and Community Care Act 1990 and implemented in waves throughout the 1990s. However, the language of commerce and competition was replaced by the less dramatic syntax of "commissioning" and "contestability", recognising the potential for competition without necessarily mandating it. A form of contract was introduced to regulate the relationship between the health authorities and NHS trusts, but this was not legally enforceable and in practice was an unsophisticated block contract.

7.3 The Labour Government of 1997 remained committed to the purchaser/provider split but sought to emphasise collaboration rather than competition. In its White Paper *The New NHS: Modern, Dependable*,[2] it proposed the abolition of GP fundholders and their replacement with primary care groups (PCGs). These were sub-committees of the new single tier of 100 health authorities which replaced the district and regional health authorities. It was intended that over a 10-year period the PCGs would evolve into PCTs. PCGs were consortia of GP practices and community health service providers to which the health authorities delegated some (limited) responsibilities for planning and purchasing services. Such groups were created from 1999, and in 2000 the first PCTs were formed.

7.4 A somewhat dramatic change of emphasis occurred in 2001. It was made clear in *Shifting the Balance of Power within the NHS: Securing Delivery*[3] that, as opposed to allowing changes to occur organically over a 10-year period of evolution, all PCGs would become 303 PCTs within a year, by 2002. This was to occur alongside a significant increase in the resources made available to the NHS with a view, in particular, to reducing waiting times. At the same time, the roles of the 100 health authorities were to be taken over by 28 strategic health authorities (SHAs).

7.5 PCTs were to be statutory commissioning agencies. They were also given a myriad of other responsibilities including public health, partnership with local authorities, and contracting for general medical, dental, optometrist and pharmaceutical services. Therefore, they were given the potentially conflicting roles of commissioning services while, at the same time, being providers of services themselves.

7.6 The commissioning role was described in *Shifting the Balance of Power* as follows:

> *PCTs will become the lead NHS organisation in assessing need, planning and securing all health services, and improving health. They will forge new partnerships with local communities and lead the NHS contribution to joint work with local government and other partners.*[4]

2 *The New NHS: Modern, Dependable* (8 Dec 1997), Department of Health, available at: webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008869
3 DH00950000148, *Shifting the Balance of Power within the NHS: Securing Delivery*, (July 2001), Department of Health
4 DH00950000153, *Shifting the Balance of Power within the NHS: Securing Delivery*, (July 2001), Department of Health, page 5

7.7 Elsewhere, it described PCTs as:

> *The cornerstone of the local NHS. Devolving power and responsibility to PCTs offers real opportunities to engage local communities in the decisions that affect their local health services.*[5]

7.8 The SHAs were to "step back" from a direct commissioning role.

7.9 This represented a very large reorganisation of the structure of the service, required to be accomplished in a demandingly short time scale. An editorial in the *British Medical Journal*, whose authors included two expert witnesses to the present Inquiry, described it as the "redisorganisation of the NHS". Commenting on a survey of NHS managers, the authors wrote:

> *The unhappiness felt by managers does not stem from Government goals for the NHS nor from this diagnosis of the problems facing it ... It is the way that policy is being implemented through endless prescriptions for change involving unprecedented micro-management from the centre, which has the effect of constraining and undermining the ability of managers to manage. The command and control style, a never ending stream of "must-do" edicts, a "name and shame" culture and the perpetual obsession with an organisational restructuring can only detract from the ability of the NHS to deliver the plan. If managers are to lead the radical changes to services demanded by the NHS plan, they need time and space in which to acquire the new skills such as work process control, developing and implementing care pathways, and changing the nature of professional work. Instead they struggle in a macho climate that demands instant delivery.*[6]

7.10 In 2003, the House of Commons Health Select Committee complained that it was:

> *... seriously concerned that the perpetual flux to which the NHS is subject does not permit the climate of stability vitally needed in order to allow clinicians and managers to concentrate on improving care for patients.*[7]

7.11 This was not an end to the changes.

7.12 As outlined in *Practice Based Commissioning: Engaging Practices in Commissioning,* in October 2004, practice based commissioning (PBC) was introduced whereby GP practices, or groups of practices, were given an "indicative" budget, enabling them to commission some services.[8]

5 DH00950000160, *Shifting the Balance of Power within the NHS: Securing Delivery*, (July 2001) Department of Health, page 13
6 *The redisorganisation of the NHS*, (December 2001) Smith, Walshe, Hunter, BMJ 2001; 323; 1262, available at: www.bmj.com/content/323/7324/1262
7 CURE0028000097, *Foundation Trusts, Second Report of Session 2002–2003, volume one HC395–1* (7 May 2003), House of Commons Health Committee, para 170
8 *Practice Based Commissioning: Engaging Practices in Commissioning* (Oct 2004), Department of Health, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090357

This was intended, among other things, to use patient choice as a driver for quality and improvement. The structure of payment for services was to be changed to one of payment by results, incentivising good practice by enabling funding to "follow" the patients as they made choices.

7.13 Following the publication of *Commissioning a Patient-led NHS* in 2005, PCTs were reduced in number from 303 to 152, and SHAs reduced from 28 to 10.[9] These changes were implemented in 2006. The declared intention was that PCTs would place and manage contracts on behalf of the practice based commissioning groups.

7.14 A review of evidence on the handling of structural reorganisation, commissioned from Birmingham University by the NHS Institute for Innovation and Improvement, warned of the difficulties caused by the extension of the functions of PCTs and commissioning groups while, at the same time, reducing the capacity of the strategic level organisations:

> *For the people charged with managing and governing PCTs, the coming two years represent a time of significant change and transition as PCTs merge, change their functions, and develop new skills and capacity to carry out these functions. For strategic health authorities, there is similarly a time of great change ahead.* [They] *are to be significantly reduced in number by the autumn of 2005 and they will assume new roles and responsibilities, largely as regional planners, market regulators, and performance managers. One of the complexities therefore, is that the tier of the NHS that will be overseeing the transition of PCTs will itself be in transition.*[10]

7.15 In 2007, the Department of Health (DH) introduced the concept of World Class Commissioning and defined what it saw as the core skills required for commissioners and the objectives commissioning should achieve. It published guidance on these themes.[11] This is considered in more detail below.

Legislative basis for primary care trusts' functions

Functions of primary care trusts

7.16 The Secretary of State acquired the power to establish PCTs in the Health Act 1999 in provisions now to be found in the National Health Service Act 2006.[12] The statutory functions of PCTs included the exercise of the Secretary of State's duty to provide:

9 DH00000004179, *Commissioning a Patient-led NHS* (28 July 2005) Department of Health
10 *Leadership in Organisational Transition – what can we learn from research evidence,* (2006), Dickinson, H., Peck, E., Smith, J, Birmingham and Warwick Health Services Management Centre and NHS Institute for Innovation and Improvement; quoted in EXP0000000038, *The Structure and Organisation of the NHS* (Nov 2010) Newdick, C and Smith, J
11 *World Class Commissioning: Vision*; *World Class Commissioning: Competences*, (December 2007), Department of Health, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080958
12 National Health Service Act 1977, section 16A (inserted by the Health Act 1999); National Health Service Act 2006, sections 18–22

- Hospital and other accommodation;
- Medical, dental, nursing and ambulance services;
- Facilities for the care of expectant and nursing mothers and young children;
- Services required for the diagnosis and treatment of illness.[13]

7.17 The regulations provided that SHAs were also enabled to exercise these powers but only to the extent necessary to support and manage the performance of PCTs.[14] However, both the Secretary of State and the SHAs had powers to give directions to PCTs as to the exercise of their functions.[15]

NHS contracts

7.18 NHS "contracts" were created as a concept at the inception of the "internal market" in the 1990s. The National Health Service Act 2006, the relevant Act for the purposes of this Inquiry, defined the NHS contract as:

> *An arrangement under which one health service body ("the commissioner") arranges for the provision to it by another health service body ("the provider") of goods and services which it reasonably requires for the purposes of its functions.*[16]

7.19 The health service bodies referred to included NHS trusts, SHAs and PCTs, as well as the Secretary of State for Health, but not foundation trusts (FTs). Although these "arrangements" were called "contracts", they were not contracts in the true sense of the word, as the Act provided that they could not be regarded for any purpose as giving rise to contractual rights or liabilities.[17] However, they were given legal effect, as either party to a dispute in respect of such an arrangement could refer it to the Secretary of State for determination. The determination could include directions, including directions as to payment, to resolve the matter, and could include a variation of the terms or termination of the arrangement as a whole. Parties to the negotiation of an arrangement could complain to the Secretary of State about any alleged abuse of a bargaining position.[18]

7.20 FTs are, in practice, commissioned to provide services by similar arrangements. Unlike NHS trusts, FTs enter into enforceable legal contracts with PCTs, but it appears that, in practice, disputes are resolved through the normal routes of discussion and adjudication between NHS bodies, rather than through the courts.

13 The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (SI 2002/2375). For a full list of functions, see TRU00010007149.
14 The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (SI 2002/2375), regulation 3(2)(b)
15 National Health Service Act 2006, section 8
16 National Health Service Act 2006, section 9(1)
17 National Health Service Act 2006, section 9(5)
18 National Health Service Act 2006 ,section 9, subsection (6), (7), (11), (12)

Duty of cooperation

7.21 As with all other NHS bodies, PCTs were obliged to cooperate with each other in the exercise of their functions.[19] NHS bodies, for this purpose, include FTs.[20]

Duty to break even

7.22 In common with other NHS bodies, PCTs were obliged to break even on a current year basis.[21]

Duty to monitor quality

7.23 PCTs shared with other NHS bodies the obligation to monitor and improve the quality of healthcare in accordance with standards published by the Secretary of State:

> *It is the duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.*[22]
>
> *Each Primary Care Trust must make arrangements to secure continuous improvement in the quality of health care provided by it and by other persons pursuant to arrangements made by it.*[23]

Primary care trusts responsible for commissioning services at the Trust

7.24 Between 2002, when PCTs were first established, and October 2006, the following PCTs existed in the South Staffordshire area:

- Burntwood, Lichfield and Tamworth Primary Care Trust (BLTPCT);
- Cannock Chase Primary Care Trust (CCPCT);
- South West Staffordshire Primary Care Trust (SWSPCT);
- East Staffordshire Primary Care Trust (ESPCT).

19 National Health Service Act 2006, section 72
20 National Health Service Act 2006, section 28(6)
21 National Health Service Act 2006, section 229
22 Health and Social Care (Community Health and Standards) Act 2003, section 45,
23 Section 139 of the Health and Social Care Act 2008 inserted section 23A into the National Health Service Act 2006, providing an amended duty to all NHS bodies.

Table 7.1: Budget for PCTs in South Staffordshire area[24]

PCT	Number of staff	2005/06 budget
BLTPCT	621	£168,630,000
CCPCT	269	£143,965,000
SPCT	262	£136,326,000
SWSPCT	445	£196,322,000

7.25 SWSPCT commissioned some 50% of the services provided at the Trust and accordingly acted as lead commissioner, acting on behalf of the others. CCPCT was the second largest commissioner for the Trust, commissioning about 40% of the services.[25] It is with these two PCTs that the narrative which follows is principally concerned.

7.26 From October 2006, these four PCTS were merged into South Staffordshire PCT (SSPCT). This organisation was responsible for public funding of more than £677 million in 2006/07 and £805 million in 2007/08. It employed over 1,600 full time equivalent staff.[26]

7.27 Therefore, the SSPCT was an organisation with much greater resources than the SHA for the area, which was charged with performance managing the PCT and with oversight of provision within the region.

7.28 SSPCT was the lead commissioner for the Trust. Its contract with the Trust was worth £108 million in 2007/08, £115 million in 2008/09 and £123 million in 2009/10. In 2006/07, five PBC consortia were established from consortia of GPs in the area. These were allocated approximately 70% of SSPCT's budget on an "indicative" basis. The consortia were:

- East Staffordshire PBC Consortium;
- South East Staffordshire PBC Consortium;
- Cannock Chase PBC Consortium;
- Seisdon Peninsula PBC Consortium;
- Stafford and Surrounds PBC Consortium.[27]

7.29 The two consortia with the strongest interest in the Trust were Stafford and Surrounds PBC Consortium, and Cannock Chase PBC Consortium, which, between them, were responsible for 90% of the referrals to it.[28]

24 PCT WS(Provisional) – PCT00000000018, paras 46–49
25 PCT WS(Provisional) – PCT00000000018, paras 47–49
26 PCT WS(Provisional) – PCT00000000020, para 56
27 PCT WS(Provisional) – PCT00000000019–023, paras 50–63
28 Griffiths WS0000014862, para 49

Commissioning

What is it?

7.30 The meaning of the term 'contract' in the context of the provision of healthcare services is somewhat different to the meaning generally attributed to the term. To a lawyer, a contract is a legal means of entering into a legally enforceable agreement under which, in this case, it is agreed that a specified service be delivered for an agreed price and subject to agreed conditions. However, in the NHS, while the law allowed for "contracts" between different NHS organisations, these were not to be legally enforceable. This was possibly due to the conceptual difficulties involved in two organisations within the same system, both beholden to the Secretary of State, entering into a legal dispute. The arrangements for resolving disputes were and are opaque, and, in practice, it was intended that they would be settled amicably between the parties. PCTs had options to impose penalties through their contracts with providers, and the facility existed to use a form of arbitration by or on behalf of the Secretary of State, but the DH did not encourage its use. In an extreme situation in which organisations within the NHS failed to resolve their differences, the Secretary of State could impose a resolution by direction.

7.31 Agreements entered into between commissioners and FTs are legally enforceable, presumably on the basis that, although FTs remain part of the NHS "family", they are legal entities independent of the NHS hierarchical structure. It has yet to be seen how, if at all, this alters the dynamic of the relationship. Organisations are no more encouraged to resort to legal means of enforcement than they have been to arbitration in the past.

7.32 "Commissioning" is a term not widely used in healthcare outside this country. Smith and Newdick argue in their report to the Inquiry that commissioning may be considered as distinct from contracting or purchasing.[29] They describe commissioning as having a more strategic and proactive intent than contracting, as it influences and shapes the services offered by healthcare providers. They refer to John Ovretveit's suggestion that commissioning can be done by way of a "cycle" made up of the following core elements:

- Needs assessment;
- Priority setting;
- Procurement through contracts;
- Monitoring of service delivery;
- Review and evaluation.

7.33 The DH version of this includes eight steps:

- Assessment needs;

29 EXP0000000031–32, *The Structure and Organisation of the NHS* (Nov 2010), Newdick, C and Smith, J, pages 31–32, para 75

- Description of services and gap analysis;
- Deciding priorities;
- Risk management;
- Strategic options;
- Contract implementation;
- Provider development;
- Management of provider performance.[30]

7.34 Therefore, the concept embraces more than the procurement of a service – it includes the strategic development and preparatory planning, as well as contract management and monitoring. Smith and Newdick quote from Woodin:

> *Commissioning is a term used most in the UK context and tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or healthcare interventions should be provided, who should provide them and how they should be paid for, and may work more closely with the provider in implementing changes. A purchaser buys what is on offer or reimburses the provider on the basis of usage.*[31]

7.35 While this may correctly describe commissioning, it arguably defines the concept of contracting or purchasing too narrowly. A purchaser of services will frequently lay down specifications, often very detailed ones, of what is required. Where the service provision is over a sustained period, it is inevitable that a relationship with the provider has to be developed and maintained. The standard and quantity of service can be monitored. For example, a client may purchase the services of an architect to design a building, or a Government may purchase the services of a designer to design a new aircraft. In each case, very detailed specifications as to what is required may be laid down, along with the standards to be observed. A supermarket chain purchasing supplies may, and often does, specify to the centimetre the height of the truck platform from which the goods are to be delivered. Alternatively, a less resourced or experienced client may give a service provider or a supplier of goods a very flexible brief and rely much more heavily on the provider's expertise.

7.36 The actual terms used to describe these functions are perhaps less important than identifying the functions themselves and ensuring that a proper understanding of what they are and their significance is shared by all those involved in these arrangements. Whether described as a purchaser/provider or a commissioner/provider arrangement, it is clear that it has, at all material times, been open to the NHS system to lay down specifications to be followed by the

30 EXP0000000051, *The Structure and Organisation of the NHS – schedule 2* (Nov 2010) Newdick, C and Smith, J
31 EXP0000000032, *The Structure and Organisation of the NHS* (Nov 2010) Newdick, C and Smith, J, page 32, para 75

provider, with regard to not only the type and quantity of treatment or service to be provided, but also the standards to be complied with.

7.37 It is beyond the scope of this Inquiry to consider every aspect of commissioning/purchasing arrangements, but the NHS system did, during the period under review, specify the service to be provided by acute healthcare providers and monitoring of the provider's performance. Commissioning continues to embrace these functions under the recent reforms. It is on these functions that this chapter will focus.

Commissioning for quality: 2002–2006

7.38 While the 2001 policy, as set out in *Shifting the Balance of Power*, implied that commissioners were responsible for monitoring the quality of care, it was less than clear what this involved. Smith and Newdick set out relevant quotations in their report.[32] They refer to service improvement, clinical leadership, connections with local communities, cooperation with other parts of the NHS, devolution of decision-making and a "cultural shift" to "build a NHS that is centred on the needs and concerns of the patient".[33]

7.39 In *Delivering the NHS Plan – next steps on investment, next steps on reform* (April 2002), PCTswere required to publish annually, through a patient prospectus, details of "the availability, the quality and the performance of local health services".[34]

7.40 This was to include an analysis of feedback from patient complaints about providers. It was envisaged that the Commission for Healthcare, Audit and Inspection (CHAI, later the Healthcare Commission) would be providing detailed information on outcomes, starting with mortality rates following heart surgery and including outcomes of individual consultant teams.

7.41 *Securing Service Delivery – commissioning freedoms of primary care trusts*, published in the same month, recommended PCTs commission care from wherever they judged the best service could be obtained:

> *Commissioning decisions should be judged against the twin tests of high clinical standards and good value for money.*[35]

7.42 The DH circular emphasised that PCTs should exercise their discretion to reduce waiting times, increase responsiveness and improve clinical outcomes.

32 EXP0000000120–121, *The Roles and Responsibilities of PCTs* (Nov 2010) Newdick and Smith
33 DH00000003873, *Shifting the Balance of Power within the NHS: Securing Delivery* (July 2001), Department of Health, para 57
34 DH00000001476, *Delivering the NHS Plan: next steps on investment, next steps on reform* (April 2002), Department of Health, para 5.8
35 *Securing Service Delivery: Commissioning Freedoms of Primary Care Trusts* (30 April 2002), Department of Health, page 2, para 2. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012216.pdf

7.43 *Shifting the Balance of Power – Next Steps* (2002) referred to "securing the provision of high quality services"[36] through direct management or agreement with others and said:

> *In order to meet its objectives, the PCT will have to develop a planning system which focuses on patient need in its broadest sense, quality of outcomes, activity and finance. This will need to be underpinned by strong clinical governance arrangements to assure the quality of services, to identify opportunities for quality improvement and to ensure patient safety.*[37]

7.44 Explicit reference was made to the statutory duty of quality:

> *Every NHS organisation has a statutory duty to assure, monitor and improve the quality of its services. This has been implemented through the clinical governance programme. Primary Care Trusts are required to have robust clinical governance arrangements in place as well as to ensure that in commissioning services from NHS and other providers that quality and safety are core elements of their commissioning decisions.*[38]

7.45 *Improvement, expansion and reform – next three years: priorities and planning framework 2003–2006* (October 2002) required PCTs to hold provider organisations to account for the delivery of commissioned services.[39]

7.46 In contrast to these exhortations, *Creating a Patient-Led NHS* (March 2005) encouraged PCTs to adopt simpler, less bureaucratic contracting arrangements.[40]

7.47 *Health Reform in England: Update and commissioning framework* (July 2006) stated that poor performance was to be "contested" by commissioners who were advocates for patients and custodians of public money.[41]

36 *Shifting the Balance of Power: the Next Steps* (January 2002) Department of Health, page 8, para 2.1.3. Available at: www.dhcarenetworks.org.uk/_library/Resources/ICN/Shifting_the_Balance_of_Power.pdf
37 *Shifting the Balance of Power: the Next Steps* (January 2002) Department of Health, page 9 para 2.1.10. Available at: www.dhcarenetworks.org.uk/_library/Resources/ICN/Shifting_the_Balance_of_Power.pdf
38 *Shifting the Balance of Power: the Next Steps* (January 2002) Department of Health, page 44 Appendix E, para 44 Available at: www.dhcarenetworks.org.uk/_library/Resources/ICN/Shifting_the_Balance_of_Power.pdf
39 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/enPublicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008430
40 *Creating a Patient Led NHS* (March 2005) Department of Health, Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106507.pdf
41 *Health Reform in England: update and commissioning framework* (July 2006) Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137227.pdf

7.48 It is clear from this brief review of policy statements throughout the period 2002–2006 that PCTs were expected to assume some form of responsibility for:

- Including quality consideration in their commissioning decisions;
- Obtaining "high quality" services by commissioning for them;
- Holding providers to account for provision of safe and high quality services;
- Monitoring quality performance of providers;
- Obtaining patient feedback on quality;
- Sharing information with patients and the public as regards the performance of providers;
- Assisting patients in making treatment choices.

7.49 What appears to have been recognised in 2007 was that PCTs did not have the competence or capacity to undertake this role.

World Class Commissioning

7.50 In 2007, "World Class Commissioning" was introduced as a means of assisting PCTs and PBCs cosortia in the complex task of commissioning services. It sought to provide a description of the competences needed for the task and included a scheme for assessing, internally and externally, the performance of PCTs. Underlying its introduction may well have been a concern that this function had not been performed well across the board so far.[42]

7.51 Gary Belfield, the DH Director of Commissioning from 2007, and from July 2009 until May 2010 Acting Director General of Commissioning and System Management, told the Inquiry:

> *The PCTs were still finding their feet in 2005 and quality standards were variable across the NHS ... My observation at that time was that some parts of the country were seeing changes and improvements through PCTs, whereas other PCTs were struggling. Until 2005, the attention and focus of the DH was on the provider side. The healthcare providers were being set national targets, for example accident and emergency targets which were very carefully monitored. There was therefore a lot of focus on acute trust providers and less focus on commissioners.*[43]

7.52 Following the 2006 reorganisation this patchy performance throughout the country persisted, and Mr Belfield recognised the DH had not provided much support to PCTs to perform this role:

> *The DH wanted PCTs to be in a stronger negotiating position with the larger acute hospitals, and merging PCTs was intended to redress the balance and give more control to the PCTs ...*[44]

42 Belfield T124.29–32
43 Belfield WS0000058353, para 7
44 Belfield WS0000058353, para 9

I think it was recognised that the DH did not give the PCTs much time to develop, nor did we offer much in the way of training and support to PCTs to enable them to do their job effectively after the previous reorganisation [in 2002]. *However, I also think that the suggestion that there was a national PCT problem tars all 303 PCTs with the same brush. In reality, some were very good. My overall impression, however, is that the DH did not have very much faith in the PCTs as a whole.*[45]

7.53 Mr Belfield was responsible for the development of the policy of World Class Commissioning which was intended to be, for the first time, a comprehensive approach to developing the required competences: "Previously no one had really defined what commissioning was in any detailed way."[46]

7.54 In *World Class Commissioning: Vision* (2007),[47] the DH set out the purpose of this approach to commissioning:

- *Better health and well-being for all*
  - *People live healthier and longer lives.*
  - *Health inequalities are dramatically reduced.*

- *Better care for all*
  - *Services are evidence based, and of the best quality.*
  - *People have choice and control over the services that they use, so they become more personalised.*

- *Better value for all*
  - *Investment decisions are made in an informed and considered way, ensuring that improvements are delivered within available resources.*
  - *PCTs work with others to optimise effective care.*

7.55 A number of organisational competences were identified, including:

8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration.

9. Secure procurement skills that ensure robust and viable contracts.

10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements and outcomes.

45 Belfield WS0000058360–61, para 29
46 Belfield WS0000058366, para 41
47 *World Class Commissioning: Vision* (3 December 2007) Department of Health
Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_080952.pdf

11. Make sound financial investments to ensure sustainable development and value for money.[48]

7.56 It was clearly intended that commissioning had to involve the promotion of quality improvement, and implicitly required the monitoring of the standard of delivery (if only through the reference to "robust and viable contracts" and "contract compliance"). However, this may not have been given the same prominence as the requirement to look for value for money, even if that too might be presumed to require a proper standard of service delivery. Nonetheless, it was made clear that PCTs were to be held to account:

... for commissioning decisions, the budget, and health, well-being and clinical outcomes. They have to be able to publish a credible account of effectiveness, efficiency and equity.[49]

7.57 Relying on the evidence of Yvonne Sawbridge, Director of Quality and Performance at SSPCT, among others, it has been argued by the PCT in its closing submissions[50] that until Lord Darzi's report in 2008 (see below), any clear definition of what was meant by "quality" was absent from these statements. It was certainly the conclusion of the reports commissioned for Lord Darzi that commissioners had not been provided with the means to commission for quality (see below).

7.58 Another characteristic of the commissioning system at the time, and not just in Staffordshire, was a practice of reliance on others to inform PCTs of problems in their provider trusts. Professor Kieran Walshe said in his evidence:

it is legitimate that the PCT would rely to some degree on the assessment processes of the regulator to assure quality.[51]

7.59 Gary Belfield accepted that it had not really been the intention of various policies that PCTs should proactively look for signs of concern, although that was not, he said, the position today.[52] This does not necessarily excuse any PCT from not acting on signs of concern of which it was or should have been aware.

7.60 In 2008, DH guidance stated to PCT Boards that they would:

48 EXP0000000041 The structure and organisation of the NHS, Chris Newdick and Dr Judith Smith, November 2010
49 EXP0000000127 The roles and responsibilities of PCTs in Commissioning for Quality, Chris Newdick and Dr Judith Smith, 13 November 2010
50 CLO0000001343–351, *PCT closing submission*, paras 17–28
51 Walshe T8.74
52 Belfield T124 53

... have a significant role in reviewing information on patient safety, patient experiences and the effectiveness of care and will need to work with providers on priorities for improvement. PCTs will be expected, on behalf of the populations they serve, to challenge providers to achieve high quality care. The PCT Board will ensure that there is strong clinical engagement in commissioning ... to drive improvements in health outcomes.[53]

7.61 This more emphatic identification of PCTs' responsibility for ensuring high quality and effective treatment coincided with Lord Darzi's report *High Quality Care for All: NHS Next Stage Review Final Report,*[54] the aim of which was said to be to "put quality at the heart of the NHS", and emphasised the role of PCTs in challenging providers to achieve high quality.

7.62 Commissioning, however sophisticated in theory, could only operate within the context of the NHS system as a whole and was always but one factor contributing to the delivery of the service. Smith and Newdick quote Professor Chris Ham, from a review of international evidence on healthcare commissioning that he conducted in 2008, to show the complexity of the considerations:

Commissioning is only one element in the programme of health reforms and its impact will be affected by how other elements are taken forward [...] *much will hinge on providers having autonomy over their own affairs and the ability to respond rapidly to changing market conditions. Similarly, the impact of commissioners will be influenced by the payment systems that are in place, the strengths of the incentives contained within these payment systems, the arrangements for market management and regulation* [...] *, and the degree to which politicians are willing to 'let go' and allow commissioners to exercise their leverage, even if the consequences are unpopular with the public.*[55]

7.63 This pointed to the importance of the balance of power, negotiating and political, between the commissioners and the providers, the degree of autonomy granted to either or both, and the pervasive influence of central Government.

7.64 In theory, an organisation empowered to choose where to commission what services has considerable power – and responsibility – to require services of a desired standard to be provided. It can specify the standards, choose the best qualified provider, monitor the performance, and change provider if the service is unsatisfactory. The evidence before the Inquiry shows that, in practice, this theoretical power has been extremely limited in effect. Smith and Newdick suggest that this was probably associated with:

53 GB/12 WS0000058807, paras 10–11
54 *High Quality Care for All: NHS Next Stage Review Final Report* (June 2008) Department of Health Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825
55 EXP0000000034, *The Structure and Organisation of the NHS* (November 2010) Newdick and Smith

- The scope and complexity of commissioning services;
- A power imbalance between providers and PCTs;
- Limitations in data and management skills;
- The debilitating effects of constant reorganisation.[56]

7.65 The evidence to this Inquiry confirms that elements of all these were present in the West Midlands during the period under review, as will be shown below, but it is appropriate to make a few general observations here.

7.66 Disregarding the wider planning function, the business of drafting procurement contracts in sufficient detail in order to specify standards, and to include effective means of measuring compliance and remedies in the case of non-compliance, requires expertise which may well not have been available to many PCTs.

7.67 While, in theory, a commissioner could cease to commission a provider, this option was, to the knowledge of both parties, often unrealistic through, for example, lack of an alternative provider, popular and political objection to change, or basic local need for a local service, such as in the case of an A&E facility. Providers were always more likely to have relevant clinical expertise at hand with which to rebut concerns raised by PCT managers or even community clinicians.

7.68 In order to have effective monitoring of compliance, reliable and relevant information is required. This was, and often remains, lacking. There may be little incentive for a provider to offer to collect information for this purpose if it is not required and accessible in any event.

7.69 Reorganisation was capable of compounding an existing shortage of appropriate management skills and the imbalance of power between providers and commissioners by dispersal of staff, and loss of corporate memory and experience. It also made comparisons in performance between various iterations of organisations difficult, if not impossible.

7.70 The result was an inconsistent application of commissioning principles and practice throughout the country. In the Joint Commission International 2008 report, which was commissioned by the DH as part of Lord Darzi's NHS Next Stage Review, it was stated that:

> *The lack of standardization is most evident in the commissioning process where each primary care trust appears to devise its own commissioning criteria, collect its own data – a stated concern of some primary care trusts – commissioning decisions appear to be made primarily on the basis of financial considerations. This created little incentive for clinical performance improvement in the acute care trusts.*

56 EXP0000000018, *The Structure and Organisation of the NHS* (November 2010) Newdick and Smith

Quality today does not drive or even influence commissioning decisions. In theory the commissioning process could drive improvement, but that capability does not now exist and may take years to develop. To do this, the primary care trusts will need more clinical leadership than is currently available, as well as skill in using improvement tools and access to standardized, reliable performance data.

... More effective oversight of the commissioning process in relation to quality, for example by the strategic health authorities, is needed ...

Public engagement in the commissioning process is lacking.[57]

Commissioning in South Staffordshire

Overview

7.71 Stuart Poynor, Chief Executive of SSPCT, told the Inquiry of his experience at ESPCT in this period. He gave an example of a contract with Burton Hospital which consisted of one sheet of A4 paper. The process was concerned with activity and financial measures, ie quantity rather than quality.[58]

7.72 Alex Fox, Chair of SSPCT, speaking of the same period and ESPCT, emphasised that they had engaged patients and GPs in the process by obtaining feedback from them. The ESPCT had clinical board members (four out of six members) and sought to drive quality forward. However, he accepted that this was not easy:

Capturing quality, whether soft or hard data, has never been easy and although things have significantly improved, remains difficult, with a limited agreed definition of quality and measurable outcomes.[59]

7.73 Geraint Griffiths, a locality director at SSPCT, told the Inquiry that, initially, PCTs had to rely on "other bits of the NHS" for scrutiny on quality, whereas, closer to 2008, such functions were being performed more in-house. This was not easy, as it led to duplication and blurring of boundaries.[60] He accepted that, until 2008, there was no independent assurance by PCTs of the quality of service provided, and reliance was being placed on providers' self-declarations.[61] PCTs were obliged, he suggested, to accept what they were told on trust:

57 PA0002000060, *Quality Oversight in England – Findings, Observations, and Recommendations for a New Model* (30 January 2008), Joint Commission International
58 Poynor WS0000014282, paras 9–21
59 Fox WS0000012992, paras 11–16
60 Griffiths T63.19–20
61 Griffiths T63.24

What the system couldn't pick up was, if the trust didn't self-declare correctly. Unless the PCT happened to have local knowledge, it didn't have the capacity to challenge that view of trusts. So it relied as much on the internal governance model within the provider, as it did on the PCT's own systems.[62]

7.74 The same witnesses suggested that there had been a step change with the introduction of World Class Commissioning.

7.75 Mr Griffiths said that an advantage of this scheme was that it enabled good commissioning practice and the elements of it to be identified, and that, until then:

Commissioners were not managing the system, were not proactively doing the commissioning, that they were very financially [driven] *and ... reactive ... I think there was a sense of let's do the structural changes and the financial management, and then let's go into this more defined commissioning world that came out later.*[63]

7.76 Mr Poynor thought World Class Commissioning gave real focus to the process.[64]

South West Staffordshire Primary Care Trust

7.77 There was clear evidence that SWSPCT was required to concentrate its efforts on correcting a financial imbalance at the expense of any focus on the quality of service being provided or commissioned. William Price, Chief Executive of SWSPCT from 2002 to 2006, told the Inquiry that his PCT had suffered financial difficulties from its creation, and that these worsened between 2002 and 2006.[65] He complained of pressure from Shropshire and Staffordshire SHA (SaSSHA) in this regard. The statutory obligation to monitor quality took a back seat:

Whilst the duties are clearly there in black and white, it was made quite clear to us by the SHA at the time that our focus should be on improving our finances and that was the bottom line ... As far as I can remember we didn't have anything routine and structured in place to comprehensively monitor the quality of services provided by the Trust. There was no external pressure applied on us as a PCT to carry out this role and I do not believe that quality monitoring was ever discussed as being part of our role when we were first established. As Chief Executives we knew that targets were the priority and if we didn't focus on them we would lose our jobs.[66]

62 Griffiths T63.25
63 Griffiths T63.17–18
64 Poynor WS00000143450, paras 290–291
65 Price WS0000016105, para 6, and WS0000016109–10, paras 23–25
66 Price WS000016114–5, paras 45 and 47,

7.78 Susan Fisher was Finance Director at SWSPCT, but also charged with responsibility for performance. She told the Inquiry that SWSPCT was too small to have a properly resourced management team, although she did introduce a deputy director of performance and commissioning.[67] She gave evidence to the same effect as Mr Price:

> *The PCT did not however monitor quality at the Trust in a systematic way; issues were identified on an ad hoc basis. This was not unique to SWSPCT; I understand that PCTs across the NHS at this time only raised quality issues that they discovered through the rest of their work, rather than having in place a system to monitor performance of acute providers on a continuous basis.*[68]

7.79 She pointed out that it was easier for the PCT to monitor the quality of the services it provided directly:

> *... we didn't have the levers with an acute trust to actually enforce anything ... We should in hindsight probably have done more balance on the acute trusts ... with the seriousness of things that have come out. But we probably focused on where we had got the levers to do something about it.*[69]

7.80 She confirmed that the focus required by the SHA was on financial control, and complained of being the subject of personal bullying in this regard.[70] This issue is considered in *Chapter 8: Performance management and the strategic health authorities*, but the fact she raised the issue at all is evidence of the stresses this caused.

7.81 SWSPCT had responsibility for 50 acute service contracts, including the highest number of contracts for health services in prisons in the country.

7.82 It is clear, therefore, that the lack of clarity as to what commissioning for, and monitoring of, quality entailed was compounded by a relentless focus on financial issues. A further complicating factor was the number of organisations with which SWSPCT had to interact. In such an atmosphere, it is not surprising that there was no proactive monitoring of quality delivery. In effect, it would have required complaints or concerns received to be judged of exceptional significance before any intervention might have been considered. As will be seen, the absence of the "levers" Susan Fisher considered were lacking, was theoretically capable of being remedied by the PCT inserting appropriate terms in its NHS contracts. It is difficult, however, to criticise an individual commissioner for following what appears to have been general practice at the time.

67 Fisher WS0000042297–8, paras 4–7
68 Fisher WS0000042302, para 23
69 Fisher T96.24
70 Fisher T96.45–50

7.83 It is accordingly fair to say that SWSPCT did not even begin to fulfil its statutory duty in relation to quality. However, it is difficult to see how it was expected to do so, given the circumstances it faced.

Cannock Chase Primary Care Trust

7.84 CCPCT looked to SWSPCT as the 'lead commissioner' for the contract with the Trust[71] and worked with, and was led by, SWSPCT in setting priorities. In practice, this meant ensuring the Trust formed a view as to its real priorities and considering how these fitted with those of the PCTs.[72]

7.85 Given SWSPCT's approach to quality, as described above, and the subordinate nature of CCPCT's role in the commissioning arrangements with the Trust, it seems a fair assumption that CCPCT similarly focused primarily on financial control, with little emphasis on commissioning for quality. Certainly, it does not appear that it went out of its way to be more proactive than its sister PCT to any meaningful degree.

7.86 Jean-Pierre Parsons, Chief Executive of CCPCT from 2002 until 2006, gave plain evidence:

> *During the CCPCT's tenure, the commissioning process focused on activity, money and achieving particular targets.*[73]

7.87 He added that money was allocated with a view to satisfying the nationally set targets which took priority, leaving, in reality, little or no funding for the development of local initiatives.[74]

7.88 In addition to there being a lack of focus on quality generally, there appears to have been a significant misconception on the part of the CCPCT as to both the nature and the extent of its obligations in that field. Mr Parsons stated:

> *I understand that at clause 45* [of the Health and Social Care (Community Health and Standards) Act 2003]*, it states that PCTs were required to implement functions for the purpose of monitoring and improving the quality of care.*
>
> *In terms of these functions ... the CCPCT had a Clinical Governance Committee. The Clinical Governance Committee focused on the quality standards that the CCPCT was providing, rather than those being provided externally. For example, it would examine community nurses or the podiatry services provided by the CCPCT, to ensure quality standards were maintained.*[75]

71 Parsons WS0000077419, paras 7 and 11.
72 Parsons WS0000077419, para 14.
73 Parsons WS0000077419, para 12
74 Parsons WS0000077419, para 14
75 Parsons WS0000077419, paras 25 and 26

7.89 He went on to say:

> *In terms of how the issue of quality featured in the context of a culture of monitoring targets and balancing books, I do not think that quality was ignored. However, it is hard to put my finger on how quality did feature.*[76]

7.90 That there was a lack of specific action taken by CCPCT in relation to quality is a theme of Mr Parsons's written evidence, which is candid and helpful. Notwithstanding his expectation that CCPCT:

> *would have received information from the Trust in relation to quality; as a minimum we would have received the information required by the SLA* [service level agreement] *...*[77]

and his expectation that:

> *In relation to data concerning serious untoward incidents ("SUIs"), I would expect the CCPCT to be notified by the Trust if, and when, these sorts of incidents occurred, and I would have expected the Trust to tell us how they intended to address the issue*[78]

There is no indication that CCPCT did receive such information nor that it became aware of any particular quality issues at the Trust as a result.

7.91 In one of the few instances in which Mr Parsons was able to recall a particular action taken by CCPCT, he referred to the manner in which it dealt with the zero star rating attributed to the Trust by the HCC in 2004.[79] He himself chaired the incident team that SaSSHA tasked with responding to the rating. Weekly meetings were convened to discuss the Trust's "performance and clinical priorities". However, in real terms, the focus of the initiative appears to have centred upon the meeting of national targets on waiting times. Once appointments were being delivered within the required timescale, the incident team was disbanded.[80]

7.92 Mr Parsons's conclusion on the matter of the CCPCT's perspective on quality was that there could have been more monitoring of quality besides the focus on targets and finances. His own analysis was that there had been "too many players", and reliance placed by parties, including CCPCT, on the assumption that someone else would deal with quality.[81]

76 Parsons WS0000077419, para 24
77 Parsons WS0000077419, para 23
78 Parsons WS0000077419, paras 22 and 26
79 Parsons WS0000077419, para 60
80 Parsons WS0000077432, paras 60–61
81 Parsons WS0000077419, para 115

Handover to South Staffordshire Primary Care Trust

7.93 A considerable degree of time and energy had to be devoted to the merger of the four PCTs into SSPCT. Geraint Griffiths estimated that it took much of the first six months after the handover to carry out the immediately necessary tasks, such as supporting over 200 commissioning staff through the transition, either by finding them jobs within the new PCT or assisting them to go elsewhere.[82]

7.94 Before the handover, the "legacy" PCTs formed a working group to plan and implement the transition. During this process, Stuart Poynor became aware that the predecessor Chief Executives did not have good relationships with the Trust but he was not informed of any clinical issues of concern. In particular, no mention was made of the 2006 children's service review. Mr Poynor initially expressed confidence that, through the processes in place, SSPCT would have picked up on any known issues of concern.[83] In his oral evidence, however, he accepted that the handover had been deficient.[84] SSPCT identified the need for detailed handovers as a lesson to be learned in its review after the publication of the HCC report.

7.95 Mr Parsons was also confident that he or his colleagues would have passed on any information requested of them.[85]

7.96 It is not possible to share that confidence in the absence of any persuasive paper trail. It seems that the handover largely depended on conversations at meetings, which were not recorded, and extremely cursory documents. Mr Poynor produced the written handover, given to him by his predecessors.[86] William Price of SWSPCT had prepared a 12-page "End of Term Report" which listed, and briefly described, some key issues in its own service provision, and two-and-a-half pages on the provider services. None of the subjects covered could be said to relate to patient safety or quality. The CCPCT briefing note from Mr Parsons consisted of two-and-a-quarter pages. The service provided by the Trust was not mentioned, positively or negatively, with the exception of the perennial subject of possible schemes for Cannock Chase Hospital.

7.97 It is difficult to believe that there were no concerns about quality apparent to either PCT in relation to any of the providers which it commissioned.

7.98 Geraint Griffiths suggested that the handover had been poor. On his arrival in November 2006, he found that:

82 Griffiths WS0000014860, para 38
83 Poynor WS0000014287, para 28
84 Poynor T65.118
85 Parsons WS0000077445, paras 106–107
86 SP/2 WS0000014365–81

... there was very little detailed handover from the previous organisations. The Chief Executives from the previous PCTs had gone to other roles and there were very few Directors left. Most of the staff that we did inherit were from a tier below Directors and therefore did not necessarily have the information we needed.

... [SSPCT] *did not receive any indication that there were any issues regarding standards of care at the Trust. Short of Board papers and financial system information,* [SSPCT] *received little documentation from its predecessors.*[87]

7.99 Alex Fox commented:

Undoubtedly the PCT did lose information around the locality of each of the legacy PCTs. For example, the contact with local services was lost, as were the personal relationships that had been built up over time.[88]

7.100 Dr Roger Beal, Chair of SWSPCT's Professional Executive Committee, suggested that this lack of continuity was deliberate, as it was desired that the new PCT start off afresh in its relationships with the provider trusts.[89] There is no evidence to support this impression. Most staff below director level were automatically transferred if they wished to stay. However, some would have chosen to leave voluntarily and some would have been made redundant. Such events inevitably led to the workforce being unsettled and some will have made protective moves to other jobs rather than wait to see what would happen to them in the new structure.

7.101 Whatever the perception of the state of relationships with providers before the merger, it is difficult to accept that this led to any deliberate attempt to withhold information: to have done so would have been counterproductive. Building new relationships would have required a working knowledge of what happened before. There was, as indicated above, an attempt to hand over information in any event. The fact that none of it concerned quality or safety issues is more of an indication that these were not considered central to the PCT role at the time. Further, as is clear from the evidence received by the Inquiry from officials who worked in the "legacy" PCTs, they had no concerns about these issues at the Trust to pass on to their successor.

7.102 In short, the absence of information indicating concerns about the quality of the Trust's service at the start of SSPCT's life did not mean that there was not cause for such concern, although it is fair to conclude that those responsible for handing over information were unaware of such concerns. Through a combination of lack of a systematic approach to the issue, a culture in which the significance of concerns for patient well-being was not considered, and a haphazard

87 Griffiths WS0000014858, paras 32–35
88 Fox WS0000013002, para 48
89 Beal WS0000040513, para 28

way of receiving and digesting intelligence relevant to quality, nothing was passed on. SSPCT did indeed have to start afresh. It started with no appreciation or knowledge of any of the matters which had arisen before October 2006 (described in *Chapter 1: Warning signs*), even though information about some of them, at least, would have been in the PCT files.

7.103 Stuart Poynor candidly accepted, while recognising the disruptive effects of reorganisation, that the merger was a lost opportunity for the system to take stock and collate all the relevant information possessed by the legacy PCTs on each provider organisation:

> *The PCT recognises that the 2006 reorganisation was an opportunity for information held by a number of different organisations to be brought together, thereby creating new knowledge. In reality, however, unless reorganisation is well planned, it causes the loss of business continuity, organisational memory and relationships. Much of commissioning – and particularly soft intelligence – is based on relationships within the system, and requires trust to be established between commissioners and providers. If there is a continuous cycle of reorganisation, there is not enough time to recover from the loss of knowledge and to build relationships and trust.*[90]

7.104 Dr David Colin-Thomé's report on lessons learned for commissioners and performance managers, which was commissioned by the Secretary of State for Health following the HCC investigation, suggested that the reorganisation had led to a gap during the transition but that it did eventually become filled.[91]

7.105 Another key factor in the failure to act on poor quality of care was lack of continuity and handover between organisations when reconfigurations and staff changes took place. But hindsight suggests that despite the time involved in establishing the new organisations and the loss of corporate memory, the reconfigurations and merging of the three SHAs and the four PCTs in South Staffordshire has been effective in pooling expertise in the area and strengthening the management of the health system.[92]

7.106 This suggests that, in a reorganisation which will result in the loss of staff with knowledge, proactive and systematic steps need to be taken to preserve corporate memory, even if a different approach to the relevant tasks is to be taken in future.

7.107 The NHS Commissioning Board, building on the work of the National Quality Board in this regard, should develop and oversee a code of practice for managing organisational transitions, to ensure that those passing over the reins of organisations such as the SWSPCT in future are

90 Poynor WS0000014350–1, para 295
91 CURE00330017469, *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation* (29 April 2009) Thomé
92 CURE00330017474, *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation* (29 April 2009) Thomé

both candid and comprehensive in their handover. This code should cover both transitions between commissioners, for example as new clinical commissioning groups (CCGs) are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers. Whilst any approach cannot be too formulaic, as the particular issues that require highlighting will inevitably vary from one organisation to another, the note on the desk must never suffice.

South Staffordshire Primary Care Trust

Workload

7.108 From November 2006, Geraint Griffiths, formerly a chief executive of various PCTs, became Locality Director for half of the area of SSPCT. In this role, he worked as:

- Lead commissioner for the Trust;
- Associate commissioner for the University Hospital of North Staffordshire and three other provider trusts, together with other hospitals accessed by GPs in his area;
- Lead director in developing three PBC consortium and four non-consortia practices totalling 63 GP practices;
- Link director to three local authorities and their overview and scrutiny committees;
- Link director to three social services departments;
- Link to the South West Staffordshire branch of the Local Medical Committee (LMC);
- Lead director for the development of a new health centre.[93]

7.109 To assist him in these many roles, he had eight managerial staff, a management accountant and administrative support.[94]

7.110 This suggests that only a limited time could have been spent on monitoring the Trust: there were many organisations for which SSPCT was responsible and, as will be seen, considerable pressure from the amount of work arising out of the difficulties in getting formal agreements in place.

Clinical expertise

7.111 Part of the problem may have been a lack of clinical expertise at SSPCT. Dr Val Suarez suggested that the PCT was not receptive to the Trust's problems and she did not feel that it understood issues if she raised them.[95]

7.112 While Ms Sawbridge was a registered nurse, and there was access to a number of GPs, none of the non-executive directors had clinical experience. A medical director, Dr Ballard, was not appointed until September 2007, nearly a year after the SSPCT was formed. However, he was

93 Griffiths WS0000014855–856, para 27
94 Griffiths WS0000014856, para 28
95 Suarez T59.142–3

not given any responsibility for quality issues, and, as he pointed out, "The main driver for commissioning was financial."[96]

7.113 The Professional Executive Committee (PEC) was not fully appointed until November 2007, consisting of a mixture of general medical practitioners and other clinicians. Its first formal meeting was not until March 2008, by which time the HCC had announced its investigation. The focus of this committee was to act as an interface with local GPs. While that might have been expected to disclose any concerns about the Trust harboured by GPs, none was in fact expressed.[97] It is therefore improbable that getting this committee operational any earlier would have made any difference.

7.114 The general tenor of the evidence was that SSPCT did not have the clinical expertise within it to enable it to consider clinical issues in any substantive sense. Thus Dr Suarez told the Inquiry that the Trust would not generally have thought of approaching the PCT for help over clinical problems.[98] At a meeting between SSPCT and the West Midlands SHA (WMSHA) in May 2008 to discuss the implications of the HCC investigation, it was agreed that it was not realistic to have expected the PCT to assess providers' staffing levels. Mr Poynor told the Inquiry:

> *The expertise required to be able to do this at a specialty level was not available in the PCT. For example, I was concerned that if we were told there were two consultants in A&E, this would not necessarily raise concerns for us. The level of expertise within a PCT has to cross many functions from primary care to acute care, dental, renal dialysis etc.*[99]

Role of practice based commissioning consortia and general practitioners

7.115 From the beginning of its existence, SSPCT allocated notional budgets to the PBC consortia. SSPCT entered into one contract only with the Trust but it would agree a strategy with the consortia and would involve GP representatives of the consortia in the negotiations. The GPs could lead on aspects of the discussions if they wished to. Their presence could facilitate changes in pathways and procedure to the benefit of patients. They were able to voice their concerns about the delivery of clinical letters and were instrumental in a term about these appearing in the 2008/09 contract.

7.116 In addition, the consortia would meet with the Trust at both executive and clinical level.[100] They did not necessarily share what had been discussed with the PCT, but there is no suggestion that anything of concern was held back in relation to these meetings.

96 Ballard WS0000040620, para 12
97 Ballard WS0000040622–26, paras 22–38,
98 Suarez T59.122–24.
99 Poynor WS0000014333, para 220
100 Griffiths WS0000014866, para 62

7.117 SSPCT also had frequent contact with the GPs of the area through the LMC, and through visits made by Mr Poynor to practices.

7.118 It is clear that, apart from the clinical letters issue, no substantive concerns about the Trust were voiced by the consortia or otherwise by GPs to the SSPCT until after the announcement of the HCC investigation. In April 2008, Mr Poynor formally asked the PBC consortia for Stafford and Surrounds and for Cannock Chase for their views on the Trust, as a result of which each held a meeting of their GPs. In each case, a majority of GPs expressed concerns about the quality of care received by their patients. The complaints included poor nursing care, low levels of nurse staffing and inadequate out of hours cover in A&E.[101]

7.119 Dr Roger Beal, who had been the SWSPCT PEC Chair, had developed concerns about leadership, staff numbers and morale in the Trust's A&E while working there between January and March 2008. He only expressed these concerns to the PCT when Mr Poynor visited his practice in April 2008.

7.120 None of these matters had been raised by the GPs before.[102] Geraint Griffiths expressed considerable surprise that this was the case:

> *From my role as Locality Director, probably the most difficult area on which to reflect is why the matters highlighted by the HCC had not been recognised by the GPs. I have been a senior leader in primary care for ten years prior to joining South Staffordshire PCT, in organisations which were regularly commended for close GP working. I had good relationships with both consortia in Staffordshire and regularly met with the Consortia leaders and their constituent practices. It is more than surprising that the views expressed in their letters to the PCT in April 2008 did not come out in any of those discussions. The GPs I have spoken to subsequently felt that by feeding back to hospital consultants directly they had taken the action they felt was appropriate and that they did not consider reporting to the PCT.*[103]

7.121 It appears there were a number of reasons why the GPs' concerns were not communicated earlier:

- GPs tended to communicate issues concerning their individual patients directly with the Trust's consultants who dealt with them.[104]
- A large proportion of local GPs were not actively engaged in the consortia.[105]

101 GG/28 WS0000015545–51
102 Griffiths WS0000014886, para 131
103 Griffiths WS0000014917–8, para 253
104 Beal WS0000040518, para 49; Griffiths WS0000014867, para 66
105 Griffiths WS0000014853, para 21, WS0000014862–350–51

- Quality issues do not appear to have been discussed regularly at the LMC, which, in the view of the PCT, focused on concerns of GPs about their terms and conditions of service.[106] In any event, relations between the PCT and the LMC may not have been very good.[107]
- Individual practices would deal with complaints and expressions of dissatisfaction or other problems relating to individual patients on a case-by-case basis and did not analyse them in any way.[108] Nor were they asked to do so by the PCT.
- The consortia had no system for collating complaints or matters of concern or indeed for encouraging GPs to raise them.
- GPs may have been unclear as to the routes by which to communicate with the PCT.[109]
- They did not connect their participatory role in the commissioning process with the information they were picking up from their work with patients.[110]

Engagement with patients and the public

7.122 The PCT experienced difficulty in engaging patients and the public. This was due, in part, to the low profile PCTs had with the public. It had no interaction with the Trust's Patient and Public Involvement Forum (PPIF), and had difficulties in attracting members for its own.[111]

7.123 It sought to address these problems by setting up a strategic public engagement committee and by running road shows. Neither of these steps brought much success.[112]

7.124 An indication of the lack of knowledge the SSPCT had of public and patient opinion was that it did not become aware of Cure the NHS (CURE) until the Trust meeting it attended in March 2008. Shortly afterwards, SSPCT officials met representatives of CURE at a public house to listen to complaints of its members. This was the first time that they became aware of the gravity and extent of the complaints being made about the Trust.[113]

7.125 Among the reasons suggested for these problems were:

- Understanding of public perception being made difficult by a lack of useable data;
- Difficulties in establishing a recognisable identity owing to the constant reorganisations;
- Lack of public understanding of what a PCT was and did.[114]

106 Griffiths WS0000014863, para 54
107 Ballard WS0000040640, para 87
108 Poynor WS0000014328, paras 192–3
109 GG/3 WS0000014935; Griffiths WS0000014866, para 62
110 Griffiths T63.136–7
111 Griffiths WS0000014909, para 219, Poynor WS0000014302, para 91
112 Poynor WS0000014320–1, paras 161–162
113 Griffiths WS0000014912–3, para 235; Poynor WS0000014321, para 163; Poynor WS0000014323, para 171
114 Poynor WS0000014302–3, paras 90–92; Poynor WS0000014352, paras 299–300

7.126 None of these reasons prevented the PCT from being more active in seeking out information about the experiences and views of local people, and as much was accepted by Mr Poynor in his evidence:

> *I have to accept that we did not broadly or widely engage with the public during this time ... As an embryonic organisation the PCT was not geared up to actively seek patient opinion.*[115]

7.127 However, laudable as this self-critical and candid attitude is, the root of the problem lay in the virtual chaos caused by reorganisation and the challenges of ensuring continuing arrangements for services while setting up new organisations. It was inevitable that it would take some time to set up working arrangements for contact with the public. A lesson for any future reorganisation is that it is important to have in place workable systems for this contact at the time a new organisation begins business.

South Staffordshire Primary Care Trust approach to quality

Appointment of a director of quality

7.128 At the outset, Stuart Poynor appointed a Director of Quality and Performance, Yvonne Sawbridge. His intention was to provide a focus on the development of quality monitoring and improvement.[116] The challenge facing her and the organisation was that, in spite of the existence of a clear obligation in that regard, they were having to start from scratch:

> *In 2006 there was clear policy intent to develop the role of commissioners. This included broadening out the measurement of quality from Key Performance Indicators to measures more relevant for patients. However, there was no road map that set out how a PCT could do this and no agreed national indicators.*[117]

7.129 She agreed that it felt as though they were starting from a blank sheet of paper. While the announcement of World Class Commissioning had succeeded in developing policy into a framework, they were not given an idea of what competences were required to achieve the goals of that programme until October or November 2007. She also had limited staff to support her in undertaking the necessary work: two in 2006 and four by 2011.[118]

Reliance on self-declarations and compliance with targets

7.130 SSPCT wanted to develop its own methods of measuring the quality performance of providers, but, for the reasons given above, this did not progress very far during the period under review. Therefore, it relied heavily on the results of the HCC's Annual Health Check (AHC) and

115 Poynor WS0000014348, para 283; WS0000014352, para 300
116 Poynor WS00000142, paras 42
117 Sawbridge WS0000013395, para 20
118 Sawbridge T64.21; Sawbridge WS0000013397, paras 27–28

performance against national targets, although the latter could amount to no more than proxy indicators.

7.131 While Mr Poynor and his colleagues believed at the time that the AHC was capable of providing appropriate assurance, he now recognised that was not the case:

> *Looking back now, I can see why the HCC's AHC would not highlight any clinical care issues on the ground. The AHC is an assurance process which is very much paper based evidence, and is predominantly about policies and procedures. However, while I may be sceptical of the AHC process, this was the standard system for assessment within the NHS at the time. In hindsight, I would be surprised if many people thought that the AHC was a robust system.*[119]

7.132 Ms Sawbridge told the Inquiry:

> *The quality agenda nationally was still being developed in 2007 ... It was unable to provide an effective safety net within the system should a Board fail in its statutory duty to govern its own services.*[120]

7.133 Her understanding of the system's expectations at the time was that the PCT was entitled to rely on self-declarations as being correct. Had it been thought that it was required to do more, it would have needed more staff.[121]

Monitoring quality

7.134 SSPCT sought to monitor the quality of service through the quarterly review meetings held with the providers. It was also able to attend Trust internal meetings, such as the Executive Governance Group.

7.135 Since October 2008, the SSPCT's Integrated Governance Committee has become the Quality and Safety Committee, meaning there is an increased clinical representation. The committee, which reports directly to the SSPCT Board, receives monthly quality reports on its providers. It reports on themes and trends of complaints, adverse incidents and serious untoward incidents (SUIs), infection rates, mortality statistics, Patient Advice and Liason Service (PALS) contacts and compliance with the quality obligations under the contract.[122]

7.136 The scrutiny of the Trust has increased considerably following the HCC report, as detailed below.

119 Poynor WS0000014312, para 128
120 Sawbridge WS0000013404, para 52
121 Sawbridge T64.13–14
122 Sawbridge WS0000013442, para 180

Commissioning interaction with the Trust

South West Staffordshire Primary Care Trust

7.137 There was a history of longstanding concern on the part of SWSPCT and its predecessor, the Stafford PCG, about the leadership of the Trust.

Concerns in 2001

7.138 In 2001, William Price and Dr Roger Beal (then Chief Executive and Chair of the Stafford PCG respectively) reported to the board of the PCG expressing the view that the chief executive of the Trust should be replaced. The report was forwarded to the then South Staffordshire Health Authority and onwards to the NHS Executive in the West Midlands. This episode is described in more detail in *Chapter 1: Warning signs*. Such concerns continued to be harboured in 2004, when Mr Price, by then Chief Executive of SWSPCT, complained that no one from the Trust attended a PCT meeting to discuss issues of compliance with national targets, which led him to consider the Trust's management to be arrogant and unwilling to engage with the PCT.[123]

7.139 As a result of these concerns, SWSPCT did not support the Trust's first attempt to develop an application for FT status in 2004. It felt that the Trust had not engaged properly with the PCT over strategy and lacked "maturity". There was also continuing and unresolved dissatisfaction among local GPs about the time taken to send out clinical letters. SWSPCT did not discuss its views about this with the SHA because the Trust withdrew from the FT application process before the PCT's annual review meeting with the SHA took place.[124]

Commission for Health Improvement clinical governance review 2002

7.140 In spite of these issues, it does not appear that SWSPCT harboured any specific concerns about the standard of clinical care. It had been aware of the critical Commission for Health Improvement (CHI) governance review in 2002 (see *Chapter 1: Warning signs*), but it is not clear what action the PCT took about this, over and above Mr Price telling the Inquiry that there were conversations with the Trust and probably an approach to the then health authority about it.[125] Passage of time makes it understandable that witnesses would be unclear of the detail of actions at that time.

Loss of stars 2004

7.141 The SWSPCT was also aware of the Trust's loss of all stars in its 2004 AHC. However, this did not raise the level of concern felt by the PCT. Mr Price told the Inquiry:

123 Price WS0000016117–8, paras 57–62; WP/1 WS0000016136–42; WP/2 WS0000016152–4; Beal WS0000040514–6, paras 33–40
124 Price WS0000016123–4, paras 85–89
125 Price T94.16

I did not consider this drop in star ratings to be a reflection of quality of care provided at the Trust. We were already dealing with missed targets as an administrative issue and were well aware that the star rating would drop as a result.[126]

7.142 The detail of the concerns which caused the loss of stars, and the briefing given to the Minister, is described in *Chapter 1: Warning signs*. As with SaSSHA and the DH, it did not occur to the PCT that these concerns could have implications for patient safety and the standard of care, even though they believed that senior management was lacking in competence. Indeed, the PCT appears to have been largely disengaged from considering issues of quality at provider trusts. Mr Price told the Inquiry:

As far as I am concerned if the Trust had had any issues they would have gone straight to the SHA. If something was really serious the Trust and the SHA would have possibly contacted the HCC, but we would not have been involved in this process and were usually the last to hear about any issues.[127]

Trust's staff reduction proposals 2005

7.143 SWSPCT was aware in general terms of the Trust's intention to reduce its staff head count in 2005. Susan Fisher told the Inquiry that she was aware of the plan, but accepted an assurance from the Trust that it largely involved removing already vacant posts. She suggested there was little she could have done about this.[128] However, she did intervene to the extent of suggesting at a meeting on 15 June 2005 that clinical changes needed further explanation in the Trust's financial recovery plan.[129]

7.144 The general attitude of SWSPCT was clear from Mr Price's evidence:

The PCT were not involved in the detail of the internal discussions in relation to the redundancies however, in hindsight, perhaps we should have asked more questions about whether the redundancies would potentially affect the service level at the Trust.[130]

7.145 Mr Price was clearly correct to make this concession.

2006 children's services peer review report

7.146 In spite of that general statement, Mr Price did believe that it would have been the PCT's responsibility to follow up the West Midlands NHS Specialised Services Commissioning Group's 2006 peer review report on the care of critically ill and critically injured children at the Trust if it received it. The concerns raised by this review, which was intended to have been copied to

126 Price WS0000016133, paras 127–8
127 Price WS0000016113, para 37
128 Fisher WS0000042309, para 48
129 WP/10 WS0000016238
130 Price WS0000016128, para 107

SWSPCT,[131] and the communications with the SHA are described in *Chapter 1: Warning signs*, as is the evidence of Mr Price and Mr Poynor about it. Essentially neither recalls ever seeing the report and there is no available documentary evidence to suggest it was in fact received by the PCT at all.

7.147 For whatever reason, no action was taken at PCT level about it. This is, at first sight, extraordinary, given the theoretical responsibilities of PCTs for quality, and the fact that this form of peer review was, in effect, jointly commissioned by the PCTs. As concluded in *Chapter 1: Warning signs*, it is not possible to attribute responsibility to any individual, but there must have been a communications failure which resulted in this important report not being seen by PCT officials. It is likely that the PCTs both old and new would have taken some form of action if aware of this report. The failure of communication which deprived them of the opportunity to do so may have been caused by the lack of clarity over responsibility for following up this type of report.

Cannock Chase Primary Care Trust

7.148 The approach of CCPCT, which in any case allowed SWSPCT to lead in the commissioning relationship with the Trust, was little different. Jean-Pierre Parsons, CCPCT's Chief Executive from 2002 to 2006, said:

> *I would agree that the relationship with the Trust was very target focused; we agreed the targets as set out by the Department of Health and monitored them. We had sporadic communication with the Trust if there were particular issues that came up, but otherwise there was little contact.*[132]
>
> *... I do not think that quality was ignored. However, it is hard to put my finger on exactly how quality did feature. There was an element of monitoring the various standards that the Trust was achieving. For example, the CCPCT did monitor the previous star rating.*[133]
>
> *... [T]here was informal liaison between the PCTs and the Trust in relation to quality standards ... Liz Onions ... Director of Provider and Nursing Standards ... would have meetings with Jan Harry, the former Director of Nursing at the Trust. I would like to think that these meetings would have included discussions about any current clinical governance concerns.*[134]

7.149 With regard to the Trust's initial application for FT status, Mr Parsons was, unlike his colleagues at SWSPCT, prepared to support it. He felt it should be supported unless there was an "overwhelming" reason not to.[135]

131 CJE/3 SHA0041000468–9
132 Parsons WS0000077422, para 20
133 Parsons WS0000077423, para 24
134 Parsons WS0000077424, para 27
135 Parsons WS0000077431, para 56

7.150 CCPCT was aware of the proposals to cut staff to assist in the Trust's financial recovery plan in 2005, but there is no evidence that it considered whether these proposals raised issues of concern with regard to the quality of the service.[136]

7.151 Martin Yeates, the Trust's Chief Executive, made a favourable impression on CCPCT on his arrival and recognised the need to make changes.[137] He made Mr Parsons aware of the unfavourable children's service review carried out by the HCC in August 2006, just before the merger. Mr Yeates' letter sought to explain the rating by reference to issues with data and this development does not seem to have made much of an impression on Mr Parsons, who told the Inquiry that he may well have thought there was not much that could be done at the time, as the HCC had already given its rating.[138]

7.152 In general, like so many others, Mr Parsons thought that his PCT relied on others, in particular the HCC, to alert it to problems in the context of there being "a high degree of trust in the system".[139]

2004/05 contract

7.153 CCPCT signed the contract with the Trust for the year 2004/05 in October 2004. Mr Parsons could not recollect why it had not been signed until so long after the beginning of the relevant year. This was, he said, "extremely late and unusual".[140]

7.154 The agreement had a term of one financial year, but was stated to "make specific" the financial and activity "structures" for 2005/06 and to give indicative parameters for 2006/07. It provided for a block contract sum of £42,572,000 for 2004/05 and for a similar sum the following year, most of it being attributed to an agreement on cost and volume case mix.[141]

7.155 It contained terms as to quality, delivery, monitoring and information, very similar to the 2006/07 contract considered below. A schedule identifying who was responsible for managing risks and how they were to be managed included the risk of underachieving planned activity, but no risk associated more directly with safety or quality.[142]

The draft 2006/07 contract

7.156 Neither CCPCT nor SWSPCT succeeded in finalising a written contract with the Trust for the year 2006/07 before they were merged into SSPCT in October 2006. An unsigned draft agreement

136 Parsons WS0000077436, para 75; JPP/12 WS0000077532
137 Parsons WS0000077441, para 91
138 Parsons WS000007744, para 101
139 Parsons WS0000077447, para 116
140 Parsons WS0000077434, para 65; JPP/9 WS0000077480
141 JPP/9 WS0000077504
142 JPP/9 WS0000077515

between CCPCT and the Trust was produced by the PCT to the Inquiry.[143] It is presumed that the terms proposed for the SWSPCT agreement were similar.[144]

7.157 Geraint Griffiths told the Inquiry that, at the time SSPCT took over commissioning responsibility – and indeed at the time he became Locality Director in November 2006 – there had been no signed contract in place between either of the predecessor PCTs and the Trust, although this process should have been completed in February 2006.[145] He told the Inquiry this was very unusual and was something for which a PCT chief executive would normally be criticised by the SHA.[146] Susan Fisher of SWSPCT believed there must have been a signed contract, as failure to have one was a "sackable offence".[147] As stated above, Mr Parsons of CCPCT said it was "extremely late and unusual" for agreements to remain unsigned for so long.[148] On the other hand, Philip Taylor, formerly Director of Performance and Finance at SaSSHA, disagreed:

> *... annual SLAs between NHS bodies were often unsigned long after a financial year had begun. That was commonplace and not a subject that would have prompted any kind of urgent call to a Director of Finance.*[149]

7.158 In spite of Ms Fisher's understandable incredulity, there is no evidence before the Inquiry that the contract was ever signed, and the difficulties to which Mr Griffiths testified, taken with the general tolerance described by Mr Taylor, were strong confirmation that it was not. It appears from Mr Taylor's evidence that this would not have been a matter of concern to the SHA at the time. This was perhaps particularly the case given the general preoccupation with the reorganisation.[150]

7.159 Even if signatures on a piece of paper were required, it is clear that the contract was often regarded as a provisional estimate rather than a concluded agreement. Mr Griffiths described the somewhat informal commissioning practice prevalent at that time:

> *... it was common practice for Chief Executives to "shake hands" at the start of the year on what they thought would be paid but this nearly always ended up being the subject of negotiation at the end of the year. If, at the end of the year, the PCT could not afford to pay the sum, or the parties could not agree on the sum to be paid, then the matter could be referred to the SHA for resolution through arbitration, albeit this was a last resort. The first thing the SHA will ask to look at is the contract to see what has been agreed previously.*[151]

143 GG/6 WS0000014942
144 TRUST00030012190, *NHS Service Level Agreement between SWSPCT and the Trust* (2005–2006)
145 Geraint Griffiths WS0000014868, para 69
146 Geraint Griffiths WS0000014868, para 70
147 Fisher WS0000042311, para 53
148 Parsons WS0000077434, para 65
149 Taylor WS(2) WS0000056082, para 15
150 Geraint Griffiths WS0000014868–9, para 73
151 Geraint Griffiths WS0000014869, para 71

7.160 The draft contract between CCPCT and the Trust for 2006/07 was for a value of nearly £45.5 million a year and for a period of three financial years starting on 1 April 2006, but terminable within that period by either party on 12 months' notice. The service requirements were to be reviewed annually.

7.161 Even though the agreement was only draft, it is instructive to consider its terms. The contract contained some terms that appear to specify standards and monitoring of safety and quality.

7.162 The specification of services (schedule 1) included maximum waiting times for inpatients, day cases, cancer diagnosis and referral for treatment, angiography and diagnostic tests.[152]

7.163 Clause 5 required the provider to:

> *... carry out the Services in accordance with best practice in health care and ... comply in all respects with the standards and recommendations;*
>
> *5.1.1. contained in the Statement of National Minimum Standards;*
>
> *5.1.2. issued by* [the National Institute for Health and Clinical Excellence]; *or*
>
> *5.1.3. issued by any relevant professional body;*
>
> *5.1.4. from any audit and Adverse Incident Reporting;*
>
> *and such other quality standards agreed in writing between the Parties.*

7.164 The clause further required the provider to ensure that:

> *5.21* [sic] *All Staff employed or engaged by the Provider are informed and aware of the standard of performance they are required to provide and are able to meet that standard;*
>
> *5.22* [sic] *the adherence of the Provider's Staff to such standards of performance is routinely monitored and that remedial action is promptly taken where such standards are not attained.*
>
> *5.23* [sic] *Adherence to current guidance on infection control in relation to MRSA reduction and any other such requirements are fully complied with and reported to the PCTs where required.*

152 GG/6 WS0000014957

5.24 [sic] *appropriate arrangements are in place to carry out patient satisfaction surveys at reasonable intervals in relation to the Services and will cooperate with any such surveys as may be carried out by the Commissioner ... Mechanisms are in place, which identifies* [sic] *improvement on the 5 key dimensions of the patient experience as measured by the national patient survey programme and other intelligence (complaints, PALS, risks).*

5.3 For the avoidance of doubt nothing in this agreement is intended to prevent this Agreement from setting higher quality standards than those laid down under the Provider's Terms of Authorisation.[153]

7.165 Clause 7 laid down requirements for the service environment, for example, that it be suitable and sterile, conforming to the "highest standards of health and safety".[154]

7.166 The agreement laid down various information requirements, including the following:

- Compliance was required with NHS minimum datasets and various other named standards. The specified information, set out in schedule 5, related principally to data covering access to treatment and activity-based financial flows;
- The provider was required to notify the commissioner "immediately" of any SUI, and within 24 hours of any "adverse patient incident", to cooperate with any investigation by the commissioner and to carry out its own investigation into patient incidents;
- The results of any clinical audit, evaluation, inspections, investigation or research undertaken by or for the provider into the quality of the services were to be provided on request;
- Disputes were to be resolved by local negotiation by the parties, using the SHA as a facilitator where appropriate.

7.167 What is remarkable to the legal eye, more accustomed to legally enforceable contracts, is the absence from this document of any provision for a routine flow of information relevant to quality and safety performance (it having to be requested) or any provision for the consequences to flow from a breach of the requirements of the agreement. A legally binding contract might give rise to a right to claim damages for losses suffered or a right to terminate for repudiation and so on. However, even these remedies would be regarded in the commercial world as insufficient in an arrangement involving such complexity as hospital services to non-parties.

7.168 It is not clear from the evidence how the parties regarded this agreement, given that it was not signed, but services continued to be provided. It cannot have been conducive to good management of the commissioning relationship with the Trust and it is a matter of surprise

153 GG/6 WS0000014946
154 GG/6 WS0000014947

that the position was not regularised shortly after the beginning of the financial year, if not before. It is an indication of the immaturity of the concept of commissioning that the absence of a completed agreement does not appear to have been taken more seriously.

South Staffordshire Primary Care Trust

2006/07 contractual issues

7.169 As noted above, at its inception, SSPCT was immediately faced with the issues raised by the absence of a concluded commissioning agreement with the Trust, in relation to commitments which accounted for a substantial part of its budget. These difficulties were made even more challenging by the financial difficulties facing SSPCT, including the fact that the PCT was in deficit, and its problems in reconciling the results of Payment by Results (PbR) calculations with what could be afforded at the time.[155] PbR was introduced in 2003 and by 2006/07 had been extended to cover most areas of the contract process. Under PbR, national tariffs were set for different diagnoses and procedures, allowing a patient to be treated anywhere in the country for the same price. Providers coded patients according to their condition or the procedure they had undergone, with PCTs then paying the set price for this activity. The purpose was to enable money to follow patients more easily and to introduce greater transparency into NHS finances, which had previously been determined largely through block contracts. The difficulty of this system was that contractual calculations had to be based on a best estimate of what services would be required in the coming year and would often require renegotiation based upon the reality of what services had actually been provided and the PCT's ability to pay those costs.[156]

7.170 Mr Griffiths and his colleagues were faced with having to address these issues without there being in place any formally agreed reference point with regard to what services the Trust had been commissioned to provide, and the basis on which it should be paid. One of the issues which preoccupied them was a continuing dispute over what amount should be deducted from the sums due to be paid for the Trust's failure to comply with the expected standards for the delivery of clinical letters. As at January 2007, the PCT was claiming repayment of £2.8 million, presumably relying on the terms of the unsigned agreement.

7.171 The dilemma faced was that the PCT did not wish to take action which could destabilise the Trust financially, at a point when it was already in financial recovery. At an SSPCT Board meeting on 31 January 2007, the Board agreed that:

155 Griffiths WS0000014869, para 74
156 Griffiths WS0000014869, para 74 and paras 88–89

... Stuart Poynor would continue with negotiations with Martin Yeates, Chief Executive of Mid Staffordshire Hospitals NHS Trust to reach a settlement which would not jeopardise the financial position of the PCT and also the Foundation status of the Trust. However, it was NOTED that there was a need to drive forward improved performance by the Trust on patient letters and ensure that inappropriate delays do not take place.[157]

7.172 For a time, it was thought that the issue might have to be referred to the SHA for arbitration, but, in the end, a settlement was reached involving a more favourable financial outcome for the Trust and avoiding destabilisation. As Mr Griffiths put it:

Clearly it was not in our interests to do anything to destabilise our provider and so we would try to find a solution that we could both live with.[158]

... the key driver is to get them to rectify the poor performance. So what ... if I put in a 2.8 million penalty on the trust, they fail their statutory duties or they have to take out services because of financial pressure, it doesn't help resolve the outcome.

... I mean, in theory over time what we could do is build up alternative providers to deliver the care, but probably not in Stafford. So, in theory, we could under a market system move the activity to Stoke, to Wolverhampton, to Burton-on-Trent, but one of our other duties is to meet the needs of the local population. And I don't think our local population would necessarily have thanked us for destabilising this trust and moving their care sort of ten/12 [sic] *miles away.*

... I'd agree it's not a true market system. What I think you've got to have is enough levers and potential penalties on the trust that gives you a lever to make the change happen. Now, what we saw during 2006/7 and this whole negotiation on clinical letters is the trust absolutely came to the table. We looked at the system for delivery of the letters. We did see a short-term improvement in delivery. Some of ... it was sustained but not to the level we'd want. So I think ... part of the levers in the contract is to put a big enough pressure on the trust to make them resolve the outstanding action, but not so big a pressure on the trust that you ultimately destabilise them and risk the delivery of patient care. And that's why it tends to be more a negotiation than it does an absolute penalty imposition.

... we have to make sure that the range of services that the population needs to receive is available, and that's why, in some cases, it might feel that we work with local trusts beyond that [sic] *... you may deem reasonable, because it is in our interests to get a*

157 GG/7 WS0000014977
158 Griffiths WS0000014870, para 77

sustainable solution with that local provider, rather than move the service somewhere else completely, or destabilise it to the fact [sic] *that the trust say "We don't want to run that service any more".*[159]

7.173 The result of the negotiation appears to have been that there were no adverse consequences for the Trust resulting from its failure to comply with the required standards for clinical letters. The Inquiry was told that there was a temporary improvement in this area, but that this was not maintained.[160]

7.174 This evidence points to a fundamental challenge that commissioning processes have to confront if they are to be effective. When faced with non-compliance with obligations under such agreements, the remedies available are limited. The option of enforcing the strict financial consequences, even of an undisputed breach of the terms of the agreement, will often be theoretical. A commissioner often cannot afford to run the risk of taking a service away or levying a financial penalty because this will jeopardise the continuity of service provision. There will often be no alternative potential providers of services, or, if there are, none which the local community and its political representatives will accept.

2007/08 contract

7.175 Apart from the preoccupation with sorting out, retrospectively, the arrangements with the Trust for 2006/07,[161] SSPCT had to negotiate a contract for the following year, 2007/08.[162] This was negotiated in parallel with the continuing discussions about the current year.

7.176 The 2007/08 contract was eventually signed in February 2007, a mere month before it was due to take effect. This would have been regarded as normal at the time.[163]

7.177 The contract terms were different to those considered above for 2006/07, following the introduction of an NHS contract for acute hospital services in February 2007. The central tenet of the arrangement was an Activity Plan which defined the type and quantity of services provided, and the means of monitoring activity levels and varying them in response to changing needs.

7.178 Both provider and commissioner were obliged by clause 6 of the agreement:

- To meet and maintain national quality standards and any other national quality requirements that might, from time to time, be specified;

159 Griffiths T63.100–108
160 Griffiths T63.44; Griffiths WS0000014881, paras 112–113
161 GG/11 WS0000014992
162 EAK/4 WS0000021775
163 Kelly T75.42

- To agree local quality improvements of health and well-being;
- To comply with locally agreed targets for MRSA and *C. difficile*;
- To maintain targets relating to national waiting time and other access targets.

7.179 The national standards referred to included *Standards for Better Health*, National Institute for Health and Clinical Excellence (NICE) technology appraisals (as part of the core standards) and NICE clinical guidelines and National Service Frameworks (which were part of the developmental standards).[164]

7.180 Commissioners were entitled to "seek assurance" from providers that they would performance manage each clinical service using clinical audit against key standards and during 2007/08, the year of the contract:

> *To implement or work towards the development for implementation appropriate outcomes and output based KPI* [key performance indicators].[165]

7.181 The aim of such indicators was to "promote the delivery of evidence based safe patient care whilst promoting innovation in clinical and service practice".[166]

7.182 It was also agreed that the commissioners would "look for evidence" that performance indicators and clinical audit had been used in the performance management of the provider's clinical services.[167] The parties were to "discuss and agree" the information flows required to monitor compliance with these obligations and such requirements were to be added to the agreement.

7.183 Gary Belfield, who was Director of Commissioning at the DH at the time, agreed that these terms, taken from the national template, indicated that the DH recognised that PCTs were likely to be unable to include locally devised quality metrics in that year's contract.[168]

7.184 Dr Rashmi Shukla, Medical Director at the WMSHA, told the Inquiry that the contract was silent on the issue of nationally determined quality metrics of which none were available at the time, and that this led the SHA to work to support PCTs in identifying what metrics, would be useful.[169]

164 Griffiths WS0000015011, clause 6.3; OTHER0000000291, *Standards for Better Health* (2006) Department of Health, page 11 – the HCC Criteria for Assessment for 2006/07 said that clinical guidelines fell within the core standards.
165 GG/11 WS0000015012, clause 6.11
166 GG/11 WS0000015012, clause 6.13
167 GG/11 WS0000015013, clause 6.14–16
168 Belfield T124.34
169 Shukla T69.36–37

7.185 Compliance monitoring was an obligation of the provider, which was required to report failures of compliance to the commissioner.[170] Commissioners were entitled to issue a contract query to the provider in relation to performance, which had to be replied to within 14 days.

7.186 Where the commissioner had "reasonable evidence" that performance "fails to meet" the requirements of the agreement, including compliance with quality standards, the commissioner was entitled to issue a performance notice. If there were unremedied breaches of the agreement, a warning notice could be issued requiring a remedial action plan.

7.187 These terms, which came the closest to provisions for enforcing the contract or providing a remedy for breach, were felt to be the best the PCT could require in the absence of a national requirement for a provision allowing financial penalties to be included.[171] Gary Belfield, of the DH, agreed that these remedies, based on national guidance, were far less forceful than those available for breach of a financial or access target. He also explained that the purpose of the national template, which was not mandatory that year, was to help even up the negotiating balance, which was still tilted in favour of providers because of their strength and experience.[172]

7.188 As with the earlier agreement, there was a mutual obligation under clause 7 to exchange specified information.[173] This included any nationally required information, relating to actual performance against stated forecast. The information required under this heading included:[174]

- Weekly UNIFY reports, which related to referral to treatment times, inpatient and outpatient activity, waiting time profiles and cancelled operations;
- Data on patients awaiting elected admission to hospital by way of either a waiting list or a booked admission, including those who had chosen to defer their admission;
- Data on how long it took various classes of GP-referred and non-GP-referred outpatients to receive their first appointment with an outpatients attendance consultant, measured in bands of 13–17 weeks, 17–21 weeks, 21–26 weeks and over 26 weeks;
- Monthly *Diagnostics, Waiting Times and Activity*, measuring diagnostic waits and activity with a view to monitoring progress made towards delivery of the 18-week target;
- Monthly returns monitoring achievement of the target that all patients should be seen by a genito-urinary medicine specialist within 48 hours, with a view to reducing the spread of HIV and other sexually transmitted diseases;
- Monthly data on waiting lists in relation to inpatients, outpatients, diagnostics and 18 weeks referral to treatment times, as well as commissioning datasets providing data related to outpatient care, admitted patient care and A&E care.

170 GG/11 WS0000015015–6, clause 9
171 Griffiths WS0000014875, para 92
172 Belfield T124.33–35
173 GG/11 WS0000015013, clause 7
174 GG/11 WS0000015021

7.189 A return relating to the progress of the Local Delivery Plan (LDP) was submitted on a quarterly basis.

7.190 These provisions, unlike those described in clause 6 (see above), were unlikely to impact on quality as such.

7.191 The 2007/08 agreement also provided for other information to be obtained:

> *It is recognised that CDS* [clinical data set] *flows have shortcomings in terms of enabling a full understanding of contract performance. In order to overcome this, the Provider shall supply further supplementary monitoring information, as necessary, to enable effective monitoring of all contract lines which are not adequately supported by CDS flows. Full details are set out in Appendix 3b.*[175]

7.192 The form of agreement included, at appendix 3, a space for such locally agreed data sets to be shared, but none was listed.[176] Eamonn Kelly, then Director of Commissioning at the WMSHA, expressed disappointment that no local metrics had been included in the agreement either at the outset or during the course of the year. He suggested that there were metrics – along with the relevant data – available to be used.[177]

7.193 It was theoretically possible for this obvious gap to be filled, as the commissioners were also entitled to make ad hoc requests for information not included in appendix 3 of the agreement. The provider was then obliged to state within one month whether the information would be provided, and, if not, the reasons for this decision. If the provider did agree to provide the information it was to give an indication of the timescale and the cost.[178]

7.194 A document describing the SSPCT's commissioning intentions[179] was said by Mr Griffiths[180] to have been annexed to the agreement, although it does not appear to be referred to in any term of the agreement. Therefore, its effect must be open to doubt. Indeed, the pressure of the timetable for concluding the agreement may have meant that it was considered to be more of a statement of intent, rather than a contract in the conventional sense. Mr Griffiths said:

> *Within the timescale of the negotiations this was viewed as a reasonable starting point to a process rather than being a conclusion. The PCT's position would not have been an outlier in national terms.*[181]

175 GG/11 WS0000015013–4, clause 7.10
176 GG/11 WS0000015023
177 Kelly T75.42–43
178 GG/11 WS0000015014, clause 7.15
179 GG/12 WS0000015050
180 Griffiths WS0000014874, para 90
181 Griffiths WS0000014874, para 90

7.195 Given the explicit recognition in the agreement that there were shortcomings in the existing datasets, it is indeed disappointing that the SSPCT did not, even at this early stage of its development, insist on including some local quality metrics, or at least a means of requiring them to be developed. Mr Griffiths told the Inquiry about the difficulties created by the lack of reliable information:

> *The main barrier to generating a clinically led work plan for the hospital was the lack of reliable information. This has been a consistent problem in the commissioning relationship with the Trust. In the absence of meaningful data, the areas prioritised for development were those where the hospital and community clinicians felt there was the largest potential for improvement, namely A&E, Geriatric linkages between hospital and community, reducing delayed transfers of care and rehabilitation for patients requiring health and social care support.*[182]

7.196 There was much that was unsatisfactory about the process of arriving at a commissioning agreement for this year. It must have been very difficult for the SSPCT to negotiate two years at once. This must have increased the pressure to do little more than adopt the national template. The agreement may have identified a process for agreeing the type and quantity of activity to be funded, but there seems to have been great scope for continual variation. This must have exacerbated the challenge not only of negotiating what was commissioned, but also of monitoring coherently the standard of what was being delivered. The pressures were such that it is not surprising that the SSPCT did not succeed in putting into place an effective scheme for monitoring and enforcing compliance with well thought out and useful measurements of safety and quality.

2008/09 contract

7.197 The terms of the contract with the Trust for 2008/09 represented a step change.[183] By this time the Trust had FT status and therefore the contract was legally enforceable through the courts, as recognised in clause 60, although referral to litigation was subject to obligations to seek alternative dispute resolution first (clause 28). With regard to the attention paid to quality obligations, it was a highly complex document running to nearly 200 pages, and what follows is intended to be an impressionistic summary, rather than a close legal analysis.

7.198 Not only did the 2008/09 contract set out more clearly and extensively the standards with which a provider had to comply, but the methods of enforcing compliance were made more sophisticated.

Standards

7.199 There were a number of notable features in the specification of standards within the contract:

182 Griffiths WS0000014876, para 98
183 GG/18 WS0000015114

- The provider was obliged to operate a consent policy in accordance not only with national standards and guidance but also with any code of practice notified by the commissioner (clause 9).
- The provider was required to implement "learning" from complaints and demonstrate at required reviews the improvements made as a result (clause 10).
- Sufficient staff were required to be employed to ensure services were provided in accordance with the agreement. The provider was obliged to ensure that all staff had proper training, appraisal and professional leadership commensurate with the services provided (cause 11).
- The provider had to participate in specified clinical networks and adhere to all protocols and procedures recommended by them unless they conflicted with protocols agreed between the parties (clause 12).

7.200 In addition to referring to national standards such as the Core Standards, the 2008/09 contract included, for the first time, locally agreed quality standards to be applied by the provider (clause 16). These were set out in a series of tables which were annexed to schedule 3 of the contract. Collectively, these tables were known as the "Quality Matrix".

7.201 The Quality Matrix was said to include the commissioning intentions of the commissioner.[184] It was intended to "Ensure high quality care for patients in the most appropriate setting, providing value for money for commissioners, patients and the public".[185]

7.202 The tables of the matrix contained:

- two "clinical quality performance indicators" (MRSA and *C. difficile* targets);[186]
- 36 "performance indicators";[187]
- nine of the third tier "vital signs" indicators (set out for the first time in the DH's Operating Framework for the NHS in 2008/09 and from which PCTs could select locally);[188]
- 48 "local requirements".[189]

7.203 In each case, a compliance rate was specified, usually 100%, as well as a method of measurement and an explanation of the consequence of breach. Not all the requirements were directly related to safety and quality, as opposed to access and quantity. However, requirements were included which concerned: the quality of clinical letters; an annual patient questionnaire (to include specified "outcomes" such as the "humanity of care"); and a requirement for 100% compliance with NICE guidance.

184 GG/18 WS0000015256
185 GG/18 WS0000015255
186 GG/18 WS0000015256
187 GG/18 WS0000015257
188 GG/18 WS0000015275
189 GG/18 WS0000015281

Information

7.204 Both the contract itself and the Quality Matrix set out measures intended to ensure that the commissioner had some relevant information to monitor performance. Those measures set out in the contract included the following:

- The provider was obliged to give the commissioner such information about its complaints procedure as the latter might reasonably require (clause 10).
- The provider had to notify the commissioner of the death of any patient on its premises (clause 14).
- Any notification to a regulator concerning a patient had to be copied to the commissioner, including SUI reports (clause 15).
- Any patient guide or written policy had to be provided to the commissioner on request (clause 17).
- The Trust was to comply with all reasonable requests for entry to the premises for the purposes of auditing, viewing, observing or inspecting it or the provision of services, made by, among others, the commissioning PCT (clause 19).[190]
- The results of any audit, evaluation, inspection, investigation or research in relation to the commissioned services had to be provided on receipt of a reasonable request from the commissioner (clause 19).[191]

7.205 The Quality Matrix also contained many requirements for the provision of, or access to, information. For example, the Trust was required to report:

- Any non-compliance with *Standards for Better Health* (matrix items 2.31 and 3.17);
- Any breakdown of activity at sub-specialty level in the monthly contract monitoring information (matrix item 2.32);
- A random sample of clinical letters, which was to be provided to each monthly commissioning meeting (matrix item 3.4);
- Any policies not compliant with NICE guidance (matrix item 3.26);
- Minutes of infection control meetings which were to be shared with the PCT (matrix item 3.40);
- National Patient Safety Incident reports at least once every quarter (matrix item 3.46).[192]

7.206 So far as the step change in the approach to reporting on quality is concerned, it seems that the most significant aspect of the 2008/09 contract was its clause 33.[193] It provided that each month, the Trust had to provide the PCT with a Clinical Quality Performance Report detailing its performance against the *clinical* quality performance indicators prescribed in the Quality

190 The Clause refers to "any NHS Authorised Person", which is defined in Schedule 1 to include the coordinating commissioner and any associated commissioner.
191 GG/18 WS0000015127–31
192 GG/18 WS0000015255
193 GG/18 WS0000015144

Matrix. However, the contract's shortcoming in this regard was that those indicators related to only two areas – MRSA and *C. difficile* targets, as stated above. Nevertheless, this was the first time that a contract had mandated that Clinical Quality Performance Reports be provided to the commissioner. These were required within 10 days of the month-end reporting deadline. Representatives of the provider and the commissioner were then to discuss them at a Clinical Quality Review Meeting which was to be convened within five days of the latter's receipt of the document. The review meetings were also to focus upon:

- Any SUIs or reports or investigations of SUIs;
- Any patient safety incidents or reports of patient safety incidents;
- Any patient deaths;
- Any information, notification or advice received from Monitor or any regulator, which related to or had a bearing upon the provider's provision of services.

7.207 Ultimately, the review meeting was entitled to reach conclusions as to: whether the provider had failed to meet the relevant quality standards; the extent of the provider's culpability in respect of any such failures; whether such failures had been resolved; and/or whether such failures were likely to recur. Unless such issues surrounding any failure could be "closed", the review meeting was to conduct a Joint Clinical Investigation into the failure in question and, if needs be, recommend a Remedial Clinical Action Plan. The efficacy and impact of such an action plan was then to be monitored at the next few months' review meetings.

7.208 In addition, the Trust was also required, through the Quality Matrix, to agree a programme of "quality visits" in collaboration with the PCT. These were to take place at least once a quarter (matrix item 3.47).[194]

Enforcement methods

7.209 The enforcement methods available to a commissioner varied according to the nature of the breach. For example:

- A breach of the requirements for *C. difficile* could lead to a financial penalty (schedule 3, para 9);[195]
- In contrast a breach of the MRSA requirement could lead to an improvement notice (matrix item 1.1);[196]
- Non-compliance with *Standards for Better Health* was to result in a report to the performance monitoring group and an action plan (matrix item 2.31);[197]

194 GG/18 WS0000015304–5
195 GG/18 WS0000015195
196 GG/18 WS0000015256
197 GG/18 WS0000015272–3

- Issues raised by the annual patient satisfaction questionnaire were also to be addressed with an agreed action plan (matrix item 3.9);[198]
- Known incidents of non-compliance with NICE guidance were to be referred to the monthly commissioning meeting (matrix item 3.26).[199]

7.210 Most significantly, perhaps, for the first time, the contract provided for an escalating regime of "contract queries", performance notices, warning notices, remedial action plans and, in the last resort, withholding of payment. This procedure could be followed in the case, among others, of non-compliance with *performance* indicators within the Quality Matrix, failure in the complaints handling process, intervention by a regulator likely to affect the Trust's ability to provide services and failure to discharge any other obligation in the agreement. (clause 32).[200]

7.211 Clause 33 also provided, in principle, for the withholding of payment in respect of failure to meet any Clinical Quality Performance Indicators set out in the contract. In the 2008/09 contract, these indicators related to MRSA and *C. difficile* and the application of clause 33 was limited by the provisions in the Quality Matrix. This stated that a breach of the MRSA target should be dealt with by way of an improvement notice, whilst failure to meet the *C. difficile* performance indicator should be dealt with by way only of an exception report or a fine under schedule 3, part 1, paragraph 9 of the contract (as referred to above). It therefore seems that, in 2008/09, the opportunity to use clause 33 to impose a financial penalty in relation to clinical quality did not exist in practice. However, the clause did also make important provisions in relation to regular Clinical Quality Performance Reports and the establishment of Clinical Quality Review Meetings, which could consider a range of quality issues including SUIs, notifications from Monitor or the regulator, and patient safety incidents.

7.212 The contrast between the consequences for failure of performance, as opposed to failure of clinical quality, was significant. A fine for failure to meet the *C. difficile* indicator, under schedule 3, part 1, paragraph 9 of the contract, could amount to a maximum of 2% of the provider's total annual revenue from the PCT. Clause 32, on the other hand, in relation to performance, allowed the commissioner to withhold up to 20% of the provider's monthly revenue, on a monthly basis and in respect of each individual performance failure. The performance "stick" was therefore significantly larger than its quality counterpart, notwithstanding that the sums withheld might ultimately be returned to the provider, whereas any fine for *C. difficile* need not.

7.213 Despite the limitations to the financial penalties available under clause 33, without doubt, this 2008/09 agreement provided far more "teeth" for the commissioner. As Geraint Griffith said:

198 GG/18 WS0000015283–4
199 GG/18 WS0000015290–1
200 GG/18 WS0000015140

What clause 33 of the national contract gave us was a mechanism to hold the trust to account for the quality matrix, in the same way we would previously hold them to account for performance targets.[201]

7.214 A mechanism had been provided whereby standards could be defined, compliance measured, and sanctions imposed for unremedied breach. The emphasis remained on self-declaration and consensual resolution, but the commissioner was enabled to seek information and trigger investigations. It is no doubt possible to criticise some of the detail, but as a matter of overall impression, this agreement took a significant step towards offering the necessary tools to a conscientious and alert commissioner to fulfil its responsibility to its patients, even if some of the methods look somewhat laborious to the outsider.

7.215 Geraint Griffiths attributed this change in part to the issues that were being flagged up by the HCC in its investigation of the Trust and a realisation that assurances from providers could not be relied on exclusively as evidence of compliance and provision of a satisfactory service.[202] Both Mr Griffiths and Ms Sawbridge saw the journey to effective commissioning for quality as being far from complete, as they considered there remained significant limitations on the measures of quality introduced; the concept depended on commissioners being able to select and include in the contract useful and effective indicators. Inclusion of indicators (other than those required nationally) in the contract depended on agreement between commissioner and provider, the former still being unable necessarily to prevail over providers in a dominant negotiating position.[203]

7.216 Clearly, selection of indicators and means of measuring compliance requires care and skill at a local level to select what is appropriate in a local setting with a close eye on what is practicable and not unduly burdensome to both parties. What is important to come to grips with in one area and with one provider may well not be the same elsewhere. The principal focus needs to be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.

7.217 An important part of the potential of this sort of commissioning arrangement, as at least implicitly recognised in the Quality Matrix, is that it provides a means for commissioners to promote a push beyond fundamental standards to seek excellence wherever this is possible and affordable.

201 Griffiths T63.178
202 Griffiths T63.94
203 Sawbridge WS0000013418–420, paras 101–104

2009/10 contract

7.218 The 2009/10 contract[204] consolidated and built significantly upon the provisions for information and enforcement in the 2008/09 contract. In particular, it:

- Expanded the number of clinical quality related indicators in the Quality Matrix[205] at schedule 3, part 4A; the PCT also inserted a further quality schedule at this point in the contract[206] which related specifically to the Trust;
- Made the sanctions for failures to abide by those indicators (namely to permit funds to be withheld pursuant to clauses 32 and/or 33 upon breach where appropriate) more severe;
- Implemented the Commissioning for Quality and Innovation (CQUIN) payment framework which had been rolled out nationally some months prior to the agreement of the contract (schedule 3 part 4C and schedule 18).

Standards and information

7.219 In the 2009/10 contract, the clinical quality indicators of the Quality Matrix numbered 21, as opposed to two, as had been the case the previous year. With the exception of the indicators for MRSA and *C. difficile*, the indicators in the Quality Matrix were added locally through discussion between the SSPCT and the Trust. The additional indicators included:

- A requirement to attain the national average HSMR, or better, in respect of a variety of ailments, and to report on any such attainments or failures in the Clinical Quality Performance Report (matrix items 4A 4–7);[207]
- A requirement that all stroke patients receive a carotid doppler arterial diagnosis test within 24 hours of admission, and that success and failure be recorded in the Clinical Quality Performance Report (matrix item 4A 19);[208]
- A requirement that the provider demonstrate 100% compliance with the national guidance on mixed sex accommodation and, again, that all success and failure be recorded in the Clinical Quality Performance Report (matrix item 4A 20).[209]

7.220 The quality schedule in the contract contained, among other things:

- A requirement for monthly reporting of patient safety incidents, thereby moving the focus from there being something that a clinical review meeting could raise ad hoc under the previous contract, to there being something that the provider had to report upon in the performance report on a monthly basis (paragraph 4);

204 ESI00149137; PCT00280074488; TRU00010007771, *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010)*
205 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010)* (NB Bates number will not navigate to direct page no. Go to ESI00149137 then page 313 of 458)
206 YS/55 WS0000014057
207 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010),* pp313–314
208 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010),* p317
209 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010),* p317

- A requirement for more detailed reporting of complaints, and contacts with PALS on a quarterly basis, together with an annual statutory report (paragraph 6);
- A requirement to develop real time monitoring of patient feedback (paragraph 7);
- An increasing emphasis on the development of patient outcome measures of performance (paragraph 8);
- An undertaking that the PCT should conduct, and that the Trust should cooperate with, unannounced visits (paragraph 15).[210]

7.221 In addition, the CQUIN payment framework was introduced into the contract for the first time. First published in December 2008, and reflected in the 2009/10 contract, the framework was intended to enable commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals. As Geraint Griffiths said:

> *Providers are paid additional sums for implementing quality strategies and providing information that can be used to establish a baseline of performance in an area which the commissioner and provider agree that quality needs to be improved. I felt ... CQINs* were a *very good idea as they allowed us to focus on something that makes a bigger impact, outside the national targets. There was also the incentive for the Trust to hit the target so it was a constructive, encouraging approach which resulted in better compliance.*[211]

7.222 PCTs determined locally the quality performance incentive payments to be covered in the contract, reflecting the national policy view that quality troubleshooting initiatives needed to be rooted in particular local quality concerns, not those aggregated broadly by the centre.

Enforcement

7.223 In addition to expanding the requirements in the Quality Matrix, the PCT set much clearer consequences for failure to meet those requirements. Breach of each of the 19 additional clinical quality indicators attracted a remedy pursuant to the regime prescribed at clause 33 of the contract. In those cases, the "consequence per breach" column in the Quality Matrix read as follows:

> *Each breach shall be deemed by the parties to constitute a failure by the Provider to achieve this Clinical Quality Performance Indicator and Clause 33 shall apply.*[212]

7.224 In respect of clinical letters, failure to supply an outpatient's GP with a clinical letter in a timely fashion could result in the PCT paying the Trust only 50% of the cost of that outpatient's attendance. The matter might then be additionally referred for disposal through the clause 33

210 YS/55 WS0000014057–63
211 Griffiths WS0000014894, para 161
212 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010)*, pp317–321

regime.[213] In addition, a breach of the MRSA target could now invoke clause 33, whereas previously, in the 2008/09 contract, it had been marked by an improvement notice.

7.225 The clause 33 procedure under the 2009/10 contract worked in the same way as it had under the 2008/09 contract. A Clinical Quality Performance Report would be provided to the PCT on a monthly basis, detailing its performance against the Clinical Quality Performance Indicators. This would be followed by a Clinical Quality Review Meeting, covering both the indicators and other clinical quality issues such as SUIs, complaints and patient safety incidents. The review meeting would deal with any unremedied failures in relation to the indicators, first by way of a Joint Clinical Investigation and second, if necessary, a Remedial Clinical Action Plan. Should the provider fail to implement that action plan, then the commissioner could:

> *... retain as liquidated damages and not pay to the provider, such percentage of all the monthly sums payable by them under* [the contract] *... and the commissioner shall withhold any sum to be withheld until the Clinical Quality Review Meeting is satisfied, whether on the basis of a further RCAP Report or otherwise, that the relevant Remedial Clinical Action Plan has been implemented or Provider's breach of the relevant Clinical Quality Performance Indicator has been otherwise resolved.*[214]

7.226 Geraint Griffiths stated that the amount withheld could equate to 10% of the Trust's income.[215]

7.227 The parallel regime of "contract queries", performance notices, warning notices, Remedial Clinical Action Plans and, as a last resort, the withholding of funds, continued to apply to breaches of those parts of the Quality Matrix that dealt with more quantitative, as opposed to qualitative, performance (Clause 32).

7.228 Accordingly, it is apparent that the 2009/10 contract had, in theory at least, real "teeth"; something the PCT found particularly empowering, feeling that it finally bestowed upon it "a credible power of enforcement" over the Trust.[216]

Conclusions

7.229 Geraint Griffiths said of the 2009/10 contract:

> *The introduction of the new national acute contract brought new levers for PCTs as commissioners of healthcare. The national contract has also led to an improvement in theory to the contractual position between PCTs and Trusts, with rules of engagement being better defined to shape negotiations.*[217]

213 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010)*, p320
214 ESI00149137 *Standard NHS Contract for Acute Services between SSPCT and the Trust (2009–2010)*, p39
215 Griffiths WS0000014895, para 165
216 Griffiths WS0000014894, para 163
217 Griffiths WS0000014894, para 164

7.230 One potential concern, suggested by Alex Fox, Chairman of the SSPCT, was that the withholding of funding, if used forcefully and frequently on a widespread basis, would simply punish a struggling provider in its time of need, rather than address its inefficiency and bad practice.[218] The process set out in clauses 32 and 33 certainly constituted a powerful lever. If conducted properly on both sides and based on frank and full performance reports, it had the potential to identify and address serious quality issues. At the same time, it seems clear the PCT had used the 2009/10 contract significantly to increase its scrutiny of the quality of services provided by the Trust. Ultimately, however, the effect of the 2009/10 contract depended on the willingness of commissioners to flex their muscles. There is a significant distinction between a commissioner feeling that it has a "credible power of enforcement"[219] and it using this power in practice. In addition to the possible risks of invoking the full force of clauses 32 and 33,[220] Alex Fox suggested that commissioners generally lacked the "backbone ... to feel that they could use [them]".[221]

South Staffordshire Primary Care Trust approach to quality issues at the Trust

The view from the Trust

7.231 Dr Philip Coates, a clinical lead at the Trust, told the Inquiry that he felt that the PCT did not adopt any real quality measure in its commissioning, but rather commissioned "from a spreadsheet".[222] For Dr Suarez, the Trust's Medical Director, the PCT commissioned for activity, not quality.[223] This evidence rather confirms the impression to be gained from the contracting process before the HCC report.

Lack of follow-up of Children's Services Peer Review Report

7.232 As detailed above, and in *Chapter 1: Warning signs*, the leadership of SSPCT remained unaware of the contents of this concerning report. William Price, Chair of the former SWSPCT, was unable to explain if anything had been done with the report, or why it was not included in the handover information given to Mr Poynor. The latter could not recollect ever seeing it.[224] He correctly said that the PCT had no formal responsibility for following up such reports and that the arrangements for doing this were not yet clear, a suggestion having been made at the time by the peer review administrator that the SHA Children's Lead would be responsible. However, he accepted that the PCT ought to have taken some form of action if the report, and the concerns expressed in it, were known to it.[225]

7.233 While there is no evidence that the PCT ever had possession of a copy of the report about the Trust as such, it did receive an overview report in November 2006, although this did not refer

218 Fox WS0000013011; Fox. T66.97
219 Griffiths WS0000014894, para 163
220 Fox T66.96–97
221 Fox WS0000013011, para 87
222 Coates WS0000004865, para 51
223 Suarez WS0000012485, para 30
224 Poynor WS(2) – WS0000044759, para 13; T65.111
225 Poynor WS(2) – WS0000044757, para 7; CJE/21 WS0000023413

to the concerns about the Trust. In March 2007, the peer review administrator circulated revised arrangements to a number of stakeholders, including Mr Poynor, in which it was made clear that it was the PCT's responsibility to agree and monitor the Trust's action plan arising from the review. In May 2007, a copy of a letter from the peer review team to the Trust Chief Executive appears to have been sent to Mr Poynor. This gave an assessment of the Trust, suggesting it had performed poorly compared with other trusts. There appears to be no record of this letter on PCT files and Mr Poynor could not recollect it.[226]

7.234 Mr Poynor accepted that the March 2007 letter should have prompted SSPCT at least to make enquiries about the Trust's action plan and that this might have exposed to the PCT the staffing problems and the consequential effects.[227]

7.235 The sensitivity that surrounded peer reviews at the time was not a reason for the PCT to abstain from concerning itself with outcomes that might affect the standard of commissioned service being delivered to patients. While it is understandable that such reviews might be met with a degree of reluctance from clinicians if they were known to result in officious performance management by the PCT, in this case the responsibility for follow-up was in the end allocated to the PCT. The purpose of such reviews is, of course, to promote improvements in standards by the application of relevant professional expertise but, as with every other professional activity in healthcare, the interests of patients should always come first. Had the PCT concerned itself with this report, it is likely it would have realised that the issues raised had a wider relevance than just to children's services and would have concerned the service delivered to all A&E patients.

Support for the Trust's FT application

7.236 Consideration by the PCT of whether to support the Trust's application for FT status was hampered by the initial refusal of the Trust to share its Long Term Financial Model (LTFM) or Integrated Business Plan (IBP), despite the PCT having asked to see them.[228]

7.237 On 13 March 2007, Stuart Poynor wrote to Martin Yeates expressing SSPCT's support for the Trust's application for FT status in relatively guarded terms:

226 Poynor WS0000044760–2, paras 17 and 21; WS(2) SP/8 WS0000044901–7; WS(2) SP/9 WS0000044909
227 Poynor WS(2) WS0000044759–62 paras 13–22
228 Poynor WS0000014308, para 112

We are pleased to support your application for Foundation Status and believe that there are several areas in your service strategy that fit entirely with our view of future service provision. Clearly at this stage, the PCT retains the right as commissioner to develop relationships with a variety of providers to ensure a cost effective comprehensive service throughout South Staffordshire. There may be services you aspire to deliver that may be provided by other organisations, however the general thrust of your proposition is supported.[229]

7.238 Mr Poynor told the Inquiry that this expression of support was based on a general impression, rather than any in-depth analysis:

Prior to the receipt of the Trust's Integrated Business Plan, my response was based on the general service strategy of the Trust and what seemed to be a good working relationship ...[230]

7.239 He was unaware, at this time, that the predecessor PCT had not supported an earlier application, nor was he aware of the critical outcome of the SHA diagnostic in January 2006. He felt that the PCT should not offer unconditional support without having seen the LTFM or the IBP.[231]

7.240 Mr Poynor told the Inquiry that the PCT had been asked at around this time to give a view on the Trust's application, and to compare its strategy in the draft application with the PCT's own commissioning intentions. He recalled that its plans assumed a continuation of the current arrangements and only assumed limited growth. He recalled specifically being asked about the Trust's financial viability. He declined to offer an opinion on the latter aspect, taking the view that this was Monitor's role. He gave an informal opinion about the management team at the Trust, saying they were "open and professional". Mr Poynor had thought that the PCT could not "sign off" its support until it had seen the LTFM and the IBP.[232]

7.241 At a meeting on 26 March 2007, SSPCT's Board formally approved its response to the consultation on the Trust's FT application. Subject to some minor points about the proposed constitutional arrangements and the name of the FT, it recorded its "full" support.[233] Mr Griffiths told the Inquiry that he was not a voting member of the Board, but he would have been asked for his view, which would have been to agree with this decision.[234]

229 SP/15 WS0000014457
230 Poynor WS0000014307, para 109
231 Poynor WS0000014308–9, para 114
232 Poynor WS0000014308–9, paras 111–114
233 GG/15 WS000150672
234 Griffiths WS0000014877–8, para 102

7.242 Mr Poynor and Mr Yeates attended a meeting with Cynthia Bower and Peter Shanahan of the WMSHA on 19 April 2007. The purpose of the meeting was to "clarify" the PCT's support. Mr Shanahan wrote to both parties after the meeting stating that:

> *The conclusion I reached was that the PCT did support the FT application in that they positively supported acute FT provision in Stafford and Cannock as per the FT application in the short and medium term.*[235]

7.243 He noted that the clinical letters dispute had been resolved and that there were good working relationships.

7.244 He referred to the fact that the Trust had not shared the LTFM or the IBP and said he accepted the Trust's reasons. He was "... quite content that the essence of these documents is understood by the PCT ...", but he wanted a discussion to take place to enable him to be satisfied that all the assumptions for the 2007/08 base case were agreed.

7.245 A further meeting was held on 24 April 2007 between Geraint Griffiths and John Newsham,the Trust's Director of Finance, to discuss the Trust' assumption in the 2007/08 base case.

7.246 Geraint Griffiths formed an unfavourable impression of the Trust's financial management at this meeting. In an email to Mr Poynor, on the same day, he listed a catalogue of criticisms of the Trust's planning:

> *The issues for me from this pm were:*
>
> *No clear link between finance plan 1 and activity plan ...*
>
> *Assumption that where activity is list* [lost] *from other commissioners SSPCT will pick up ...*
>
> *No understanding of the detail behind the numbers (eg inflation assumptions, activity changes) ...*
>
> *No transparency on integrated business plan, no feel for how much they need to be community provider of choice ...*
>
> *No obvious link between service strategy and financial strategy ...*
>
> *No sharing of scenario assumptions or detail ...*
>
> *No feeling of viability cut off for the Trust ...*
>
> *Real life scenario assumptions ...*

235 SP/16 WS0000014461

No benchmarking of the PCT against access rates to determine likely trend (given we are 95% of the Trust) ...

Assumption that 2007/8 contract issues agreed this year will be charged in trust favour in 2008/9 ...

No real joint planning with PCT on scenarios or PCT strategy development ...

Information provided to MSGH Board appears vague, incomplete or wrong ...
[Mid Staffordshire General Hospital]

Assumption costs can be shed with income loss to stabilise plan, no feel for impact of fixed costs ...

No joint planning on LTFM with PCT, eg do MSGH income assumptions match PCT expenditure assumptions ...

Apart from that thought it went well![236]

7.247 While none of these criticisms of the management of the Trust directly referred to the quality of service being delivered, if they were justified they should have raised serious question marks over the Trust's ability to deliver an acceptable standard. If Mr Griffiths's critique was correct, the Trust was being over-optimistic, was failing to connect its planning with the real world, and had a board which was not being given the full and accurate picture on core issues. In addition, it was continuing to keep itself isolated from NHS organisations on which it would have to rely in future for commissioning and appeared to be failing to observe the spirit, if not the letter, of cooperation required of all NHS bodies. None of this would appear to present encouragement of the view that this was a body worthy of continuing to be supported in its application for FT status and the greater autonomy which would result.

7.248 Significantly, on the same day as this meeting, Mr Poynor wrote to Martin Yeates to warn him that the PCT's monthly performance report identified "issues" concerning the level of healthcare acquired infections at the Trust. He requested a "personal response" to assure him that action was being taken.[237]

7.249 The PCT does not appear to have considered whether the serious concerns being voiced by Mr Griffiths about the Trust's planning ability had any implications for patient safety, or the PCT's ability to have confidence in that regard. Subsequently, Martin Yeates reported to Peter Shanahan that, at this meeting, the Trust had confirmed that the figures used in the assumptions were in line with the local delivery plan,[238] a somewhat different impression to that obviously gained by Mr Griffiths.

236 PCT00280017755 Email from Geraint Griffiths to Stuart Poynor and Helen Smith: 'Thoughts from this afternoon'.
237 SP/13 WS0000014454
238 SP/17 WS0000014465

7.250 What was still, and surprisingly, missing from this meeting was a presentation of the actual draft LTFM or IBP to the PCT.

7.251 This defect was at least partially put right on 26 April 2007 at a further meeting between, among others, Martin Yeates, John Newsham, Karen Morrey (Director of Operations at the Trust) and Geraint Griffiths, when a copy of the IBP submitted that day to the Trust Board had been disclosed in confidence to the PCT. Subsequently, it also disclosed a copy of the IBP as submitted to the DH.

7.252 In a letter of 1 May 2007 to Mr Shanahan, copied to the PCT, Martin Yeates described the outcome of these meetings as "constructive and positive".[239] He said that two matters needed "further understanding": resources for therapies and clarification about a loan of £1.8 million. This description of the outcome was obviously inconsistent with the depth of the earlier critique offered by Mr Griffiths to his Chief Executive.

7.253 On 2 May 2007, Mr Poynor wrote to Mr Shanahan confirming that the PCT had now seen a draft of the IBP and he confirmed the PCT's "general support" for the application.[240] However, he declined to underwrite the Trust's financial plans or its proposed developments. For example, he could not confirm that the PCT would choose the Trust as its provider for certain community based services, an assumption made in the plan. He also pointed out an error in the figures presented by the Trust.

7.254 Asked about the PCT's role in the FT process, Mr Poynor responded that he regarded it as "extremely limited".[241]

7.255 The PCT continued to give its support, after a presentation to the PCT Board by Martin Yeates in October 2007. Mr Poynor told the Inquiry:

> *The PCT Board had no information at the time to indicate there was a problem with the Trust and therefore supported their application.*[242]

7.256 The situation remained the same at the time of Monitor's interview with Mr Poynor and others from SSPCT on 14 November 2007. The record of the meeting suggests that SSPCT endorsed the Trust's management as being "good" and that it was "embracing the quality agenda". It described Martin Yeates as a "firm leader" respected by his staff, although some concerns were expressed about the Director of Finance and the non-executive directors.[243] Mr Poynor's explanation for the continuing support was that:

239 SP/17 WS0000014465
240 SP/18 WS0000014468
241 Poynor T65.168
242 Poynor WS0000014318, para 151
243 SP/29 WS0000014563

... clearly, with the benefit of hindsight, they ... weren't embracing the quality agenda. And I'm not sure specifically, other than my awareness of the work that we were doing with them around care pathways that would have driven me to make that comment ... I guess I do need to put this in context for me. I believe the meeting was for an hour, with representatives of Monitor, and that was our only involvement ... in the application process with the exception of the meeting with the SHA, as far as I can recall. This ... wasn't a detailed analytical conversation, and I didn't feel we were playing a particular role. It felt like we were just one of many people they were asking a view on the trust about.[244]

7.257 It appears that the SSPCT's support was largely informed by a view that FT status was a good end in itself in reducing bureaucracy and encouraging improvements in performance.[245] It is clear from the evidence that it was prepared to support the Trust initially at a time when there were serious concerns harboured about the plans being put forward, and without sight of those plans until after the PCT Board had agreed to support the application. The impression given is of an organisation largely disengaged from the FT process. When, in November 2007, quality was specifically raised, SSPCT offered what, in retrospect, was clearly a wrong view. At that time, it knew of the high HSMR, which was at that point still an unresolved issue; it knew of problems in A&E; and there is no evidence that Geraint Griffiths's damning critique of the Trust's planning assumptions and its implications had been addressed at all.

7.258 Alex Fox's justification of SSPCT's position does not answer these points:

Q. Do you accept the possibility that others, perhaps including Monitor, might have ... taken some reassurance from the primary care trust's support of the application at that early stage?

A. That could be possible. I wouldn't fall out with that as a hypothesis but the reality is that the ... application to be an FT trust, as I understand it, is between the SHA and the ... organisation wanting to become a foundation trust. And that the assurance of its ... fitness for purpose lay with the ... SHA and, of course, particularly with Monitor. So we were, as it were, an interested bystander in that sense, rather than a direct player ... in being part of the ... accreditation process.

Q. But the support of the commissioning organisation must count for something, must it not?

244 Poynor T65.172–173
245 Fox T66.154

A. Of course, but ... in all honesty, I don't think we had any evidence at that stage, ... we might have had issues and there was a letter, as you know, between Stuart Poynor and Peter Shanahan, the acting chief executive of the strategic health authority, where ... the chief executives of the organisation got together and, as you would do in an ... discussion around ... a policy, they hammered out their differences. And the conclusion in that letter was that there was no reason ... for the PCT to hold up the application to become a foundation trust, notwithstanding some concerns that had been expressed up to that meeting taking place.[246]

7.259 The plain fact is that the SSPCT did not take its responsibilities in this process sufficiently seriously. It did not make it clear how limited the basis of its expression of support was, and it did not take the chance plainly offered by this process, to consider more deeply whether it was or should have been satisfied with the service which the Trust was providing. Regrettably, it is not clear on the evidence before the Inquiry that this was an exceptional approach and that other PCTs would not have acted in the same way. This is an example of an organisation going through the motions, rather than thinking seriously about the implications for patients in everything it did.

The Trust's non-compliance with the A&E waiting time target

7.260 An email was sent by Karen Morrey to Yvonne Sawbridge and Geraint Griffiths at 15:20 on the afternoon of 11 April 2007. It read:

... we're sinking under patients in A&E. Any support would be gratefully received. We've tried to get hold of the Community matrons but only got a voicemail service. We have 12 ambulances queuing. K.[247]

7.261 Asked about the type of concern that this email caused him, Mr Griffiths said that it "wouldn't cause concern", and that it was "absolutely not" out of the ordinary. His understanding of the problem underlying Ms Morrey's request was that there were too many patients in A&E who ought properly have sought treatment in the community. He added:

Karen and I would have conversations like that on a regular basis, whether A&E or other [sic]. *If she'd got a problem on the hospital side, she would come to me as the conduit to the GPs and community services. So there are – every hospital trust A&E at some point will come under pressure, and at that point one of the PCT's roles is to mobilise community support to hospitals.*[248]

246 Fox T66.124–125
247 KM/30 WS0000011520
248 Griffiths T63.115–116

7.262 Yvonne Sawbridge confirmed this approach:

> *Q. The inquiry was shown yesterday an email from Karen Morrey to the PCT, and we can put it up on the screen if necessary, but it was the one about having the ambulances –*
>
> *A. A&E.*
>
> *Q. A&E and having ambulances waiting, and it looked very much like a cry for help. Is your attitude the same as that of Mr Griffiths, "Well, we as a PCT get these all the time and it was nothing to worry about"?*
>
> *A. As Mr Griffiths said yesterday, the performance varies. It goes up and down in every trust around A&E, and at one stage, in that same time period, Mid Staffs was the best performing A&E. It – A&E is very – the email that was shown yesterday did indicate that too – at one time in that time period. A&E fluctuates. It's a very dynamic service. It depends on the number of people coming through on the day and the throughput of patients through* [sic]. *So most trusts at some stage have difficulties in meeting their A&E four-hour target. It's probably the only call you ever get as an exec director on call – PCT – is around A&E four-hour targets.*
>
> *Q. If you had asked to look through the adverse incident reports, you would have seen, what I'm going to describe, I think not unfairly, as an almost constant flow of complaints about nursing shortages and staff shortages generally, leading to compromised patient care. Now, first of all, you never asked to see those ... adverse incident reports?*
>
> *A. No.*[249]

7.263 Quite apart from this specific instance, pressures in A&E had been recognised by the PCT.

7.264 In an email exchange on this point involving the Trust (Karen Morrey), the PCT (including Mr Poynor and Mr Griffiths) and the SHA (Jonathan Lloyd, former Director of Performance), dealing with the Trust's action plan in March 2007 to meet the target, Karen Morrey identified "severe pressure" with increased numbers attending A&E and a backlog in admitting patients in a timely fashion.[250] The response of Geraint Griffiths on 7 March 2007 focused on bed management, discharge arrangements and what the PCT could do to assist, such as providing GP support to A&E on Mondays and Fridays to assist in the triage of patients. The PCT was said to be "happy" with the Trust's action plan.[251] As is clear from the email exchange, at the time the Trust had the highest cumulative average performance against the A&E target (98.06%) for the year. By the time of a meeting in May 2007, the Trust's monthly performance against the target had increased to 99.05%.[252]

249 Sawbridge T64.114–115
250 GG/13 WS0000015058
251 WS0000015059
252 PCT00280019072, Minutes of Commissioning Meeting of South Staffordshire PCT/MSGH (22 May 2007), item 5

7.265 The only measurement of A&E performance available for consideration by the PCT was the waiting time target. This was not capable in itself of flagging up any concerns about the qualiy of care. Any episodes such as that which occurred in April 2007 were considered to be typical one-off events, common throughout the NHS. It is clear from the evidence that no consideration was given to what were the implications of these pressures for patients. However, the PCT did not in any event have the tools available to it to identify safety and quality issues. The approach of the PCT was entirely reactive, focused on providing assistance to solve the immediate problem. This might be equated to treating the symptom, not the disease.

Complaints

7.266 The PCT did not routinely receive information about complaints made to the Trust. The regulations did not require reports to be sent to the PCT on this topic. It could possibly have requested such information but it did not. There may have been nothing exceptional about the PCT in this regard.

Serious untoward incidents and safety reporting systems

7.267 In December 2006, the DH published *Safety First*.[253] This highlighted evidence that there was:

> *... a lack of confidence that the current standards and monitoring processes can effectively detect NHS Organisations whose safety performance may be of concern.*[254]

7.268 The report's recommendations included making PCTs

> *... accountable for ensuring that all providers used by their patients have effective safety reporting systems and are implementing technical solutions satisfactorily ... PCTs should be responsible for ensuring that patients are aware of safety issues as part of the patient choice pathway.*[255]

7.269 In 2007, SSPCT adopted the WMSHA's SUI reporting policy and procedure,[256] which was published in January 2007. It said that PCTs had a key role as commissioners in receiving SUIs from providers.[257] This required the lead commissioning PCT to be responsible for receiving SUIs from providers and ensuring that the SHA received the report.[258] This overall statement was somewhat qualified later in the policy where it was said: "It is good practice for a provider service to inform its commissioners of any SUI."[259]

253 YS/4 WS0000013470
254 YS/4 WS0000013494
255 YS/4 WS0000013499
256 YS/6 WS0000013515
257 YS/6 WS0000013519
258 Sawbridge WS0000013399–133400, paras 35–36; YS/6 WS0000013520, para 1.3
259 YS/6 WS0000013525

7.270 Ms Sawbridge told the Inquiry that, initially, the PCT had difficulties in accessing SUI reports. The Trust did not send reports with any regularity and, for this reason, the PCT requested access to the regional Strategic Executive Information System (STEIS) on which SUIs were logged. This was provided as from February 2007, which enabled confidential reports to be given to the PCT Board. However, these SUI reports were limited to a summary of the incident and the date it occurred. Therefore, the information was of little use in analysing any trends or in monitoring whether the Trust was implementing any learning from the incidents.

7.271 It is clear that the SSPCT did not prioritise the recommendation published in the *Safety First* report, as the response to it was not produced until August 2007, 18 months after *Safety First* and 10 months after its establishment. No doubt, it had many other priorities due to the reorganisation, and may have had inadequate resources to attend to this as well as everything else.[260]

7.272 A report to the SSPCT Board in August 2007 included the PCT's response to the recommendations in *Safety First*. The response to the above recommendation was:

> *It is difficult for PCTs to monitor whether providers are implementing technical solutions. The PCT recognizes its responsibility as a commissioner of services and the need to ensure all its providers have effective reporting systems.*[261]

7.273 In November 2007, a report was presented to SSPCT's Finance and Performance Committee on work being undertaken to develop a view on the quality of commissioned services based on patient experience.[262] However, this referred to the use of national data, mainly from the HCC, and the Trust's own patient survey. The report included the total number of SUIs at each provider, but with no other description or analysis. The report's conclusion accepted that it was "embryonic" and would be built on.

7.274 Little had been done by February 2008 to advance this position. In a report presented to the Board in that month, following a West Midlands Patient Safety Summit, it was stated that:

> *The PCT has a responsibility both as a provider and a commissioner to ensure patient safety is a priority and continuously improves in line with best practice.*[263]

260 Sawbridge WS0000013400–1 paras 37–39
261 YS/12 WS0000013628
262 YS/5 WS0000013503
263 YS/13 WS0000013634

7.275 Among action suggested in its commissioning role, it was said that:

> *As commissioners we need to develop better understanding of safety of services. The patient experience report submitted to the Finance and Performance Committee begins this process, but needs further development, and additional support via the introduction of quality visits to our providers.*[264]

Dr Foster hospital standardised mortality ratio

7.276 SSPCT was aware of the high HSMR at the Trust reported in April 2007 and of the intervention of the WMSHA. The PCT took no additional action and effectively accepted the Trust's own view that the figures were the result of poor coding. Stuart Poynor told the Inquiry:

> *Given this context, the Trust's explanation was thought to be reasonable, pending the receipt of the SHA study commissioned from the University of Birmingham, and the PCT Board raised no further questions ...*
>
> *In hindsight, the health economy could have taken a more precautionary approach to the statistics, and considered the possibility that these could be an indicator that highlighted poor care.*[265]

7.277 Ms Sawbridge was aware that the commissioned work included the analysis of a limited number of "tracker" conditions to establish if there were clinical concerns.[266] She, too, felt that the PCT could not go behind the Trust's assurances that there was no cause for concern and that the matter was one of coding.[267] She told the Inquiry:

> *... we clearly were not proactive in terms of analysing and looking behind a lot of the evidence that we were given by the trusts. We were working in a high trust area, with a board responsible for its governance. And we asked them "Are you sure this is a coding issue, have you looked to make sure it's not about clinical practice?" And we took those assurances on face value.*[268]

Royal College of Surgeons review 2007

7.278 SSPCT was aware of the existence of this review through the attendance of the PCT representatives Yvonne Sawbridge or Liz Onions at the Trust's quarterly Executive Governance Group meetings. The minutes of its meeting on 22 October 2007, the first attended by a PCT representative, in this case Ms Sawbridge, recorded:

264 YS/13 WS0000013636
265 Poynor WS0000014314, paras 135–138
266 Sawbridge WS0000013407, para 62
267 Sawbridge WS0000013408, para 66
268 Sawbridge T64.134

The final clinical review has now been received. This will be reviewed and an action plan submitted to the next meeting.[269]

7.279 At the meeting on 21 January 2008, a more expansive minute recorded:

The Royal College of Surgeons was asked to conduct a service review following concerns raised, complaints and inquests into the colorectal and laparoscopic cholecystectomy service. Interpersonal relationships deemed to be the main problem and an action plan has been drawn up to address the issues including psychometric testing. Val Suarez asked that the report be treated with the utmost confidentiality.[270]

7.280 Ms Sawbridge recollected this report being raised at the first meeting, but she neither saw the report nor appreciated its significance. She told the Inquiry:

I hadn't heard anything about it before this meeting. And at the end of this meeting my reflection would be this trust [is] *looking at its complaints, ... it's seeking help in a review for some areas of its services, it's looking at NICE, its governance processes. At the end of this meeting* [this] *would have told me that they had a system in place to look across their trust at the things that needed to be looked at. This would have been a typical agenda I would have expected to be discussed at an executive governance group of this nature.*[271]

7.281 She did not ask to see the report and was not familiar with the invited review mechanism. She was unaware that the report described the surgical division as "dysfunctional". Had she known that, she told the Inquiry, it would have caused her concern and she would have discussed the matter with Geraint Griffiths and probably her Chief Executive, Stuart Poynor.[272]

7.282 While it is true, as submitted by the PCT, that it was not directly informed by the Trust of the concerns raised in the Royal College of Surgeons (RCS) report, it is clear that it was in a position to ask about it. The impression given by the evidence of PCT representatives who were in attendance at Trust meetings of this sort is that they were passive spectators rather than officials present with a purpose of exercising their continuing supervisory responsibilities for ensuring the safe delivery of care to the patients on whose behalf they had commissioned services. Once again the mere mention of an action plan seems to have been taken as sufficient reassurance that any possible cause for concern had been addressed satisfactorily.

269 YS/16 WS0000013659
270 YS/20 WS0000013743
271 Sawbridge T64.94
272 Sawbridge T64.95–96

South Staffordshire Primary Care Trust knowledge of concerns on announcement of the Healthcare Commission investigation

7.283 On 17 March 2008, following the HCC's announcement of its investigation, Yvonne Sawbridge submitted a briefing note to Cynthia Bower regarding SSPCT's involvement with the Trust.[273] In it she said:

> *The PCT had been an active commissioner of MSGH as the following report indicates. We have no specific concerns about the Trust being an outlier in the quality of services which they deliver. We have based this assessment on several interactions and data, as outlined below. In summary, the annual health check scored fair for quality, they achieved good for Maternity services and a CNST* [clincial negligence scheme for Trusts] *level 3. They also achieved FT status after scrutiny by Monitor. The two areas of ongoing concern has* [sic] *been the Dr Foster mortality rates, which we have addressed by being an active participant of the research group established by NHSWM* [NHS West Midlands]*, who have the technical expertise to take this forward, and the nursing establishment. We are aware that this is now being addressed with a 1m investment agreed at the Feb Board.*[274]

7.284 With regard to the HSMR issue, she recorded that the SSPCT had participated in the SHA group and that:

> *To date this group has not indicated any areas where Mid Staffs is a clinical outlier in terms of mortality and has focused on improved data recording and coding of episodes ...*

7.285 She listed the interactions with the Trust which had not given rise to any concerns about the quality of services. These included:

- Visits to the Trust including by the SSPCT Chief Executive (Stuart Poynor), Executive Nurse (Yvonne Sawbridge) and members of the commissioning team;
- Regular liaison meetings between the SSPCT and the Trust's Medical Director, including meetings to discuss patient safety, clinical areas and areas of joint working;
- Regular meetings between respective Directors of Nursing;
- SSPCT Performance Director's attendance at the Trust's Executive Governance Group;
- Performance management assessments;
- Trust meetings with the PCT's Director of Infection Prevention and Control;
- Involvement of clinicians from PBC consortia in commissioning meetings.

273 YS/24 WS0000013831
274 YS/24 WS0000013834

7.286 The warning signs that were available had appropriate enquiries been made have been considered elsewhere in this chapter. Obviously many of these are easier to see with hindsight than would have been apparent at the time with the systems then in place.

7.287 At the time of the HCC announcement, the SSPCT was aware that its tools for monitoring performance on quality were insufficient. It was for that reason that it had been developing more sophisticated measures in the 2007/08 and, more extensively, the 2008/09 contracts. It might have been expected that such a realisation would have brought with it a concern that it might not be aware of important quality issues. This proposition was not accepted by Ms Sawbridge. In the context of a discussion of the terms of the 2007/08 contract she was asked:

> *THE CHAIRMAN: Do I read into that, therefore, a realisation or an acknowledgement, at least on the PCT's part, that monitoring by assurance against national standards was not sufficient?*
>
> *A. Yes, that's the reason for the change in PCTs was to be able to get more sophisticated around commissioning tools, and for me it was around trying to understand how we measure the patient experience and have some outcome measures, not process measures that were broader around the environment of care.*
>
> *THE CHAIRMAN: Does that not, therefore, suggest that the PCT and, therefore, you were aware that there was, potentially at least, a gap in your knowledge about whether the trust was delivering a safe service?*
>
> *A. I don't think there was a conscious thought or a concern about a gap in our knowledge about the trust delivering safe services, because in those days we were working on the premise that every trust had the responsibility to deliver their safe services, and our role then was the definition of quality around Standards for Better Health in the national targets. So we were recognising we wanted more tools. I'm not sure it was necessarily around feeling we think there's a gap although I suppose, you could argue it is, but it's more around we're growing into our new role. We're moving into the more sophisticated approach to commissioning.*[275]

7.288 By 2008, after the HCC's announcement of its investigation and the previous year's very poor HSMR results, the PCT should have taken a greater role in commissioning for quality and ensuring patient safety. The greatly enhanced provisions with regard to quality in the 2008/09 contract clearly illustrated what might have been possible by more intensive monitoring. There was in 2008 a recognised gap in commissioning for quality and the ability to identify failures of service provision. The superficiality of the briefing note in respect of the HCC investigation and the quoted response of Ms Sawbridge evidences a culture of passivity – of reacting to events and relying on externally generated indicators rather than proactively seeking to insist

275 Sawbridge T64.57

on the compliance with standards of service to which patients were entitled. This was an organisational and systemic failure rather than one which can be attributed to any individual.

South Staffordshire Primary Care Trust interventions during the Healthcare Commission investigation

7.289 The approach of the SSPCT during the investigation was characterised by a marked increase in vigilance, and increasing recourse to the provisions of the contract.

Interaction with complainants

7.290 Mr Poynor met Julie Bailey and members of CURE at an early stage, when they attended one of SSPCT's regular "roadshows" in Rugeley. Mr Poynor felt that many of those present did not understand what a PCT did and he sought to explain that. However, in the main he felt obliged to listen to the stories those attending clearly wanted to tell him. He was "shocked and appalled" at the "harrowing stories" he heard:

> *Even now I can recall the details of the stories that were relayed to me on that evening, some of which I will never forget ... People were visibly upset and I was upset.*[276]

7.291 Mr Poynor agreed to act on their behalf in asking the HCC to extend its coverage of contact with patients to include Rugeley, and also arranged for a further meeting to take place with PCT officials so that the detail of the complaints could be received, recorded and followed up.[277] The following day Mr Poynor spoke to Martin Yeates about what he had heard. He had previously been made aware by Mr Yeates that there was a patient group, but was not aware of the level of concern they were expressing. Mr Yeates expressed his own concern at what had been reported and appeared to Mr Poynor to be keen to receive details.[278]

7.292 On 1 April 2008, he wrote to Martin Yeates requiring that the PCT be part of the review of complaints Mr Yeates had indicated he would be conducting.[279]

7.293 On 3 April 2008 Mr Poynor attended the resulting further meeting with complainants, along with other officials of the SSPCT. He told the Inquiry that:

> *The passion and depth of the grievances that were raised by people will live with me forever.*[280]

276 Poynor WS0000014322, para 165
277 Poynor WS0000014320 paras 162–171; SP/32 WS0000014572
278 Poynor WS0000014324, paras 175–176
279 SP/33 WS0000014575
280 Poynor WS0000014325, para 181

7.294 Ms Sawbridge also told the Inquiry how shocked and upset she was by what she heard.[281] There were more people attending than had been anticipated and as a result the details of only eight complainants' cases were taken down and arrangements were made to meet a further nine later.

7.295 Mr Poynor wrote to Julie Bailey on 8 April promising to offer support to those with whom the PCT had contact to take the "next step" in the statutory complaints process to the extent that they had not done this already.[282] He sought to explain the limited role of the PCT:

> *The PCT as a commissioner has no direct managerial control over MSHFT* [the Trust]. *However, by monitoring the Trust's performance and standards of care on an individual basis we can facilitate a response to the concerns that you and members of the public have raised over the last few months and, more importantly, ensure that any lessons learnt/actions identified as part of a complaints investigation are implemented within the Trust in a timely fashion.*[283]

7.296 It was apparent from the stories of CURE members and others seen on these two occasions, that the problems at the Trust ran very deep indeed. These were people who had suffered extensively not only in terms of the clinical treatment offered to themselves or their relatives, but also in terms the unsatisfactory complaints process most of them had endured. What Mr Poynor offered at this stage was to monitor a further complaints process which was unlikely to be thought helpful. The letter betrayed a limited view of the responsibilities of a commissioner when unsatisfactory service has been delivered.

7.297 While the commissioner/provider concept makes the provider directly responsible for the provision of care, and for addressing complaints about it, patients have only been treated by a provider because a commissioner on their behalf has arranged for it to be provided. To continue to rely on a provider's processes – in this case the statutory complaints procedure for which the Trust was responsible – when they are seen to have broken down or failed is akin to the holiday company offering a package tour requiring customers to make all complaints to the inadequate hotelier directly without assuming any responsibility. In the NHS context the commissioner is given powers, including those in the contract, which are not available to the individual patient. As described earlier, these include, for example, the power to insist on receiving information about the Trust's compliance with quality standards, its handling of complaints and SUIs, and sanctions including performance notices and, ultimately, withdrawal of funding. Mr Poynor and his colleagues were rightly shocked by what they had heard, and clearly wanted to help in what for them was an unprecedented situation. Their powers were not as limited as indicated in this letter as in fact their subsequent actions showed. It should have been apparent that at issue was not only the seeking of proper

281 Sawbridge WS0000013429, para 137
282 Poynor WS0000014325, para 182; SP/34 WS0000014579
283 SP/34 WS00000145780

recourse for those who had complained to the SSPCT, but the taking of whatever steps were necessary to safeguard existing patients whose safety and well-being were potentially at risk from substandard services. It would have been helpful to have offered reassurance to Julie Bailey and the other complainants that the PCT intended to take such action.

Engagement with the Healthcare Commission

7.298 Mr Poynor contacted Dr Heather Wood, the HCC's Investigating Officer, on 7 April 2007 to pass on the stories that he had heard. He offered to share information with the HCC and to provide whatever support they required. He informed her that the SSPCT would be conducting unannounced visits to the Trust.

Views obtained from general practitioners

7.299 Dr Roger Beal was Chair of the Professional Executive Committee (PEC) of SWSPCT between 2002 and 2006, and a member of the Interim PEC during the transition to SSPCT up until April 2007. Following his return to practice, in January to March 2008 Dr Beal worked seven shifts in the A&E Department at the Trust as part of a "winter pressure initiative". This was the first time he had worked at the Trust since 1996. In the course of those shifts, Dr Beal realised that there had been a significant change for the worse at the Trust in terms of clinical care.[284] He was concerned that patients were prioritised according to the amount of time they had been waiting, in the context of the four-hour target, rather than on the basis of need. Doctors would be allocated to patients by the nurse in charge, with little other leadership. On one occasion, Dr Beal, like other doctors present, was directed to abandon one patient, and move to another who was shortly due to have been waiting for four hours. He noted that the department was significantly understaffed and that the overworked staff were under so much pressure that they were often brisk and curt with patients when they did finally attend to them. In the meantime, many patients were left waiting in bays and cubicles with their basic nursing needs overlooked. The whole A&E department was visibly dirty, and Dr Beal noted that it was abundantly clear that some examination cubicles were not being cleaned because the dirt in them was present from one week to the next. He concluded:

> *Overall, I didn't recognise the hospital where I had trained and worked.*[285]

7.300 Coincidentally, on 4 April 2008, Stuart Poynor conducted a routine visit to the practice at which Dr Beal worked. During the visit, Dr Beal raised his concerns about his experience of the poor quality of clinical care in A&E with Mr Poynor, in addition to stating that he had had concerns about the culture at the Trust dating back to his time in the SWSPCT.[286]

284 Beal WS0000040516–7, paras 41–44
285 Beal WS0000040516, para 44,
286 Beal WS0000040517, paras 45–46

7.301 In response to what he had heard from Dr Beal, Stuart Poynor formally asked the two PBC consortia, Stafford and Surrounds PBC and Cannock Chase PBC consortium, for their views on the quality of care at the Trust. He received their responses in letters on 16 and 17 April respectively. Like Dr Beal's observations, many of the significant concerns outlined in the letters were closely aligned with the HCC's ultimate findings.

7.302 Although neither consortium reported any concerns regarding clinical competence or outcomes, both indicated that they had received numerous reports of poor quality clinical care at the Trust. They further stated their understanding that things had been consistently bad, and without improvement, for two to three years.[287]

7.303 Cannock Chase PBC consortium summarised the main areas of concern as follows:

- Cleanliness of wards;
- Poor discharge planning;
- Poor management of medication on admission and discharge;
- Poor staffing levels, particularly for nursing and support workers;
- Poor communication with patients' relatives/carers;
- Disorganised management on wards, eg inter-ward transfers of patients;
- Slow, or no, response to complaints;
- Inadequately completed discharge letters (although the timeliness of their receipt had improved).

7.304 They highlighted in conclusion:

> *The common link for a number of the above revolve around the apparent reduced nurse staffing levels and the impact this inevitably has had on the basic care and respect for patients.*[288]

7.305 Stafford and Surrounds PBC consortium's concerns fell under similar headings to the above. They, however, gave specific examples of negative patient experiences. These included:[289]

- The story of an 18-year-old girl who spent three weeks in the Intensive Treatment Unit only to be discharged with discharge information amounting to "a couple of lines" which were completely inadequate to ensure the continuation of proper care;
- The specific example of a patient who was discharged with an MRSA-infected skin ulcer which he/she had reported to the ward staff during admission, to no avail. MRSA was diagnosed upon the ulcer being swabbed for the first time by a GP in the community;

287 GG/28 WS0000015546 and WS0000015550
288 GG/28 WS0000015549–50
289 GG/28 WS0000015546–7

- More than one example of patients being discharged with venflons still in place, and vulnerable patients being discharged with no support;
- Many anecdotes about inadequate levels and quality of nursing care, in particular failure to feed patients properly or deal with them in a polite manner whilst taking them to the toilet;
- Instances of patients' need for pain control being overlooked in A&E by staff who were diverted to deal with patients with more minor injuries simply to satisfy the A&E target;
- The case history of a patient who presented herself to the Trust on three occasions whilst feeling particularly unwell and suffering from palpitations. On each occasion she was made to wait three hours to be seen, such that her symptoms had subsided by the consultation, making diagnosis impossible. Finally, her cardiac arythmia was diagnosed by her GP;
- Waiting times in A&E, which were described as a problem generally, with some practices making the policy decision to send even those capable of making their own way to hospital to A&E in an ambulance, so as to afford them the comfort of waiting to be seen on a trolley.

7.306 Both consortia indicated that they had sought to address the concerns brought to their attention by contacting individual consultants and/or departments at the Trust, often with little or no response, let alone any which dealt with the root of the problem.[290] Dr Beal similarly said that GPs would normally raise any concerns directly with consultants.[291] This was no doubt one reason why the PCT struggled to identify common themes of poor care in relation to the Trust.

Unannounced visit to the Trust – April 2008

7.307 The SSPCT conducted a number of unannounced visits to the Trust, starting very soon after the announcement of the HCC investigation and the receipt of the patient complaints. These visits took place with the agreement in principle of Mr Yeates. Yvonne Sawbridge described the rationale of the visits:

> *We were aware it* [the HCC investigation] *was going to take some time. We had live issues coming forward of incidents happening, poor care happening currently in the trust. We had a responsibility, as a commissioner, to our residents and we wanted to go in and see for ourselves if there were any immediate actions we felt we could take to support the trust to start putting things right, rather than wait for the process to finish ... We were in touch with them throughout their visit – throughout their investigation and they had assured Mr Poynor that if there were any serious concerns they would raise them with us.*

290 GG/28 WS0000015548 and WS0000015551
291 Beal WS0000040518, para 49

But we still felt we needed to do something else more promptly because, of course, on the back of that we were able to offer some practical support more immediately than waiting for another investigation – sorry, the outcome of that investigation.[292]

7.308 More light on the rationale was offered by the report prepared following the first visit, which took place on 17 April. In describing the background to the visit, this stated that the PCT had been:

Working with MSGH re issues and concerns and there was a sense that the quality of services and standards were improving. This was based on a range of activities; reduction in HSMR and personal testimony – Director of Nursing (MSGH), talking to relatives and hearing more positive stories; some GPs stating it was improving and LMC [local medical committee] *public support for the Trust etc. There was clearly more work to do, but actions were in place to take this forward.*[293]

7.309 However, the report went on to say, it was no longer clear that the Trust was improving, leading to the visit described. This concern was based on a number of factors: the views elicited from GPs at the recent meeting; the failure to recover A&E performance, with particularly bad performance that month and the end of year target already in danger of being breached; and analysis of the patient stories received by the PCT (see above), the majority of which had occurred in the previous 12 months.

7.310 To say that these recent events triggered concerns that the Trust was no longer improving suggests that there had been previous cause for concern about the Trust harboured at the PCT over a sustained period. During this time, the PCT had been hampered by the absence of an effective handover of information available to predecessor bodies, and of accepted and effective quality metrics. It had been reassured that there was continuing improvement by assurances, anecdote and impression, without any sustained focus on what the implications of issues, such as the HSMR, were for patient safety and well-being.

7.311 Ms Sawbridge claimed in her statement to the Inquiry that:

In early 2008 prior to the HCC investigation there were no substantial concerns raised with the PCT which would have suggested that the other albeit limited indicators of quality … were giving a false picture.[294]

7.312 While this may well be an accurate description of the state of mind of the PCT in 2008, a system allowing this to be the case was deficient. It had insufficient regard to the risks to

292 Sawbridge T64.169–171
293 YS/34 WS0000013880
294 Sawbridge WS0000013421, para 112

patients implied by the concerns and issues of which the PCT was aware, and the system in which it worked did not encourage it sufficiently to do otherwise. The reliance on the assessments made by others as amounting to a fulfilment of the responsibilities placed on the PCT by statute may be thought to be an example of a more widespread culture, which discouraged independent analysis, action and assumption of responsibility.

7.313 In practice, the visits were not completely unannounced in that one hour's notice of the visit was given to Mr Yeates, but not of the areas to be looked at.

7.314 The first visit, on 17 April 2008, was undertaken by Yvonne Sawbridge, two GPs and a nurse consultant. While they saw much on which they were able to report positively, they also recorded significant areas of concern, including the following:[295]

- An elderly patient in the Trust's Emergency Admissions Unit (EAU) had not been offered food, drink or pain relief since the morning and, if ordered to be "nil by mouth", had been left unaware of this.
- Another EAU patient complained of the length of time waiting for discharge.
- A third had witnessed a cleaner using the same cloth to clean the toilet and the sink.
- A&E was so busy and understaffed that with two seriously ill babies in resuscitation there was no triage available. Patients were left without communication of what to expect or how long they would have to wait. Some were unsure whether it was safe to eat or drink. Pain relief had not been offered for "many hours" to some patients, including a man with steel in his eye, and a child with a minor head injury.
- In wards 11 and 12, staff were found to be very demoralised and the wards were short-staffed: there were three registered and three non-registered staff on duty for 22 beds against an establishment of four and four, with one sister for three ward areas. One patient had been in a soiled nightdress since lunchtime: relatives had been forbidden to clean her because of the risk of infection. Relatives of another patient who had been there for a week complained of not having been informed of the reasons for this or the plan for her care.

7.315 The report's conclusion was:

> *Clearly wards 11 & 12 and A&E were the areas needing most support, but the situation was not considered unsafe and A&E clinical care was appropriately prioritised. Some patients had noticed improvements, and several felt the care was good or excellent. In fairness this was in areas where staffing levels were at establishment levels. The first*

295 YS/34 WS0000013880; PCT00280070309

priority for the Trust is to improve staffing levels therefore, and implement their recruitment plan. There were other areas where short term measures might be appropriate to support staff who were struggling at the moment.[296]

7.316 Given the matters uncovered, the conclusion that the "situation was not unsafe" was surprising, and indeed the PCT's subsequent actions did not suggest that it had been reassured. It is not clear on what basis the PCT representatives were justified in that conclusion. Ms Sawbridge pointed out to the Inquiry that the members of her group were not trained to undertake inspections, but, as she herself asserted, they were experienced clinicians.[297] Ms Sawbridge agreed in her evidence that what they found was a "shocking state of affairs".[298] She described their reaction at the time:

Our reaction was there are serious issues here. We can't wait for the Healthcare Commission to look any further. We need to work with the trust to put things right, and those areas that we agreed were what seemed to us the immediate things to start and carry on meeting with the trust weekly and offering what support we could to get things right.[299]

7.317 Yet the inspection party's conclusion was that the situation was not unsafe. Her explanation for that conclusion was:

Our assessment – or the clinicians' assessment on that night was that it wasn't so unsafe that we had to close A&E, even if that was within our powers, because ... you're balancing the what are you going to do with all the patients? It's much better to go in and work with the trust to make it right ...

... if people had been sitting there for hours with very serious clinical issues and not being prioritised, then I think that would have felt different. But the people waiting, my understanding from the clinicians that went there, was that they were – they'd been prioritised accordingly. It wasn't right for them to be waiting so long, clearly, and it wasn't a good-quality service, but the clinical priorities were being dealt with, you know, in a managed way.[300]

7.318 An A&E without triage, failure in the provision of pain relief, or failure in communication to or advice for waiting patients through understaffing is one in which the safety of patients is at risk. A short-staffed and insufficiently led large ward caring for elderly patients, with norovirus present, is an environment putting vulnerable patients at risk of neglect, as evidenced by the patient who had not been cleaned. Regrettably the conclusion of the report suggested an

296 PCT00140002584, *Report on Unannounced visit to Mid Staffordshire General Hospital* (17 April 2008)
297 Sawbridge T64.177–178
298 Sawbridge T64.186
299 Sawbridge T64.187
300 Sawbridge T64.188–189

inappropriate degree of tolerance for the unacceptable. The argument advanced by Ms Sawbridge as to the potential consequences of closure of A&E properly pointed to the severe challenges that have to be faced when a service is found to be unsafe. However, this report found serious concerns elsewhere in the hospital as well. The proper approach would have been to face up to those challenges in the report, rather than concluding that the "situation" was not unsafe. The A&E department and the wards referred to were clearly unsafe; it would have been better for the report to recognise that to have been the case and then address the need to protect patients' safety.

7.319 This was particularly the case, given a background of the PCT having been previously assured that matters were improving. Furthermore, the PCT now had some additional means to take action, through the 2008/09 contract, which was now in force. Clause 10.4 entitled the PCT to insist that the Trust implement a "learning from complaints" initiative with a view to evidencing improvement to services.[301] This could have been used in respect of some or all of the complaints gathered by the PCT first hand whilst speaking to patients during the inspection. The PCT could also have called a series of monthly Clinical Quality Review Meetings under the new clause 33 to discuss quality concerns at the Trust.[302] However, the first mention of any consideration of clause 33 does not appear until the PCT's review meeting with the Trust of 15 July 2008, at which it was ruled out.[303]

Other action

7.320 The reaction of the PCT was more assertive than might have been suggested by the tone of the report's conclusion.

7.321 Ms Sawbridge met Dr Helen Moss, Director of Nursing at the Trust, on 18 April 2008. She emphasised to the Inquiry that to call such a meeting at such short notice was highly unusual.[304] At the meeting, Ms Sawbridge agreed that the staff plans formulated in February were "sound" but that a short-term action plan was needed. Ms Sawbridge told the Inquiry the steps she thought were required included:

- Additional senior nurses to work with the existing staff to develop practice and challenge poor practice;
- The recruitment of a deputy director of nursing;
- Nurses to focus on relatives during visiting times;
- Provision of "hostesses" in A&E to provide "simple advice" to patients.

Some short-term financial support was offered.[305]

301 GG/18 WS0000015127
302 GG/18 WS0000015144
303 YS/40 WS0000013945
304 Sawbridge WS0000013434, para 156
305 Sawbridge WS0000013434, paras 157–158

7.322 On 22 April Mr Poynor wrote to the Trust describing what the PCT intended to do in response to the concerns raised by the visit, the patient complaints and the local PBC consortia. This included:

- Recruitment of a project manager to take forward a project to introduce GPs to assist in A&E;
- Facilitation of the appointment of clinical tutors to assist with service development until the arrival of the intended Modern Matrons;
- Support to introduce a rapid response team to assist patients on the wards with essential care needs.

7.323 The PCT would assist with funding of these measures, but Mr Poynor noted there had been "slippage" by the Trust in its previously agreed investment, and required details of the shortfall. He also required the Trust to provide the PCT with all complaints dating back to April 2005, and with Monitor's views of the current situation. Finally he required facilities for a half day personal visit to the wards.[306]

7.324 Further action taken by the PCT included:[307]

- Agreement of further measures in A&E;
- Further non-recurrent funding of £350,000 for senior nursing staff (in addition to the £1.15 million already agreed for support of the changes needed following the nursing skill mix review);
- Monitoring of the Trust's A&E action plan;
- Commissioning of a review of A&E by Heart of England NHS Foundation Trust.

7.325 Mr Poynor was concerned at the Trust's approach to the financing of the necessary nursing staff. He perceived that the Trust was expected to make a surplus for the year of £1.6 million, but that it appeared unable to fund sufficient staff for the wards. He told the Inquiry that he had a heated discussion with Mr Yeates whose position was that the Trust had to meet Monitor targets. Mr Poynor thought it was morally wrong to put targets of that sort ahead of the nursing needs of patients:

> *This is when the impact of Foundation Trust status really hit me and I told Martin that the approach they were adopting was morally wrong ... I think it was at this point that the business environment at the Trust and the quality of care versus the financial regime really came together for me. My view was that the Trust had to go back to Monitor to say that they could not meet the financial targets; it was not a case of sacrificing care.*[308]

306 SP/36 WS0000014586
307 Poynor WS0000014335, paras 225–227
308 Poynor WS0000014334, paras 223–224, page 55

7.326 There is no doubt that the PCT undertook a considerable amount of action in the immediate aftermath of the inspection on 17 April 2008. It is, though, open to question whether it adequately addressed the short-term need to protect patients from risk. Most of the actions taken, for example the recruitment of more nurses and the proposed review of A&E, were not going to bear fruit immediately. It has to be accepted that closure or withdrawal of a service are theoretical options, but ones which are made practically difficult because of the impact on patients needing treatment. If no better tools are available to a commissioner faced with a situation like this, serious consideration needs to be given to the development of mechanisms, such as some form of immediate clinical intervention, which will provide immediate patient protection. A capacity needs to be developed whereby commissioners, acting if necessary in conjunction with the regulators, can source and place appropriately experienced and authoritative teams of medical and nursing practitioners to take any necessary steps to ensure that fundamental standards are being observed for all patients.

7.327 The unannounced visits by the PCT continued and Mr Poynor thought that by December 2008 improvements were being noticed:

> *Gradually, there became some sense of assurance and normality as we moved through 2008. We continued to conduct unannounced visits, and were aware that the HCC went back and visited A&E around Christmas 2008. The HCC appeared to be comfortable with how things had improved.*[309]

7.328 Such visits were unprecedented, but in the circumstances, it was decided to visit other providers. Mr Poynor told the Inquiry that the PCT did not have the power to insist on such visits. However, as has been seen above, the 2008/09 contract did in fact oblige the Trust to acquiesce to visits at the request of the PCT.

7.329 From April 2008, commissioning meetings were reordered to enable a greater focus on quality issues; Yvonne Sawbridge led for the PCT and the meetings were attended by clinicians from the Trust. The purpose of the meetings was to consider evidence that the measures in the quality schedule were being delivered.[310]

7.330 The PCT received copies of the HCC's letters to the Trust of 23 May and July 2008, which are considered below.

7.331 Ms Sawbridge maintained regular contact with Helen Moss, including quarterly review meetings. For example, in July 2008 Ms Moss shared with her the plans she had for improving

309 Poynor WS0000014336, para 230
310 Sawbridge WS0000013435, para159

the quality of care.[311] Progress against this plan was checked on behalf of the PCT by its attendance at the Trust's Executive Governance Group meetings.

7.332 The SSPCT commissioned a report from Dr Foster Intelligence (DFI) which was produced in July 2008.[312] It described the different methodologies used by it, CHKS (an independent company providing healthcare intelligence) and the HCC, and set out the HSMR figures for the Trust and two other trusts for 2005/06. It suggested that the high rates for all three trusts were associated with non-elective admissions. It also reported that DFI's own analysis did not suggest very poor data coding for any of the trusts of interest to the PCT. With the exception of the last point, the report appears to have been of limited use to the PCT. It did not even offer an analysis of the most recent figures. This was noted by Mark Powell, Head of Performance Management at SSPCT:

> *It appears that the main rationale for obtaining the report was to try to gain an insight into the Trust's then current position. The DFI report simply did not achieve this.*[313]

7.333 More helpfully, the PCT began using the DFI real time monitoring tool which enabled it to see the same data as the Trust had available. The PCT Board was then able to receive up-to-date mortality reports on a monthly basis. However following 2009/10, the PCT has relied on its contract to obtain monthly figures for specific specialties from the Trust.[314]

7.334 Dr Ballard found the real time tool to be very useful in challenging the Trust and to spot trends.[315] However, the SSPCT struggled to understand the significance of changes in the rate. In December 2008 a dramatic reduction in the Trust's HSMR concerned it. The SSPCT's suspicion was that this had been due to a change in coding practice and it wished to confirm that the Trust had been applying the correct processes. A report in February 2009 to the PCT Board stated that the Trust had indicated that the change had been due to a "change of pathways in A&E" and also that clinical coding would have had an impact.[316]

7.335 While it was commendable of the SSPCT to seek to inform itself about HSMR methodology and to obtain and consider up-to-date figures, without its own statistical expertise it was very difficult for it to interpret the information available in a way which would assist the performance of its duties. Mortality analysis is clearly an important source of information but it was understandably beyond the ability of an individual to do more than was done by SSPCT.

311 YS/41 WS0000013948
312 RT/20 WS0000044197
313 Powell WS0000077131, para 12
314 Powell WS0000077134, para 20
315 Ballard WS0000040634, para 65
316 Powell WS0000077134, para 21; MP/15 WS0000077324

Enforcement action

7.336 The SSPCT found difficulty in enforcing the strict terms of its contract with the Trust as the instruments provided in it were blunt. Financial sanctions or withdrawal of a service from the Trust might have been self-defeating and have resulted in a deterioration of service rather than an improvement. This dilemma was expressed by PCT witnesses.

7.337 Yvonne Sawbridge said:

> *A Performance Notice was a powerful tool as it had financial repercussions for the Trust. Clearly, we had to balance up the benefit of invoking this to bring about change, against the effect it would have on patients, given that the Trust would have even less money as a result.*[317]
>
> *... It was a frustrating time for us as we could see things needed to change but did not always have the mechanisms to make the changes. Our only real options were to escalate matters through the contract, but this was not straight forward as service withdrawal took time and the performance notices had cost implications which were not necessarily helpful in the long run.*[318]

7.338 Alex Fox told the Inquiry:

> *These contracts, okay, you can argue they're legally binding, but the reality is that how do you implement a contract when you've got a service like Mid Staffordshire hospital and you have a contract with* [section] *32 and 33? The ultimate sanction is you either close the hospital or you take significant funds away. Neither is an option. So that's what I mean; there has to be other sanctions brought to bear, because it would not be acceptable, it wouldn't have been acceptable to take either of those actions ...*[319]
>
> *... THE CHAIRMAN: Does it amount, then, to an acceptance that to some extent, not completely, the concept of commissioning by contract is a little bit of a fiction?*
>
> *A. My own personal view that in these circumstances, if you take away from the additional scrutiny that actually is now going in on quality, if you just leave that to one side, then the contract could be described as a fiction, because if it has no teeth, how do you implement the penalty that drives the contract?*
>
> *THE CHAIRMAN: So that means you are then reliant on a regulator who is not bound by a contract or commercial considerations, although, no doubt, we'll hear that they were also concerned that people continued to get treatment.*

317 Sawbridge WS0000013437, para 166
318 Sawbridge WS0000013440, para 175
319 Fox T66.97

A. And goodwill.[320]

7.339 This is not to say that the SSPCT did not use the contractual provisions at all. In July 2008 at a commissioning meeting, Geraint Griffiths expressly reserved the PCT's right to invoke the enforcement provisions in clause 33, although it was prepared to defer this pending the HCC investigation and the Heart of England A&E review.[321]

7.340 A performance notice under clause 32 of the contract was finally issued on 1 October 2008 in connection with the Trust's continuing failure to meet the A&E waiting time target.[322] Although the PCT sensed that the Trust was trying to remedy the deficiencies relating to the A&E target, the reality was that the Trust remained at a compliance level of 70% when the national target was 98%. The Trust described the performance notice as "unhelpful" and asked the PCT not to take the formal step of issuing it. The PCT nevertheless felt compelled to do so in the circumstances:

We had to hold the Trust to account in relation to that, or there would have been no point in having a contract.[323]

We would have failed in our role as commissioner if we had not taken this step and might as well have torn up the contract. The Trust could not have it both ways.[324]

7.341 The performance notice required the Trust to resolve its failings by 31 October 2008, and reminded it that a warning notice could follow any further performance notices.

7.342 The issuance of the performance notice did have some benefit in that it prompted the Trust finally to give the PCT sight of, and an opportunity to comment upon, its action plan and proposals. Geraint Griffiths said:

It also meant we could hold the Trust to account in terms of their planned delivery.[325]

7.343 Nevertheless, in light of their prior representations, the Trust did not respond well to receipt of the notice, complaining that it was "unhelpful", making commissioning meetings particularly difficult throughout 2008/09. That said, in light of the fact that performance and quality were now being dealt with in separate meetings, the negative impact of the Trust's complaint did not extend to the conversations that the PCT was having with the Trust on quality issues. Those conversations were more positive.[326]

320 Fox T66.99–100
321 YS/40 WS0000013945
322 GG/36 WS0000015609; YS/48 WS0000013993
323 Griffiths WS0000014893, para 158
324 Griffiths WS0000014893, para 157
325 Griffiths WS0000014893, para 158
326 Griffiths WS0000014893, para 160

7.344 Ultimately, this performance target was not met and a further performance notice concerning missed targets in A&E was issued on 4 November 2008.[327]

7.345 In the end, the main contribution the contract appears to have made in assisting the PCT's intervention in the Trust's affairs was through the access it gave to information, the right to visit, and the close communication around the commissioning review meetings.

Response to the Healthcare Commission's letter of May 2008

7.346 On 23 May 2008, Heather Wood copied Stuart Poynor into her letter to Martin Yeates, detailing the findings and concerns arising from the HCC's visits to the A&E department between 20 and 22 May 2008.[328] Mr Poyner had already been notified by Dr Wood of the general outcome of the visits by phone at 23:00 that night.[329] Mr Poynor told the Inquiry that he had asked Dr Wood whether the A&E should be closed, and that she had said it should not.[330] This was indeed her view. She told the Inquiry that:

> *Because we unearthed such serious concerns about the safety of patients in A&E, the team had to consider whether to issue a notice to close the Department. However this would have been a major step to take with very serious implications – not least where patients could go ... This was an occasion where the risks to patient safety required immediate attention and we flagged those up for action straight away.*[331]

7.347 The concerns expressed in the letter centred around poor staffing, the poor quality and efficiency of care delivered, and the almost complete lack of effective governance. It was concluded that:

> *The quality of care is compromised and ... this constitutes a risk to the safety of patients.*[332]

7.348 A meeting between the Trust and the PCT had already been convened on 22 May 2008 in light of the phone calls, and this was followed up in a report by Geraint Griffiths on 28 May 2008 dealing with the Trust's financial capacity to address the matters outlined in the letter (which was referenced).[333] At the meeting, the Trust had asked that the PCT provide an additional £775,000 to pay for additional staff, including two consultants, seven mid-grade doctors, and further nursing and support staff. This request had been refused. In the report, it was explained that the Trust had also identified a £2.5 million shortfall in the funds

327 Griffiths WS0000014892, para 154
328 HW/6 WS0000025130
329 KM/50 WS0000011712
330 Poynor WS210 WS0000014331
331 Wood WS128 WS0000025057
332 HW/6 WS0000025133
333 KM/50 WS0000011712

available to correct nursing capacity and skill mix issues. They had asked that the PCT provide £1.35 million to make up the shortfall, on the basis that the Trust could gather £1.15 million for that purpose. Mr Griffiths's report stated that the PCT:

> *is not sympathetic to their request to fund the £1.35 million gap … Under PbR there is no mechanism to make an additional payment for these costs.*[334]

7.349 The report did, however, recommend that the PCT should meet a total of £354,400 in non-recurrent costs relating to the Trust's response to the investigation, including the funding of a "senior nurse secondment", a "peer support consultancy", a "project manager" and an "administrator". Their application for funding for "public relations support" and a "PWC due diligence review" under the same heading was refused.[335]

7.350 Yvonne Sawbridge recalled that following on from this, the PCT did ultimately fund some additional staff sourced by Peter Blythin of the WMSHA.[336]

7.351 Notwithstanding his statement in the report, in his oral evidence Geraint Griffiths used the PCT's response to the Trust's requests for finance following the HCC's inspection of A&E as an example of reasoned and pragmatic commissioning, as compared with the approach favoured by GP commissioners:

> *A … following the Healthcare Commission inspection of A&E, which led to the meeting with – with Martin Yeates and others, the PCT took a decision to invest in the trust over and above tariff to meet immediate concerns, which was opposed by the GPs. And I think at times the PCT has had to take a view of the wider interest, rather than being purely driven by the views of the GP commissioners.*
>
> *THE CHAIRMAN: Can I ask what your understanding is of why they took that view?*
>
> *A: I think it's – an ideological approach, really. I think their view is "Tariff is tariff, we should put the money into the trust that would be generated through the national contract but no more". And it would be the trust's total responsibility from that point to deliver or not deliver. As we – as we discussed earlier, there is a wider issue about sustainability of service and being able to maintain safe running in the short-term while you put a longer-term plan in place, that the GPs wouldn't always recognise.*
>
> *… their view is simply if the trust has got the money under tariff, the trust is responsible for dealing with all issues within that money* [sic].
>
> *THE CHAIRMAN: That's the theory, isn't it?*

334 KM/50 WS0000011713
335 KM/50 WS0000011715
336 Sawbridge WS0000013437, para 164

A. And that's right. At a pure – at a pure contractual level, that's absolutely true. But, clearly, when you uncover issues which – which are much more difficult to resolve and which have a much longer time frame, if you take a simple contractual approach, you are more likely to make the problems worse in the short-term. There are times where you have to recognise you've got a problem and work with the trust to fix them, rather than simply saying "It's over to the trust to resolve. You've had the money, you're on your own". So it's a difference of approach.[337]

7.352 On 7 July 2008, Stuart Poynor was copied into a second letter from Dr Wood to the Trust. This disclosed that the HCC had received over 100 complaints about poor care from patients and relatives, and that a third of those related to medication. Some patients had been taken off the correct medicine, some had been given incorrect medicine, and some had not been given medicine. The medication issue, the HCC said, required a response in the short term.[338]

7.353 The minutes from the commissioning meeting held on 15 July indicate that the "medicines management" issue had come as something of a surprise to the Trust, and that the PCT appears to have accepted the Trust's assurance that they "believed that they had everything under control".[339]

7.354 The third letter to the Trust, into which the PCT was copied, was sent by Heather Wood on 15 October 2008.[340] Although by this time the PCT had been sufficiently concerned to issue its performance notice relating to the four-hour A&E target, Dr Wood's letter, which again highlighted continuing failures in clinical care, does not appear to have been mentioned at the meeting of the PCT's Quality and Safety Committee on 31 October.[341] Whilst the letter stated that it was being forwarded to the DH, Monitor, the SHA and the PCT "for information only", it is perhaps surprising that the PCT does not appear to have engaged with all the issues it raised.

Interaction following the Healthcare Commission report

7.355 The PCT's intervention with the Trust increased following the publication of the HCC report in March 2009:

- The unannounced visits continued.
- Stroke services at the Trust were decommissioned on the basis that clinical safety was compromised.[342] Alternative arrangements were made with local accredited providers of

337 Griffiths T63.206–208
338 HW/7 WS0000025135
339 YS/40 WS0000013943
340 HW/8 WS0000025138
341 YS/49 WS0000013997
342 Griffiths WS0000014899, para 182

stroke services in the short term until May 2009, at which point providers in Wolverhampton and Stoke were commissioned to provide all stroke services on a permanent basis. The PCT's decision to move services to those higher capacity centres followed a lengthy and detailed consultation between the SSPCT and various local hospitals, PBC consortia and ambulance services. Each stroke admission of the previous 12 months was mapped, and detailed calculations performed to gauge how long it would take to get patients to particular providers by ambulance. The PCT invested in additional ambulances to support the venture.[343] Karen Morrey, Director of Operations at the Trust, supported the move, but the decision was met with significant resistance from senior clinical staff at the Trust. The PCT also took the opportunity at this time to harmonise stroke systems across Wolverhampton and Stoke so as to enable the creation of a "stroke register" and a joint audit programme to monitor quality development.[344]

- At the request of the Secretary of State, the PCT took over from the Trust the Independent Case Note Review for families affected by poor care. The themes that came out of this review correlated with those highlighted in the HCC report.[345]
- Further performance notices were issued. A further six were issued to the Trust between June and October 2009.[346] They arose in the areas of six-week diagnosis, "Choose and Book" (two notices, issued in July and September 2009), cancer targets (all), thrombolysis and A&E. The latter was issued in October 2009. It is apparent that the PCT was taking a reasoned but very firm approach to issuing these notices.[347]
- By agreement with Monitor, and with the Trust's consent, a Quality Assurance Project was run by Yvonne Sawbridge between May and August 2009. This afforded PCT staff free access to the Trust. Ms Sawbridge led a small team of senior nurses and an experienced external consultant in viewing 25 areas of the Trust. They spoke with patients and staff alike, and attended internal meetings.[348] Their goal was to satisfy themselves first hand that the Trust was making the appropriate level of progress, as stories of poor patient experience were still coming through.[349] They adopted the Quality Assurance Project approach, as opposed to launching a service review under clause 33 of the contract, so as to avoid restricting the scope of their inspections, and in order to keep the Trust on side.[350]

7.356 Yvonne Sawbridge met with the new Chief Executive at the Trust, Antony Sumara, on 15 September 2009 to discuss the Quality Assurance Project. The following day, she sent him a letter confirming what they had discussed and what the PCT expected of the Trust going forward.[351] The letter stated that:

343 Griffiths WS0000014898, paras 178
344 Griffiths WS0000014896–7, paras 171–177
345 Sawbridge WS13451, para 210
346 GG/35 WS0000015607
347 YS/61 Ws0000014213
348 Poynor WS0000014342, para 257
349 Sawbridge WS0000013448–9, paras 203–204
350 Sawbridge WS0000013449, para 205
351 YS/61 WS0000014208

- In respect of SUIs, and feedback to staff about incidents:

  We expect a much higher and faster standard of investigation and risk management than the routine contract obligations, given the need to manage anxiety, and rebuild the reputation of the Trust.

  ... feedback to staff from incidents is not systematic and this is a critical component in building the requisite culture to learn from events;[352]

- In respect of the need for a stronger focus on patient experience:

  The complaints process indicates that ownership and levels of expertise in the divisions needs to be embedded, moving away from a defensive response to a more open and responsive attitude;[353]

- Any further failure to provide outpatient waiting list conciliation information would result in the PCT imposing a financial penalty of £350,000, something which the PCT had chosen not to do earlier in the year;[354]
- The PCT would require regular, detailed and up-to-date reports on the Trust's work to improve staffing levels;[355]
- The Trust and the PCT would work together to identify ways of measuring the implementation of the Trust's plans, particularly the Transformation Plan.[356]

South Staffordshire Primary Care Trust scrutiny of the Trust during this Inquiry

7.357 The scrutiny operated by the SSPCT towards the end of its life has clearly been more intense than it had been in earlier days:

- The Quality and Safety Committee was receiving monthly analytical reports on complaints, incidents, infection and mortality rates.
- Announced and unannounced visits continued routinely.
- Use was made of the WMSHA's Quality Dashboard which brings together a range of quality information and seeks to highlight areas for attention. The contents of this tool are still in development.
- The SSPCT had, and has, access to the Care Quality Commission (CQC) Quality Risk Profiles (QRPs), although its experience is that these do not highlight issues of which they were not already aware through other means.
- "Soft intelligence" from PBC consortia is sought to be captured in a new system set up by the PCT. Information is sought systematically at meetings and collated centrally. The PCT has found this a useful tool.[357]

352 YS/61 Ws0000014209–10
353 YS/61 Ws0000014211
354 YS/61 WS0000014214
355 YS/61 WS0000014210
356 YS/61 WS0000014212
357 Poynor WS0000014349, para 285

- The SSPCT's PEC was restructured to enable each PBC consortium to elect a representative.
- GPs were offered a form on which to communicate concerns to the PCT, but they were not happy with this and it was instead hoped to develop a telephone helpline for them.
- At the end of 2008, the PCT created a Patient Council as an umbrella group for the patient participation groups or forums. These groups had been developed in GP practices with the help of £3,000 funding per practice from the PCT. Each of the 98 groups elects representatives to the Patient Council which in turn has access via nominees to the PCT Board.[358]
- The PCT appointed patient engagement managers who would visit patient groups rather than wait for them to offer concerns and views.

Conclusions

Policy background

7.358 The development of commissioning from its origins in the purchaser – provider split of the 1990s was characterised by a theoretical emphasis on improving the quality of service without great attention being paid to the tools with which to deliver this. The emphasis in practice was on financial control, and in relation to quality the balance of bargaining power remained firmly in the hands of the provider organisations.

7.359 It is important to remember, as submitted on behalf of the PCT, that commissioning was not a tool which sat in isolation but was part of a complex system of oversight and regulation.[359] However, there can be little point in setting up something as complex, and expensive, as a commissioning system, unless it is effective to achieve the objectives for which it was created. In its 2008 review of standard setting in the NHS, the Rand Corporation commented:

> *We were struck by the degree to which Commissioning was talked about as the answer to many problems. This was particularly striking because the basic infrastructure that would be necessary to make Commissioning accomplish the many goals attached to it does not appear to exist. Further, the idea of Commissioning appears to be driven more by heavy handed purchasing strategies than a cooperative approach. Both Kaiser and VA* [Veterans Association] *start with the assumption of mutual exclusivity – the health plan and the medical group (Kaiser) or the regions and the central office (VA) are dealing only with each other. In negotiating their respective contracts, the groups both approach the engagement from a collaborative rather than a contentious viewpoint. The negotiation focuses on how the groups can accomplish shared goals by using their resources in a coordinated manner. The negotiation entails an equal mix of clinical judgement (are we delivering right care, where are the gaps), operational understanding (how best can we*

358 Griffiths WS0000014911, paras 227–231
359 CL0000001342, *South Staffordshire PCT closing submissions*, para 16

organize staff), business expertise (what financial arrangements will we require), legal (what degrees of regulatory freedom are allowed). Ultimately, the negotiation requires excellent leadership from all parties.[360]

7.360 At the same time, the JCI reported in the same exercise a finding that there had been:

unachievable expectations of the commissioning process as the driver for quality improvement at the provider and practitioner levels. [361]

System and resources for monitoring quality

7.361 PCTs were large organisations with substantial budgets and staff, particularly in comparison with SHAs. They were over time provided with tools which in theory would have enabled them to lay down safety and quality standards, monitor performance against those standards, and pursue remedies on behalf of patients, individually and collectively, where those standards had not been met. In general, however, the nationally available guidance did not lend itself to more than relatively crude measures in this regard, the focus remaining, as elsewhere in the NHS system, on financial control. Development of more sophisticated tools both locally and nationally was slow with the result that it is not in the least surprising that, in spite of the rhetoric of quality, one of the worst examples of bad quality service delivery imaginable was not detected by this system.

7.362 Once the full extent of the deficiencies at Stafford became clear, the PCT substantially increased the intensity of its scrutiny of the Trust. The evidence made it clear that this would be unsustainable on a long-term basis. Yvonne Sawbridge said:

For any commissioner to have such a hands on approach to commissioning was unheard of. In the space of two years we had moved from a situation when access to data about patients' complaints was not accessible to the PCT to one in which we had full access to staff and patients and the freedom to witness the Trust in operation, from inside the organisation. It is self evident that this amount of time, effort and energy being devoted by a commissioner to one of the many provider organisations we deal with would be unsustainable as an ongoing activity without a significant increase in capacity.[362]

7.363 This will be the dilemma facing the NHS Commissioning Board and the commissioning groups in the reformed system. They must be provided with the infrastructure and the support necessary to enable a proper scrutiny of their providers' services, based on sound

360 PA0002000048, *Developing, Disseminating and Assessing Standards in the National Health Service*, McGlynn et al., page 48
361 PA0002000055, *Quality Oversight in England, Findings, Observations and Recommendations for a New Model* (January 2008), Joint Commission International, page 2
362 Sawbridge WS0000013447, para 201

commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.

7.364 Geraint Griffiths offered his view:

> *Q. Do you think it's actually desirable that commissioners, going forward, are involved so directly to such a great extent with providers of services, in terms of monitoring exactly how they provide their services, or do you think that it is preferable for some other body or bodies to do that task?*
>
> *A. I think ultimately it's going to come down to how much capacity you want to put into the quality monitoring area. I mean, if you look at the quality monitoring that's gone around Mid Staffs since 2008, that would be absolutely unsustainable for every commissioner to do for every provider, particularly if we start to expand the range of providers. So I think the danger of centralising everything into one regulator is it is then quite difficult to triangulate the data. I mean, one of the advantages at the moment of having CQC, Monitor, the PCT and the SHA involved round the trust is we're all sharing our experiences of what we know and we can sort of sense check what we know against other views. So the danger of putting all that into one body is that one body then only has its own interpretation. I think at some point it's very difficult to get a real in-depth view of how an organisation performs when you're outside that organisation. Unless you're in there all the time, seeing how services run, you can only ever get a snapshot for the time you're in or you can only ever look at information provided. Now, I think you need to do that and I think it's become more sophisticated, and I think can take more out of that. But ultimately the prime responsibility has to come within the provider, because they're the only people who have got that real-time data. So I think there's a balance between what the commissioner can do and what it needs to do.*[363]

Reorganisation

7.365 Throughout the period under review the purchaser/commissioning arm of the system was subjected to repeated reorganisation, usually taking place well before it had been possible to put fully into practice and embed the aspirations of the previous changes. The time and resources required to be devoted to reorganisation undoubtedly made it more difficult for PCTs to develop effective methods of imposing standard quality requirements and of monitoring their delivery. Professor Walshe's overview to the Inquiry of the effect of the reorganisations of regulators was echoed by the evidence about the experience of PCTs in South Staffordshire:

363 Griffiths T63.192–193

An obvious but important lesson is that establishing an effective set of regulatory arrangements takes time, and repeated revisions of the policy objectives, purposes and mechanisms make effective regulation more difficult and less likely.[364]

7.366 As Counsel to the Inquiry submitted, this logically must apply equally to the effect of the reorganisation of PCTs.

7.367 Sir Hugh Taylor, former Permanent Secretary of the DH, said:

The 2005 restructure was difficult, although I was not close enough to the detail to be able to comment further. In relation to the speed of the changes being rolled out, I believe that a sensible timetable was set but that, as is the case in any restructure, people rush towards their new role, as they sense their status and power in the old position diminishing. In practice, the whole process becomes accelerated as a result. Of course there are advantages and disadvantages to this, and the risks arising from the disadvantages need to be managed closely. The NHS, having been through a number of restructures, is good at coping with them on the whole. Nevertheless there will still be the inevitable loss of corporate memory and other challenges, as with any restructure. It is the role of the DH to ensure that people responsible for the reorganisation, and the people moving into the new roles, are aware of their responsibilities. This is always a risk and will continue to be so with any future reorganisation.[365]

7.368 Sir David Nicholson, Chief Executive of the NHS, also recognised these risks:

The risk with all reorganisation is that unless you are clear, you can lose momentum, focus and the very skills and people you need to take things forward.[366]

7.369 While the principle of putting GPs in charge of commissioning is one way of engaging clinicians more in informing and leading healthcare systems, it is very important to ensure that they have access to the wide range of experience and resources necessary to undertake a highly complex and technical task. The Inquiry has heard that the National Quality Board is undertaking continuing work on ensuring effective handover and legacy processes are in place for the new reforms. It is also working to ensure that the NHS Commissioning Board will only allow CCGs to assume their responsibilities when satisfied that they are ready. The National Quality Team has been working on production of guidance for handovers and quality monitoring.

364 EXP0000000097 *The development of healthcare regulation in England: A background paper for the Mid Staffordshire Public Inquiry,* Professor Kieran Walshe, page 17
365 Taylor WS0000061936
366 Nicholson WS82 WS0000067653

Concerns not raised by local general practitioners

7.370 The PCTs can legitimately point out that the doctors with whom they had the closest contact, the local GPs, only expressed substantive concern about the quality of care at the Trust after the announcement of the HCC investigation, when it had become obvious there were concerns and when they were specifically asked. There were clearly ample opportunities for GPs to raise issues, whether through the PBC consortia, the LMC, or direct to the PCT. It is likely that they did not do so because none of them thought the issues of which they had experience were sufficiently significant to raise in this way, as opposed to talking to the relevant consultant at the Trust to ensure that any immediate issue for a patient was addressed. There was no system, either at practice level, or within the consortia or the LMC, for such matters to be considered on a regular basis or for any collation of concerns. No individual or organisation can be singled out for criticism in this: they were not required to act in this way, and unfortunately it did not occur to any of them to suggest it.

7.371 It will be important for the future that all GPs undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They have a role as an independent professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.

Approach to safety and quality issues

7.372 The period under review was characterised, as found by Dr Colin-Thomé in his report, by at best a passive approach on the part of the PCT to the monitoring of safety and quality issues. PCT managers told him they had not been expected to take an active role in assuring the provision of high quality care.[367] Undue comfort was taken from the assumption that others had responsibility in that area, and little if any attempt was made to collect quality information in a systematic way. Agreements with provider organisations were lacking in sophistication or the tools to enforce standards.

7.373 It is not possible on the evidence before this Inquiry to determine if the PCTs of the West Midlands were exceptional in this regard, but those who worked for them who gave evidence did not believe they were. If this is true then there was a highly concerning gap in the system of oversight of safety and quality throughout the country. The implication would be that consecutive governments, and the DH, failed to accord sufficient priority to this area, being

367 DCT00000000022, *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation* (April 2009). Dr David Collin-Thomé

content with what was mainly rhetoric and lip service to a principle rather than effective implementation of a policy.

7.374 The aspiration to be "world class" was laudable, but the policy adopted did not succeed, at least in Stafford, in achieving reassurance for the public that "world class" service was always available to them.

7.375 It must be acknowledged that achieving the aim of World Class Commissioning would have made this country unique. The Rand Corporation in its 2008 report for the DH commented:

> *We would argue that being world class starts with getting the fundamentals right. From a clinical perspective, this might mean delivering care consistent with NICE Clinical Guidelines and the National Service Frameworks 95% of the time ... one imagines that this might contribute to substantial improvements in the health and well-being of the people of England. No other country has achieved this which would truly make England world class.*[368]

7.376 The difficulties in achieving this emerge from the evidence in Smith and Newdick's assessment of the effect of policy in this area over a prolonged period:

> *Much store has been laid by the potential of commissioning to plan, procure, monitor, review and reshape health services in ways that can assure clinical quality and cost-effectiveness. What emerges from research evidence and routine assessments of commissioning is however a picture of commissioning as struggling to have a significant or strategic impact, especially in relation to acute care, and more particularly unplanned and emergency services.*[369]

7.377 The situation appears not to have changed by 2010 when the House of Commons Health Select Committee reported in relation to commissioning:

> *Weaknesses remain, 20 years after the introduction of the purchaser-provider split. Commissioners continue to be passive, when to do their work efficiently, they must insist on quality and challenge the inefficiencies of providers, particularly unevidenced variations in clinical practice. Weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation has been made worse by constant reorganisations and high turnover of staff. Commissioners do not have adequate levers to enable them to motivate providers of hospital and other services.*[370]

368 PA0002000046, *Developing, Disseminating and Assessing Standards in the National Health Service*, McGlynn et al., page 46
369 EXP0000000048, *The Structure and Organisation of the NHS (November 2010)*, Chris Newdick and Judith Smith, page 48 para 118
370 *Health Select Committee Fourth Report of Session 2009–2010,* House of Commons (2010), page 38

7.378 Against that background it is a matter of no surprise that the poor care at Stafford went largely unnoticed by the PCTs. Or that such signs of concern as came to their attention were not accorded their proper significance and did not result in any effective corrective action until the full state of affairs began to emerge under the HCC investigation.

Reaction to high Hospital Standardised Mortality Ratios

7.379 While the SSPCT lacked specific expertise to address the detailed technical issues raised by the debate over the significance of the high HSMR in April 2007, it did have a responsibility to examine the consequences for the patients on whose behalf it had commissioned services at the Trust. On its own admission it relied on the assurances it received from the Trust and the work being carried out on behalf of the WMSHA. It would be wrong to attribute responsibility for not doing more to any one individual. At the time the PCT lacked sufficient clinical expertise to engage deeply in this sort of issue and it faced many organisational challenges. The temptation to be satisfied by the assurances and the work of the WMSHA must have been very great. However the PCT could, and on its own admission[371] should, have asked more questions designed to elicit the risk to patients and the possibility of past harm having been inflicted on its patients. What it did was to commission a report from DFI which did little more than explain the methodology and recite the figures. The PCT did not sufficiently put itself in the position of patients and their families and ask itself what they would have wanted to know.

Reaction to concerns

7.380 The SSPCT did monitor quality at the Trust with increasing intensity following the announcement of the HCC investigation. It did not rely entirely on an assumption that it had to await the outcome of the investigation. It was not deterred from action by the notional barrier created by the Trust's FT status, while always recognising that the responsibility for managing the Trust remained with its Board. What was less satisfactory was the time taken to address issues and the difficulty experienced in using contractual solutions to expedite improvements. This was in part due to the dilemma faced by many commissioners in not wishing to exacerbate an already undesirable situation by destabilising the provider when there was no alternative available.

7.381 The undoubted practical difficulties in closing hospital departments appear to have led to a willingness to accept that clinical safety was not compromised in spite of evidence which, if viewed from the perspective of a patient, should have suggested that it was. It should have been clear from the history and the nature of the deficiencies being reported, particularly in relation to staffing, that a dangerous situation had been allowed by the Trust leadership to develop and that urgent action and intervention were required. The PCT did take a great deal of action as described in this chapter. Indeed Dr Wood told the Inquiry that once the HCC

371 CL0000001466, *South Staffordshire PCT closing submissions*, para 214

investigation began, the HCC's impression was that the PCT took the matter seriously, undertook its own inquiries and tried to support the Trust in making the necessary changes. However, it is far from clear that steps were taken which fully protected patient safety in the immediate aftermath of the HCC's letters of May and July 2008. To the extent that this is because the PCT lacked the relevant tools for immediate intervention, consideration needs to be given to their development.

Insight

7.382 The SSPCT was a body which exhibited an encouraging degree of retrospective insight into the issues raised by the sad story of Stafford, and its witnesses provided many helpful reflections on the lessons to be learned. This aspect demonstrated the importance of providing continuity of knowledge and experience into the new commissioning bodies.

Commissioning in the future

7.383 The commissioning landscape has now changed with the introduction of the NHS Commissioning Board, its regional offices, and CCGs.

7.384 The Secretary of State and the NHS Commissioning Board are under a statutory duty to secure continuous improvement of services in relation to effectiveness, safety and experience, and to promote the NHS Constitution.[372]

7.385 However, the essential tenets required of the commissioning process may not have changed. The experience of Stafford shows an urgent need to rebalance and refocus commissioning into an exercise designed to procure desired standards of service for patients as well as to identify the nature of the service to be provided.

7.386 It is not possible from the evidence to this Inquiry to prescribe the detail of how commissioning should work by, for instance, laying out the terms of a new commissioning contract. Indeed that would not be helpful as it is likely that different terms will be needed to meet different requirements in different parts of the country. What has become clear are the overall principles that should be common to all healthcare commissioning for acute services. Some of these are clearly already being applied, but others may not be or may require greater emphasis:

- Commissioners act on behalf of the public on whose behalf they commission services with the resources provided by the Government. They must be accountable to Parliament (via the NHS Commissioning Board and, ultimately, the Secretary of State for Health) for their stewardship of the resources allocated and compliance with other centrally issued requirements, but they should also be accountable to their public for the scope and quality

372 Health and Social Care Act 2012 section 2; National Health Service Act 2006 section 13C, 13E inserted by 2012 Act section 23

of services they commission. Local clinicians have the advantage of being closely in touch with their individual patients and their needs, but that is not sufficient to make them aware of concerns, as the experience of Stafford shows. Acting on behalf of the public requires its full involvement and engagement:

  - There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners.
  - There should be lay members of the commissioners' board.
  - Commissioners should create and consult with patient forums and local representative groups. Individual members of the public, (whether or not members) must have access to a consultative process so their views can be taken into account.
  - There should be regular surveys of patients and the public more generally.
  - Decision-making processes should be transparent: decision-making bodies should hold public meetings.
  - Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.

- Commissioners should decide what they want to be provided, not providers. They need to take into account what can be provided and for that purpose will have to consult clinicians both from potential providers and elsewhere and be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.
- The commissioner is entitled to and should, wherever it is possible to do so, lay down a fundamental safety and quality standard or specification in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance require redress for individual patients who had received sub-standard service to be offered by the provider.
- In addition to fundamental standards, commissioners may wish to promote improvement by requiring compliance with or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.
- Commissioners need wherever possible to identify and make available alternative sources of provision. Apart from the obvious benefits to patient choice, having such alternatives reduces the commissioner's, and its public's, reliance on one source of service. It then becomes more practicable to resort to contractual sanctions if required standards are not met and is reduced the risk of leaving patients without a service.
- In many areas this may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers. The experience with PCTs was that the

initial number had to be reduced to give them the ability to make the changes thought necessary in an area and to enable them to have the necessary infrastructure.

- Commissioners need expert support to provide them with clinical expertise, not all of which can come from GPs, as well as procurement expertise. Where commissioning groups are too small in themselves to acquire such support they will need to collaborate with others to do so.
- Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period:
  - Such monitoring may include requiring quality information generated by the provider.
  - Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases.
  - The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation.
  - Monitoring needs to embrace compliance both with the fundamental standards and with any enhanced standards adopted. In the case of the latter they may be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.
- Commissioners should be entitled to intervene in the management of an individual complaint where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services. Each substantiated complaint of substandard service is likely to be evidence of a breach of an obligation under the commissioning agreement, and commissioners should be concerned on behalf of their patients with such a failure of performance by the provider.
- Commissioners should monitor complaints and their outcomes on as near a real time basis as possible.
- Consideration should be given to whether commissioners should be given responsibility for commissioning patient's advocates and support services.
- Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. Such powers should be aligned with similar powers of the healthcare regulator so that both commissioner and regulator can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.
- Performance notices are potentially valuable tools and more likely to be effective than financial penalties, particularly where imposition of the latter may destabilise an otherwise

acceptable provider. Non-compliance with a performance notice should be grounds for intervention by the regulators.

- Commissioners should have contingency plans with regard to the protection of patients from harm where it is found that they are at risk from substandard or unsafe services.

7.387 None of this will turn a theory of effective commissioning or monitoring into practice unless commissioners are recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Much assistance can doubtless be provided centrally, for instance in standard forms of agreement, and portfolios of standards and evidence based metrics. However, effective local commissioning can only work with effective local monitoring. And that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.

Summary of recommendations

Recommendation 123

GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.

Recommendation 124

The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub-standard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.

Recommendation 125

In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.

Recommendation 126

The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.

Recommendation 127

The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.

Recommendation 128

Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.

Recommendation 129

In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.

Recommendation 130

Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.

Recommendation 131

Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.

Recommendation 132

Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period:

- Such monitoring may include requiring quality information generated by the provider.
- Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases.
- The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation.
- Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.

Recommendation 133

Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.

Recommendation 134

Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.

Recommendation 135

Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement:

- There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners.
- There should be lay members of the commissioner's board.
- Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account.
- There should be regular surveys of patients and the public more generally.
- Decision-making processes should be transparent: decision-making bodies should hold public meetings.

Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.

Recommendation 136

Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.

Recommendation 137

Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.

Recommendation 138

Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.

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