Thursday, 1 December 2011

(10.00 am)

Closing submissions by MR KARK

THE CHAIRMAN: Good morning, Mr Kark.

MR KARK: Good morning.

THE CHAIRMAN: On a nice sunny day, the field is yours.

MR KARK: Sir, we want to begin, as others have done, by paying tribute to those who have participated in this inquiry, whether it's been by giving oral evidence, submitting written information or observing from the public gallery. All have been participants and all have contributed in different ways to the inquiry. It is particularly difficult to give evidence to a public inquiry and it has been impressive how many have been willing to do so voluntarily and how few have required orders to direct them to do so.

When I opened this inquiry, I assured you that we would leave no stone unturned in exploring the issues within the terms of reference and that aim, as far as it can be accomplished with such a task, has been.

The purpose of this inquiry was to bring to the attention of the Secretary of State for Health a clear explanation of why the commissioners of healthcare services and the regulators of the trust failed the people of Staffordshire, and how the same sequence of



events might be prevented from ever happening again, not only in Staffordshire but in any other part of the National Health Service.

This inquiry has allowed the widest and most intricate examination of the workings of the NHS and its regulatory bodies to take place, and it is crucial that we do not let this opportunity for recommending changes which will increase both the quality of care for patients and the safety of those having to enter hospitals in this country to slip through our fingers.

Our written submissions, which will follow next week, are extensive. Unlike others who have addressed you from a particular standpoint and with a particular focus, we have attempted an analysis of all of the evidence that you have heard. It is important that when you make recommendations you can do so in the certain knowledge of having an accurate factual matrix to support them. We have attempted to provide you with that matrix.

Having said that, and despite the length of that document, we cannot guarantee to have covered absolutely every piece of evidence you have heard. We have focused on that which seems important. It is not for us, of course, to make recommendations. That is a task for you. But we will be addressing some features of the NHS



where it seems to us that thought might be given by you to making recommendations which will make a difference to the service for the future.

Any examination of the NHS is bound to involve a selection of material, but you have the advantage of the enormous resource of the transcripts and exhibits produced to this inquiry. My comments now, which represents as much the work of Mr Fitzgerald, Mr Baker and Ms Hughes as myself, are merely our submissions. They carry no more weight than any other submissions made to you. They're intended to assist, but insofar as our submissions reflect our view of the evidence, or amount to criticisms of organisations or individuals, you will, of course, form your own view based on the evidence, and you will no doubt either accept or reject our view accordingly.

As Sir David Nicholson told us, the NHS in England is the largest fully-integrated health service in the world. It employs over 1.3 million people and has an annual budget of GBP 100 billion. On average, we were told 1 million people are in contact with the NHS every 36 hours:

"The NHS [he said] is not just an organisation, it's not just a set of organisations, it's also a set of cultures, a set of principles. It's loved broadly by



the general public."

When we designed this inquiry we did so with a view to building the foundations of evidence from the bottom-up. We started, therefore, with patients, relatives and carers. Gradually we moved outwards, so we then heard who dealt with patients within the trust, those who dealt with their complaints, the GPs who sent them there and were involved in using the services of the hospital. We then called evidence from those who should have been looking at this trust from the patient perspective, the PPIF and LINks. Moving on, we called evidence from the commissioners, the PCT, the performance managers and the fund providers, the SHA. We looked then at the regulators, the HCC and the CQC, and we looked at a number of other bodies with responsibility for the regulation and education of individuals working within the hospital system. We called evidence from Monitor, responsible for assessing this trust for foundation trust status and then ensuring that it met its service commitment.

We heard from those who collect the data and analyse it. And, finally, we heard from the Department of Health. We heard from the policy makers, the ex-Secretary of State and the ex-Minister for Health. We heard from those in the Civil Service working in the

1 highest ranks of the Department of Health who have to
2 implement the policy of the government of the day and
3 run the service on a day-to-day and year-on-year basis,
4 despite the various policy changes with which the
5 service is sometimes inflicted.
6 We hope that all will accept that that approach to
7 the evidence did work to the inquiry's advantage,
8 because it allowed to us build a foundation from which
9 we could launch questions and sometimes criticisms of
10 the policy makers and the large organisations.
11 What I propose to do today in this relatively brief
12 oral submission, which will nevertheless take, I am
13 afraid, the rest of the day, is to reverse the order, so
14 that we look, first of all, at the Department of Health
15 and work our way down through the system to see how the
16 policy and the guidance turned into reality on the
17 ground, for the regulators of the hospitals and for the
18 doctors on the wards and for the patients in the beds
19 and for those sitting next to them.
20 What I say today can only be a brief summary of the
21 written submission. These are the relatively short
22 points which can be made fairly simply. Although I will
23 refer to the evidence we've heard, were I to delve into
24 it in any detail I wouldn't finish today, nor indeed
25 next week, and no one would thank me for that. For



1 a detailed analysis of the evidence you'll have to wait
2 for the written submissions, which I hope will meet that
3 expectation.
4 By starting with the Department of Health, we will
5 in fact cover the role played by a number of other
6 organisations. The inquiry heard evidence from a number
7 of witnesses from the Department, and from the last
8 government which was in power at the time of these
9 events. We heard from Andy Burnham, appointed Minister
10 of State for delivery and quality at the Department of
11 Health in May of 2006, and later appointed Secretary of
12 State for Health under Prime Minister Gordon Brown on
13 5 June 2009.
14 We heard from Ben Bradshaw, MP for Exeter, and
15 between June 2007 and June 2009 Minister for Health
16 under Alan Johnson.
17 We heard from: Dame Christine Beasley, the chief
18 nursing officer; Warren Brown, the head of the
19 Department of Health's NHS foundation trust branch;
20 Sir Andrew Cash; John Holden, director of system
21 regulation; Una O'Brien, currently serving as permanent
22 secretary at the Department of Health; Sir Hugh Taylor,
23 a career civil servant who was made group director of
24 strategy and business development and became the
25 Department of Health permanent secretary in 2006.



1 We heard from Sir Liam Donaldson, chief medical
2 officer. Professor Sir Bruce Keogh, currently medical
3 director. David Flory CBE, the NHS deputy chief
4 executive and, Sir David Nicholson KCB CBE, the NHS
5 chief executive.
6 The Secretary of State for Health is ultimately
7 accountable to Parliament for the performance of the
8 NHS. However, the statutory scheme also provides for
9 the Secretary of State to devolve his functions to other
10 bodies, including strategic health authorities, primary
11 care trusts and special health authorities.
12 The responsibility to maintain standards and improve
13 performance in the NHS has, therefore, been discharged
14 over time through a number of NHS bodies and arm's
15 length bodies, but it is ultimately the responsibility
16 of the Secretary of State for Health and, as we found in
17 the right circumstances, the Secretary of State, and the
18 Department will intervene where necessary whether
19 a trust is a foundation trust or not.
20 Can I turn to the heading "Safety, quality and
21 culture within the NHS".
22 Sir Liam Donaldson stated that in his role as chief
23 medical officer from 1998 to 2010, he sought constantly
24 to drive quality up the agenda and lobbied for it to be
25 taken on board as a central theme to healthcare



1 improvement. However, his evidence described a picture
2 of slow progress in putting quality centre stage within
3 the priorities of the Department of Health.
4 A number of scandals arising in healthcare had
5 arisen in the UK and elsewhere in the late 80s and early
6 90s. Cases of single practitioners causing harm to the
7 public were hitting the headlines, and there were
8 a number of whole organisation failures which took
9 place, most notably in Bristol, which provided
10 particular impetus for his work.
11 Sir Liam Donaldson said this in relation to his
12 observation of the "whole organisation failures":
13 "Such whole organisation failures upon analysis have
14 common characteristics such as a failure to place the
15 patient at the heart of everything that clinicians do,
16 allowing other values (such as the need to meet
17 financial and activity targets) to prevail."
18 He explained further in his oral evidence that when
19 he later visited a number of organisations providing
20 high quality services as part of Lord Darzi's review,
21 there were some striking similarities between the
22 services, which were that they proactively used data to
23 assess their services, there was continuity of
24 leadership, such that the culture was sustained by
25 people who stayed for a long time then handed over to

others, there was good patient involvement, and there was no distinction between management objectives and clinical objectives.

Sir Liam sought to promote quality and safety in the NHS from 1998 by means of his concept of clinical governance, which incorporated many if not all of those factors. His big idea was set out in the Department of Health publication "A First Class Service" in 1998, and that document also set out a number of key components of clinical governance including the following:

Clear lines of responsibility and accountability for the overall quality of clinical care through the NHS trust chief executive who carries ultimate responsibility for assuring the quality of services provided by the trust.

A designated senior clinician responsible for ensuring that systems for clinical governance are in place and monitoring their continued effectiveness and regular reports to NHS trust boards on the quality of clinical care are given the same importance as monthly financial reports.

A comprehensive programme of quality improvement activities, which includes full participation by all hospital doctors in audit programmes;

Procedures for all professional groups to identify



and remedy poor performance, for example: critical incident reporting ensures that adverse events are identified, openly investigated, lessons are learnt and promptly applied; complaints procedures are accessible to patients and their families, and fair to staff, lessons are learned and what recurrence of similar problems avoided; staff are supported in their duty to report any concerns about colleagues' professional conduct and performance with clear statements from the board on what is expected from all staff; and clear procedures exist for reporting concerns so that early action can be taken to support the individual to remedy the situation.

Sir Liam told us that that these ideas were revolutionary in 1998 but that they remained as relevant in 2011 as they were then. As we sat here and listened to the evidence, it became clear that none of those features of good governance, not one of them, were present in the day-to-day activities of the trust with which we have been concerned.

The two key purposes of clinical governance were, Sir Liam said, to establish the duty of doctors and others to improve quality generally, not just in relation to their individual patient, and to prevent poor performance being overlooked or ignored. He said



clinical governance established the principle that the patient's interest was paramount and that it was not acceptable to turn a blind eye to the bad practice of a colleague.

However, we have seen how clinical governance simply wasn't working at the trust. Once suspects that there was little time for clinicians to take part in clinical audit, and it may even have been regarded as something of a luck she. As Sir Bruce Keogh explained, time spent on clinical governance not only increases the quality of care, but saves trusts money. Despite the acceptance within the Department of Health that clinical governance is crucial, at a badly run trust those sentiments do not translate into action. One has to ask, why not? There was clearly insufficient motive within the trust to do so but how can it be encouraged?

We submit that it is most of all to do with clinical engagement. Without clinical engagement and a belief in the benefits of clinical governance, no carrot nor stick will work and no government guidance will be effective.

These principles were further expounded by Sir Liam in the publication An Organisation with a Memory in 2000. The report emphasised the scale of harm being caused to patients in the NHS and the problems of failure to learn from mistakes. It propounded the need



for changes to systems and culture, to ensure that learning from adverse incidents took place.

It said this:

"When things go wrong, whether in healthcare or in another environment, the response has often been an attempt to identify an individual or individuals who must carry the blame. The focus of incident analysis has tended to be on the events immediately surrounding an adverse event, and in particular on the human act or omissions immediately preceding the event itself.

"It is of course right, in healthcare as in any other field, that individuals must sometimes be held to account for their actions -- in particular if there's evidence of gross negligence or recklessness, or criminal behaviour. Yet in a great majority of cases the causes of serious failures stretch far beyond the actions of the individuals immediately involved ..."

We believe that if the NHS is successfully to modernise its approach to learning from failure, there are four key areas that must be addressed. In summary, the NHS needs to develop:

Unified mechanisms for reporting and analysis when things go wrong.

A more open culture in which errors or service failures can be reported and discussed.

Mechanisms for ensuring that where lessons are identified, the necessary changes are put into practice.

A much wider appreciation of the value of system approach in preventing, analysing and learning from errors.

That document was published 11 years ago, but it's quite clear that the lessons in it have taken a very long time to filter through the NHS, and there are some sections of the service where those practices are still not being adopted.

The creation of the National Patient Safety Agency was a major step forward, in Sir Liam Donaldson's view. Prior to its inception, he explained, there was no unified system for reporting adverse incidents and learning lessons within the NHS:

"The NPSA introduced a new national learning system for learning from adverse events and near misses, and in 2004 the NRLS system managed by the NPSA was launched to draw together reports of patient safety errors and system failures to help the NHS learn from when things go wrong."

The mere introduction of the NRLS system did not in itself effect a change in the culture of reporting, but was only a step in the journey. For example, Sir Liam explained that reporting wasn't mandatory until 2010

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because of the need to establish confidence in the system gradually. Suzette Woodward of the NPSA explained that reporting levels from doctors remained low, even in 2011.

Again, we suggest that there's a reason for this, which is the lack of clinical engagement and a lack in some areas of clinical acceptance of the importance of the routine learning from adverse incidents. Greater transparency should lead to better learning from errors. Learning from errors should mean better care for patients, which should make for better places for doctors and nurses to work in.

Sir Bruce Keogh criticised the current reporting system for SUIs as being "a bit of a black hole", on the basis that the person reporting the incident received no direct feedback and may never be sure what action if any has resulted from the report. This provides little incentive to encourage good quality timely reporting and misses the opportunity to provide feedback that could trigger early improvement action. There is, of course, a proposed enhanced reporting system, which would be via a single national portal that would be widely and securely accessible via the Internet, which would make reporting easier and more comprehensive.

In 2006 Sir Liam commissioned the DH publication

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entitled Safety First as part of his continued efforts to put the safety agenda. That report stated:

"There is greater awareness of the importance of the problems of patient safety. It has become part of the Department of Health's agenda and the principles of An Organisation with a Memory are now more widely understood. However, there is a perception that the NHS has not yet fully embraced patient safety as a key organisational priority. This has been compounded at times by inconsistent messages about priorities being given by the Department of Health."

Sir Liam stated that these comments in Safety First bore out his evidence that the message on patient safety was not being lived out in the interactions between managers right down the chain. He said it was quite unusual at the time for a civil servant like him to be critical of the government or the system, so he was being quite bold in his assertions, and he accepted your suggestion that one of the reasons why safety wasn't at the fore in the same way that finance was, because there were more easily recognised and understood measures of financial performance than there were of safety and quality. This, we submit, has to change, and it's a question of culture.

Sir Liam commissioned reports from three US-based

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organisation, and that included the report from Joint Commission International, the JCI report, and the Institute for Healthcare Improvement. Well, Sir Liam was sceptical about the use of the JCI report and as regards its claim about a blame culture, he described it as a wild-eyed attack on very flimsy evidence, but he was more willing to set store of the report by the IHI, which has spent time within the NHS for over a decade and observed the way it worked. But it may be thought that the reports in fact contained consistent messages about the limits to which Sir Liam's goals had been achieved.

The JCI report, which was drawn from interviews with over 50 stakeholders within the NHS, contained the following comments. There was a 'shame and blame' culture of fear, which pervaded the NHS and at least certain elements of the Department of Health. This culture generally stifles improvement and the kinds of chief executive officer risk-taking behaviours that are necessary for creating organisation cultures of quality and safety. The standards development process is basically a top-down effort that does not meaningful engage physicians, other clinicians and other parties of interest. There appears to be no process for setting priorities for developing and using performance

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measures. Similarly, there appears to be no systematic effort to derive relevant clinical performance measures from the NICE guidelines. Performance improvement is ostensibly driven about the setting of targets with which compliance is expected, and that process is subject to gaming and has resulted in unintended consequences, leading to the apparent intent now to reduce or eliminate use of targets.

The IHI report, which also took into account interviews with 58 individuals within the NHS, contained the following findings:

"The patient doesn't seem to be in the picture. We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations, whether we were discussing aims and ambition for improvement, ideas for improvement, measurement of progress or any other topic relevant to quality.

"The NHS doesn't have a comprehensive balanced, widely-agreed upon definition of quality, and therefore defaults to the definition 'quality means meeting targets'.

"The NHS has developed a widespread culture more of fear and compliance than of learning, innovation and enthusiastic participation in improvement."



David Flory told us that he had not seen the JCI report when it came out and didn't read it, until it was brought to his attention by the solicitor to the inquiry. He told us he didn't recognise the Department which it portrayed. This may be thought to have demonstrated a lack of insight within the Department, which was repeated by other senior officers.

Sir David Nicholson told the inquiry that he didn't believe the JCI report was significant. Indeed, in general, the Department witnesses did not accept or even recognise some of the criticisms contained in the American reports, and yet many of those criticisms of a top-down and bullying culture were described by witnesses to the inquiry.

It is perhaps inevitable, given the size of the organisation and the size of its budget, that there has to be a strong element of top-down control. That can be mitigated, in our submission, by a transparent, clear and open approach and very clear lines of communication.

Sir David Nicholson, having said that he didn't regard the report as significant, accepted a number of the conclusions, even if he didn't accept the language in which it was written. In particular, he accepted the criticism that there were flaws in the oversight mechanism. However, he said this was an issue being



worked upon by the Department, in particular through the development of High Quality Care for All.

He also accepted that there were weaknesses in the current data collection, data quality monitoring and data use processes. However, he responded to this criticism by pointing to the work done in relation to the quality risk profiles, the introduction of quality accounts and the work of the National Quality Board, and the work on aligning information in the systems and early warning signs.

Well, sir, I'll turn to the QRPs a little later, but they are, in our submission, at this stage insufficiently robust to be a reliable indicator or warning of poor care.

When asked how it could be that 13 years after the publication of A First Class Service key components of clinical governance weren't universally in place, Sir Liam stated that people factors were by far the most difficult things to change, and I am going to repeat a comment repeated by Mr Clarke for the Department of Health:

"The NHS is not the army, these are not orders given out which people then jump up and follow ... each single one of them requires not just changes to procedures, but changes to attitudes, behaviour, values and whether



people are inspired to follow them, because they really believe in them, and those things are very, very difficult to achieve."

He agreed that effecting such a cultural shift required a concerted effort from the Department of Health. Well, Una O'Brien emphasised the limitations of what could be achieved from the top-down. Sir Liam was more positive about what change could be brought about by "people at the top", and he said that what was required was a constant focus on quality and safety, which have not always been present.

He gave the example of his insistence on focus on HCAIs, and another example he gave was the four-hour A&E waiting time target, which was first set in 2002 to be achieved by each trust for 98 per cent of patients by the end of 2004.

NHS organisations which failed to meet this target will be subject to routine performance management intervention. Well, the coalition government changed that threshold to 95 per cent for 2010 to 2011 on 21 June last year, in order to allow for greater clinical freedom, and that change has now been widely criticised in the press.

Sir David Nicholson in dealing with the issue of targets and the dangers of gaming told us:

1 "Unfortunately, it was perfectly possible for some
2 places to hit the target, i.e. reduce a waiting time or
3 deliver within a standard, but to do so in a way that
4 didn't improve the patient experience. This problem was
5 particularly prevalent with A&E targets, with some
6 trusts putting systems in place purely to meet the
7 target, rather than achieving the intention behind it --
8 to improve the patient experience. The this [he said]
9 was unacceptable and missed the whole point of having
10 the target ... Despise this [he said] I do not think
11 that the manipulation of targets in this way was
12 widespread."
13 Well, certainly there's evidence that there was
14 manipulation of the targets at Stafford.
15 What then is the best way of identifying failures in
16 the system?
17 Sir Liam expressed other concerns that the HCC did
18 not have the right methods for evaluating safety and
19 quality within provider organisations. He admired the
20 fact that the CHI had had, as he put, "boots on the
21 ground" and conducted routine inspections of hospitals.
22 He felt strongly that a regulator should visit the
23 organisation it was regulating.
24 He said this:
25 "It's to do with the softer factors, I think, it's

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1 not to do with data per se. It's about getting the look
2 and feel of the place, perhaps informally chatting to
3 some of the patients or relatives who might be around.
4 Talking to some of the junior staff in private when
5 their bosses aren't necessarily there, and feeling
6 confident that you've got a real feel for the place, as
7 well as more formal set piece meetings with the
8 management team."
9 Well, the expression "boots on the ground" takes me
10 almost as neatly as I could hope for into an examination
11 of the processes of the Healthcare Commission, and we'll
12 come back, of course, to the role of the Department of
13 Health as we look at various issues along the way.
14 Just before I turn to the HCC, can I deal with one
15 discrete area which falls within the Department of
16 Health's province, perhaps, about which we've heard in
17 fact very little evidence, and that relates to the
18 training and regulation of non-clinicians, by which
19 I mean those who work in the role of healthcare
20 assistants.
21 The skill mix at Stafford Hospital, that is the
22 ratio of trained nurses to untrained and unregistered
23 healthcare assistants is widely accepted to have been
24 wholly wrong. On some wards it appears that there were
25 more assistants than there were nurses. And, as we

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1 know, as part of the plans to meet the CIP, Mr Yeates
2 said that the medical directorate had proposed a change
3 to the skill mix of nursing staff, and he described
4 himself as instinctively worried by that plan. He
5 accepted that times had changed and the need to cut
6 costs was clear, and senior nurses supported the plan.
7 Likewise, Adrian Legan of the RCN was concerned. He
8 said:
9 "Despite the level of discomfort, all of those
10 involved concluded that our options were limited and
11 this could be made to work."
12 The lack of regulation and the variable nature of
13 the training and qualifications of healthcare assistants
14 in all of their many guises is a serious issue for the
15 health service. This was not just an issue for
16 Mid Staffs trust. This may be thought to be a national
17 issue and one which the Department of Health has not
18 dealt with because of the size of the problem.
19 Sir David Nicholson was asked his views on the
20 relevance of a registration system for this type of
21 employee. His view was that education and training were
22 more appropriate uses for limited resources than the
23 setting up of a system of registration and regulation.
24 I asked him this:
25 "Where things have gone wrong and appear to have

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1 gone wrong in this particular trust was the overuse of
2 healthcare workers, and ... I don't mean to malign
3 healthcare workers as a body, the majority of whom no
4 doubt do a brilliant job, but it's an easy solution
5 sometimes for trusts to take."
6 And I reminded him of the call from
7 Professor Dickon Weir-Hughes for the registration of
8 healthcare workers, and I asked him:
9 "What is the problem about regulating healthcare
10 workers?"
11 He said:
12 "[Well] I don't know whether there's a problem or
13 not. The issue for all us is ... the quality and
14 training of those people and are they equipped to do the
15 jobs that they do ... it's a big task to try and
16 regulate such a huge workforce from a standing start.
17 And they are used in very, very different ways. You've
18 got healthcare assistants who are doing literally
19 everything from housekeeping through to the direct care
20 of patients, right the way through to people who are
21 doing very complicated issues with individual patients.
22 So I think it's the complexity of that that I think have
23 stopped people doing it. I'm not convinced that
24 spending a huge amount of time and effort in doing the
25 registration organisation as opposed to putting the

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1 effort into training and education, might be a better
2 way forward ... I think it's an issue ... it's certainly
3 something to take away from the evidence."
4 And you asked him, sir:
5 "Well, how much more by way of top importance is it
6 to ensure that the people who generally speaking are
7 charged with feeding and providing basic care to our
8 most vulnerable patients should be fit and proper people
9 to do that?"
10 He said:
11 "You're absolutely right, and it seems to me that is
12 an issue much more about training and education than it
13 is about setting up a regulatory framework to cover
14 their work. That it seems to me is the -- and to make
15 sure they have proper nursing and medical supervision in
16 the work that they do, I would have thought that's the
17 effort that we need to place into it. Whether that
18 would result in regulation or not is a separate issue."
19 Well, Professor Dickon Weir-Hughes was a proponent
20 of better training and regulation for these workers. He
21 said:
22 "I suppose part of this is born out of the
23 frustration that we feel with members of the public
24 wanting to refer healthcare support workers to us, and
25 we, of course, in light of those referrals, can do

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1 nothing ... we know that even if people are well managed
2 in the NHS ... if they're dismissed from their post in
3 the NHS they will walk down the road and get a job in
4 a nursing home tomorrow ... So we feel quite strongly
5 that healthcare support workers should be consistently
6 trained across the four countries. We believe that they
7 should be consistently regulated across the four
8 countries."
9 Sir, because of the lack of direct evidence which
10 the inquiry has heard on the issue, I am diffident
11 obviously about making any positive suggestions. I can
12 only submit that it appears to be a surprising and
13 potentially dangerous lacuna in our healthcare system
14 that there is a complete lack of registration and
15 regulation of a sizeable number of those who work in the
16 health service and who have direct contact with the sick
17 and the vulnerable.
18 Can I turn, then, to the issue of the core standards
19 and the Healthcare Commission.
20 The development of the Standards for Better Health
21 was, in Sir Liam Donaldson's view, a major stride
22 forward in the development of the themes of safety and
23 quality in the NHS. He said:
24 "Until this point, the NHS had no formal standards
25 governing the delivery of care, except for those

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1 specialist areas of care [national service frameworks],
2 in relation to particular treatments or technologies
3 [produced by NICE] or by professional bodies directed to
4 practitioners rather than the NHS at organisational
5 level."
6 He said:
7 "In my view the development of those standards was
8 a most enlightened and essential development which was
9 ahead of most other countries."
10 Sir Liam disputed the evidence of Sir Ian Kennedy
11 that the core standards were handed down as tablets of
12 stone from the Department of Health to the HCC. He
13 produced as exhibits a number of items of correspondence
14 from Ian Kennedy and Anna Walker as part of the
15 Department of Health's consultation exercise leading to
16 the production of the standards. But it was clear from
17 listening to Sir Ian Kennedy that he didn't feel that
18 the consultation had been an effective one in terms of
19 producing core standards which worked.
20 The question is asked, why were the regulators not
21 more closely involved in shaping the system which they
22 were to adopt? There was wide criticism of the annual
23 health check and the core standards which underpinned
24 it. It was brought to Andy Burnham's attention that the
25 turning point so far as the government's attitude to the

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1 AHC appeared to be the report into Basildon Hospital,
2 and counsel to the inquiry put to him:
3 "Now, the question for you is really why does the
4 government need a disaster like Stafford or Basildon for
5 you in government to listen to the concerns of the
6 people who you have put in charge of the system to
7 regulate it? You have Sir Ian Kennedy, Anna Walker ...
8 Baroness Young, all of whom were trying to change the
9 system, but they didn't manage to do it. Why is there
10 that sort of resistance?"
11 And he answered:
12 "[Well] ... we did listen to their concern over
13 a long period of time. And as I was explaining a moment
14 ago, [that] was an evolving ... story about, how do we
15 improve the system of inspection and regulation in the
16 NHS? There's considerable expertise within the
17 Department of Health on these matters, not least the
18 chief medical officer, who was a huge support to me in
19 my time on quality issues, and the chief nursing
20 officer."
21 Sir, you may feel that the core standards were
22 a good example of form over content. They provided
23 a relatively simple route for the health service to be
24 able to rate and rank hospitals. The annual health
25 check may have been effective for public presentation

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1 purposes, but it was in reality, we submit, relatively
2 useless if the intention was to present to the public
3 a true and honest evaluation of the quality of care
4 provided by the trust assessed or indeed as the name
5 implied the health of the provider assessed. Some will
6 have filled in their self-assessment honestly, carefully
7 and diligently. Others may not have done.
8 We submit that the evidence demonstrates that the
9 HCC's ability to cross-check by using a variety of
10 systems which they did was not in fact as effective as
11 was claimed by them. We do not submit that
12 self-assessment has no role in a proper regulatory
13 environment, but regulators must be extremely cautious
14 about placing too much reliance upon self-assessment,
15 and the wording of the forms against which
16 self-assessment is based has to be directed at the right
17 issues of outcomes, rather than processes and
18 documentation.
19 Sir David Nicholson was asked whether in his view
20 the core standard element of the AHC was an effective
21 assessment tool. He said:
22 "I thought it was the basis upon which you could ...
23 I thought the way we tried to make it was not the best
24 way of doing it."
25 And I repeated my question, was it an effective



1 assessment tool:
2 "We all understand [I said] it was an assessment
3 tool; was it an effective one?
4 "Well, if you look at what were the consequences of
5 it for individual organisations, and time and again
6 I saw the consequences of it being a whole lot of people
7 running around trying to measure things in different
8 ways in order to satisfy it, when my guess was the whole
9 purpose of it was to focus people on improving the
10 services to patients."
11 I asked him:
12 "... it didn't necessarily have that effect, did
13 it?"
14 And he agreed it didn't necessarily have that
15 effect.
16 The political reaction provided by Mr Ben Bradshaw
17 MP, when it was suggested that the core standards were
18 subject to widespread gaming and the AHC was not
19 effective tool was one of denial, and I minded him of
20 what Professor David Haslam, the national clinical
21 adviser to the HCC, had written in an email
22 To Nick Bishop. He wrote these words about the annual
23 health check. He said:
24 "My particular personal concern is that on the whole
25 the annual health check is meaningless to clinicians.



1 Those in primary care don't use it and those in
2 secondary care don't recognise it. There are many
3 reasons for this, partly too do with the fact that it
4 isn't seem to be a measure of things that actually
5 really matter to clinicians and their patients, partly
6 because of overt gaming and partly because few
7 clinicians actually personally identify with their trust
8 anyway."
9 And I put to Mr Bradshaw:
10 "Well, were you wholly unaware of these sort of
11 concerns?"
12 He said:
13 "I fundamentally disagree with what he says. It may
14 have been uncomfortable read thing in some cases for
15 clinicians. No clinician likes their hospital to be
16 rated badly. My concern was that the health check was
17 useful and of interest to the public ... it was
18 certainly not my experience that hospitals didn't take
19 the health check seriously. They did take it seriously.
20 And, as I say, concerns were not raised with me by the
21 Healthcare Commission about widespread gaming. Any
22 gaming of that sort, in my view, should have been
23 stamped on very, very firmly indeed. I would imagine
24 the gaming that he may be talking about ought to be and
25 probably is [as he put it] a disciplinary and



1 contractual offence."
2 Well, it may seem surprising to some, with respect
3 to him, that a politician who was in post for such
4 a relatively brief period of 18 months felt able so
5 fundamentally to discount the views of the national
6 clinical adviser of the Healthcare Commission, and one
7 wonders what better source of evidence he had upon which
8 to base such firm views.
9 Setting the AHC to one side, there were, of course,
10 regional teams of the HCC on the spot; the eyes and
11 ears. Why did the local regional teams not pick up on
12 the issues at the trust prior to the investigation team
13 doing so as a result primarily of the mortality alerts?
14 In Ms Grey's submission, she was quizzical about the
15 use of the phrase "regulatory capture", which in fact
16 came from the witnesses, not from counsel, and she
17 wondered why it wasn't used in relation to the PCT, the
18 SHA, the HSE and others. Well, the simple answer to the
19 that is none of those bodies were regulators in the way
20 that the Healthcare Commission was intended to be. They
21 did not have the same access to information, and
22 regulation is not the same as performance management.
23 But whatever term one uses is, frankly, irrelevant. The
24 issue is whether the regional arm of the HCC was
25 sufficiently independent and applied sufficient scrutiny

to identify the problems which there were. The short answer to that, we submit, on the evidence is that they were not and they did not.

Shelagh Hawkins was the regional assessor for the trust between 2005 and November 2007. Her background was as a qualified nurse. She described how she used to visit the trust in her area once a month. Part of her role was to carry out core standard assessment of trusts which had been selected for examination. She did have the ability to recommend a trust for a CSA but never did so in relation to Mid Staffs, although it was, as we know, subject to such an examination in 2007.

Andrea Gordon recognised the issue of regulatory capture in her statement. She said it was important for the assessors to strike a balance between the relationship management with the providers and regulation in order for the regulatory framework to be effective:

"The region's role was to build a relationship with the organisations we regulated and myself and the regional team made every effort to do this whilst maintaining a distance from the organisations being regulated."

Martin Bardsley, who had to assess the information coming from local teams, told us this:



"I think with any operational field force for a regulator you run a tension between the advantages of having people close to the ground, close to the trust, in touch with local community leaders, which is the positive side, and able to think about and synthesise evidence and intelligence locally; the good side. The negative side is the danger that they become accepting of local organisations. They make assumptions which they may not want to do, and in a sense that's when we get into a world of regulatory capture when they may not be providing the right level of effective challenge."

Heather Wood, the investigation team leader, told us:

"... in some instances I think they, the regional assessors, did go a bit native. They perhaps, from my perspective, became too sympathetic to the problems of trusts and too remote from the experience of patients."

There was, according to Nigel Ellis, a similar concern in relation to the HCC's relationship with both the PCT and SHA.

He told us:

"The Healthcare Commission, as the regulator of the NHS, is responsible for the providers, regulation of providers, hospital trusts and of commissioners ... So it is very important that we retain that formality and



that level of, I suppose, respectful distance between organisations such, as PCTs and SHAs when we're investigating a trust."

He said:

"So the distance between ourselves and the regulated bodies and SHAs, although we weren't regulating them in the same way, it was very important to me that we would work with them, that we would be constructive whenever possible, but that we were not partners in undertaking this investigation."

Shelagh Hawkins explained her frustration at not being able immediately to correct issues which she found at NHS trusts for fear of being seen to be interfering or adopting a performance management role which was not appropriate.

In March of 2006, by way of example, she received specific information from Mr Terry Deighton who had concerns about cleanliness at the trust, and as a result of that she visited the trust on 16 March, and she noticed problems in A&E with torn old chairs and bloodstains, but she was shown that plans were in place to replace them and completed an engagement form reflecting that.

Andrea Gordon formed the impression that the trust was as an organisation making every effort to engage



with the HCC and requested a number of meetings to ensure compliance.

She said:

"We always felt there was an attempt by the trust to get things right."

She told us that one issue which did become apparent within the HCC was that there was not a unified facility within the organisation to feed through local assessors' knowledge about trusts, and as a result of that recognition the HCC developed a process called Organisational Risk Profiles, which were introduced in 2008, and those were populated by the assessors, who would be gathering local information about each trust in their area, and that appears to have been the precursor to the CQC's QRPs.

In short, neither the annual health check nor the regional arm of the HCC really identified the problems at the trust, and there is, we submit, an important lesson to learn about the limits of regional scrutiny. Later I am going to turn, briefly, to the HCC investigation, which, as we know, was triggered by specific mortality alerts, and the Department of Health reaction or lack of reaction to that.

But chronologically it now seems sensible to turn to the topic of foundation trusts.





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1 All of the material that we've looked at so far may
2 go to demonstrate that the process of self-assessment
3 and cross-checking was in fact flawed. It was
4 insufficiently independent and the importance of
5 effective local inspection was not provided here. We'll
6 look again at this issue of the importance of good local
7 data when we turn to the processes adopted by the CQC.
8 Can I turn, then, to the issue of foundation trusts.
9 On 7 November 2005 the Secretary of State,
10 Patricia Hewitt, made the decision to widen the entry
11 pool to two-star trusts. In the same year, the whole
12 health community diagnostic was developed as a joint
13 project between the Department of Health, SHAs and
14 Monitor, whereby all NHS trusts were assessed as to
15 their readiness to apply for foundation trust status.
16 The ex-Secretary of State, Andy Burnham, said this
17 of the change in eligibility criteria from three to two
18 stars:
19 "In allowing two-star acute, specialised and mental
20 health trusts to apply to Monitor in addition to
21 three-star organisations, there is no question of
22 lowering standards for authorisation as an NHS
23 foundation trust."
24 Warren Brown stated in his oral evidence that the
25 change from the requirement of three stars to two was



1 not a matter of reducing the criteria, but widening the
2 pool.
3 It may be correct to say that Monitor's eligibility
4 criteria didn't change. However, the inquiry may find
5 it hard to accept that the reduction in the requirement
6 of three-star status for eligibility to be put forward
7 for Monitor's consideration did not have the effect of
8 removing one of the only safeguards of quality within
9 the application process, if in fact it was a safeguard
10 at all.
11 It appears that there were also those within the
12 Department who supported the concept of there being no
13 entry criteria whatever. In an internal Monitor email
14 from Stephen Humphreys to Bill Moyes in March of 2006,
15 he wrote:
16 "I raised with Warren Brown the question of the
17 [Department of Health's] entry criteria for foundation
18 trust applicants post star ratings. His response below
19 suggests that the foundation trust unit supports no
20 entry criteria. If we have clear views on this subject,
21 we could use the proposed note to Lord Warner on the
22 diagnostic programme to highlight them."
23 The email he was referring to from Warren Brown to
24 Stephen Humphreys read:
25 "Off the record we need to go to ministers in the



1 next month or two and will use the HC's change of system
2 and the diagnostic as an argument to remove the entry
3 criteria but I expect it will be a tough argument.
4 Ministers will be very sensitive to any public criticism
5 that entry standards have lowered, even if they
6 understand the arguments (which they do)."
7 It's clear that those arguments didn't win the day,
8 but there was, some might think, a sort of halfway house
9 policy of reducing the criteria, not removing it. On
10 one view it would have been better and clearer if the
11 Secretary of State's entry criteria were removed,
12 because it seems to have added very little to the
13 process. Alternatively, the process needs to be
14 significantly strengthened in terms of an examination of
15 quality which, we were told, has now happened.
16 By 2007 and the trust's application, the basis for
17 eligibility had changed again, in the context of the
18 replacement of the star ratings system with the HCC's
19 annual health check and a greater reliance on the
20 diagnostic. Sir Andrew Cash presented a paper to the
21 NHS Management Board in September of 2006 in which he
22 set out the proposed new eligibility criteria for the
23 Secretary of State support.
24 The Department of Health witnesses in general did
25 not accept that the change in criteria lowered the bar



1 in terms of quality of care for a trust to receive the
2 Secretary of State's support for an application for
3 foundation trust status.
4 David Flory described it in this way:
5 "This merely meant that more trusts could apply, not
6 that the pass mark would be altered to allow them to
7 succeed in the application."
8 However, the inquiry will need to consider how that
9 approach sits with the evidence from Monitor to the
10 effect that it should have adapted its assessment
11 procedure to have a greater focus on quality of care
12 when the eligibility criteria were changed.
13 For example, Miranda Carter told us:
14 "I feel very strongly that Monitor didn't and
15 shouldn't lower its own assessment bar, but equally
16 Monitor did not reflect on the impact of the Department
17 of Health's decision to lower the quality threshold for
18 applicants, and specifically on whether the declining
19 eligibility threshold meant that particular issues were
20 more likely to fall between the cracks in the
21 application process."
22 It is also a matter of fact that had the criteria
23 not been amended to allow a rating of fair for quality
24 of services to be sufficient for the application to go
25 forward to Monitor, this trust would not have been in

1 a position to apply in 2007.
2 The inquiry may well conclude that the criteria for
3 the Secretary of State's support, insofar as quality was
4 concerned, were lowered over time as an inevitable
5 consequence of the drive to achieve more foundation
6 trusts across the country. The inquiry may conclude
7 that in allowing those with only a fair rating for
8 quality to go forward to Monitor and in allowing
9 applications to proceed on the basis of plans to be
10 compliant, and not putting in place any additional
11 measures of quality, the Department of Health made it
12 easier for a trust like Mid Staffs to slip through the
13 net of the application process.
14 The reason for these changes is fairly obvious.
15 They were consistent with the government policy to
16 ensure that all trusts became foundation trusts.
17 Warren Brown was referred to an email he wrote on
18 13 December 2006 to Mike Gill and David Meek, in which
19 he stated:
20 "Paul Corrigan is not happy about the size of
21 wave 5..."
22 Wave5, of course, was the wave in which Mid Staffs
23 surfed through, as it were:
24 "... i.e. half what we told him SHAs had promised.
25 Have we any sense [he wrote] off that we can retrieve



1 ground in wave 6 i.e. that we get the lost eight or so
2 trusts back without any other losses? Can we think up
3 any clever tactics?"
4 Well, Warren Brown that explained that Paul Corrigan
5 was the Prime Minister's special adviser for health.
6 Foundation trusts were a fundamental part of the health
7 reform and, unsurprisingly, the Prime Minister's office
8 had an interest in their progress. But it is clear that
9 it wasn't politically acceptable to admit that there was
10 a lowering of the criteria for entry to the process.
11 You may form the view that there clearly was
12 a lowering of the quality criteria for entry to the
13 process, and unless Monitor was going to examine quality
14 in any depth, the inevitable result was going to be that
15 a trust providing a lower quality of care than would
16 have got through the system previously would get through
17 thereafter.
18 I am going to turn to the trust's application for
19 foundation trust status.
20 In the lead-up to the application in 2007, the
21 trust, as we know, had undergone the rigours of an
22 ambitions CIP. Sir David Nicholson describes something
23 of the finances of the NHS across the UK during this
24 period of time.
25 The period 2005/2006 closed with a net deficit for



1 the NHS of GBP 547 million. The NHS ended the year
2 2006/2007 with a net surplus of GBP 515 million, the
3 gross deficit having been reduced to 917 million. This,
4 he said, was not about trading off quality of care with
5 financial control, "the two should go hand in hand".
6 David Flory told the inquiry that Mid Staffs had not
7 been identified as requiring designation as a trust in
8 turnaround and accordingly had not had a turnaround
9 director appointed to its board. By standards of the
10 deficits reported elsewhere in the West Midlands SHA and
11 the wider NHS, Mid Staffs didn't stand out as having
12 been in significant financial difficulty during the
13 period.
14 It was clear that SASSHA expected the majority of
15 trusts in its area to cut their funded establishment of
16 staff in order to ensure financial balance, and that had
17 been reinforced in a letter from Antony Sumara, then
18 managing director of SASSHA back in October 2005 in
19 relation to the 2006 cost-cutting programme. The SHA's
20 attitude to the trust's finances at this stage was
21 uncompromising, but it should be noted that this was not
22 something that the trust finance director found
23 surprising or indeed objectionable.
24 In his oral evidence, Mr Taylor, deputy chief
25 executive and the financial director of SASSHA, was



1 asked whether, in the light of the SHA's clear
2 expectation, trusts would carry out headcount
3 reductions. He was asked whether SASSHA had carried out
4 clinical risk assessments of the impact of these
5 programmes on the quality of care, or if the trust
6 themselves had carried out such assessments whether the
7 SHA would have seen them. His evidence on the point was
8 confused, but its effect was that the SHA neither risk
9 assessed proposals such as the one made in the trust's
10 financial recovery plan, nor asked to see the trust's
11 own risk assessment. An assurance that such an
12 assessment had been carried out would suffice.
13 In light of that evidence, the value that any part
14 of the SASSHA, the clinical governance group included,
15 could to add to the process of risk assessment must be
16 in doubt.
17 Back in 2005 the trust had been through the SHA's
18 diagnostic procedure, the detail of which I will not go
19 into here. The board-to-board for the trust took place
20 on 22 December 2005. Mr Brereton was present, as was
21 David Nicholson, then chief executive of all three West
22 Midlands SHAs, and Antony Sumara.
23 Mr Sumara recalled that there were no great issues
24 around performance, although there were some minor
25 issues in relation to infection statistics:

"I recall having concerns about the lack of any clear plan ... The presentation was flamboyant, although [it] didn't appear to have much substance behind it."

Whatever the impression gained of the trust, Mr Sumara was clear that:

"The assessment was a purely financial one, and would not, therefore, have picked up on any of the issues regarding quality of care that were later found at the hospital. This, in hindsight, was a failing of the assessment. The SHA were too distant to be aware of patient experience issues."

In any event, Mr Sumara said that the SASSHA team were not particularly impressed by the trust's performance in the meeting:

"After the hospital left, one of our board members described the plan as a 'strategy-free zone'. [And] it was agreed that the hospital was a long way off being ready."

The trust's chair, Toni Brisby, agreed with Antony Sumara's assessment of the trust's presentation. She said that at that stage of the December board-to-board, the trust board "had little idea of what was required of it". In terms of the trust preparedness for the foundation trust application process, she



considered that:

"I was in no position to form a view as to how long it would be likely to take to pull the organisation round and I largely accepted what I was told by the SHA."

There was mention in the diagnostic report of staffing levels and skill mix. As we know, in late 05 and early 06, the clinical floors reorganisation and the concomitant removal of senior nursing posts was under way. The children's services peer review team had found that the trust's A&E was dangerously understaffed, and the headcount reduction was being contemplated that would dilute the skill mix in the medical division in a way which the inquiry has heard presented a risk to patient safety. Against, that background and notwithstanding SASSHA's negative assessment of the trust's risk management procedures, it appears that all the foundation trust diagnostic required from the trust was that it acknowledge in broad terms the existence of a potential risk arising from the clinical staffing and the skill mix.

The diagnostic report refers to the trust carrying out a review of services to mitigate the risk arising from clinical staffing and skill mix, but it would seem that SASSHA had neither the resources nor perhaps the



inclination to assess whether such a review was carried out or, if it was, how effectively it was done. This may have been because the principal risk that diagnostic and foundation trust application processes were concerned with were financial ones -- the risk that the applicant trust might not be capable of being financially independent once it was authorised as a foundation trust and the cushion of SHA brokerage was removed.

The SHA board-to-board was conducted 18 months before the Department of Health assessment, and that resulted, as we know -- in the board-to-board assessment resulted in the "two years away" letter from Sir David Nicholson, but many of the same problems seem to have persisted right up until the application was made to the Department of Health in 2007.

It appears that the trust was not on the SHA radar in terms of clinical problems, until April 2007 shortly before the application went to the Department of Health. Before the publication of the HSMR statistics in 2007, which I am going to deal with later, Ms Bower was not aware of any problems with performance or quality of care at the trust. She would meet with the trust's chief executives once a month, and Martin Yeates regularly attended those meetings. Mr Yeates apparently



presented himself as highly engaged and committed to enhancing the performance, status and reputation of the trust, and he gave no impression that the trust was experiencing any particular problems.

What the West Midlands SHA did not have in 06/07, which it says it does now, is a means of discovering relatively quickly and easily a trust's nurse-to-bed ratio, temporary staffing rates and other information which would give an indication of the relative safety of the nurse staffing levels.

It is also of note that both SASSHA and the West Midlands SHA considered that the process of applying for foundation trust status was in itself a quality initiative. One of the criticisms of the trust board made by the report of the independent inquiry was that it treated the foundation trust process in that way, leading to it being distracted from its proper priorities.

During the first part of 2007, the SHA sign-off of an applicant trust for the Secretary of State stage consisted of a four-page feedback form, which asked the SHA 11 questions about the trust. Within the West Midlands SHA, the completion and sending of the form appears to have been entirely responsibility of the finance directorate. The contents and sending of the

1 form did not require board approval.
2 On or about 18 May 2007 the SHA sent the feedback
3 form relating to the trust's application for foundation
4 trust status to the Department of Health. It was filled
5 by in Dr Howard Shaw, who had day-to-day responsibility
6 for the SHA's involvement in FT applications.
7 Mr Shanahan signed it off, and the SHA board didn't see
8 it before it was sent.
9 The form began with this question and answer:
10 "In relation to the recommendations of the
11 diagnostic, how confident is the SHA that the trust has
12 addressed the key findings to date?
13 "Answer: There are no outstanding matters from the
14 foundation trust diagnostic process."
15 Asked to explain this answer in his oral evidence,
16 Mr Shanahan said:
17 "We would have seen evidence on each of the action
18 plans issued that they had resolved them."
19 Many of those issues had related to the trust's
20 approach to governance and risk. Whatever the evidence
21 that the SHA might have seen of the trust's progress on
22 them, that progress was monitored it would appear by the
23 finance team, not by those with responsibility for
24 clinical governance or patient safety. Dr Shukla, the
25 then WMSHA medical director, had no recollection of



1 being involved at all in the trust's progress towards
2 foundation trust status.
3 In the context of the application procedures focus
4 on whether the trust was well governed, there cannot
5 have been any depth of scrutiny by the SHA of the
6 effectiveness of the trust's clinical governance
7 procedures. None of the questions on the feedback form
8 related directly to clinical governance or quality of
9 care.
10 The final question and answer read:
11 "Is the SHA aware of any additional information
12 about the trust that may have a bearing on the Secretary
13 of State's decision about whether or not to support this
14 application?"
15 The answer to which was:
16 "None."
17 In his oral evidence, Mr Shanahan was asked why the
18 trust's HSMR of 127, published a few weeks before in
19 April of 2007, had not been included in this section of
20 the form.
21 I think it was me, I put to him:
22 "The month before this, Dr Foster had published
23 their results and it had identified six hospitals in
24 your area as being among the worst in the country, one
25 of which was the Mid Staffs trust. Why did that not



1 cause you to make an entry in this box ... there have
2 been some extremely poor mortality results recently?"
3 He answered:
4 "Well, I don't think it was flagged the time because
5 it was an issue we were still trying to understand.
6 And, as you know, there was work stream initiated to
7 actually try and understand the Dr Foster outputs. We
8 certainly flagged it later in the process as ... an
9 ongoing issue."
10 And I asked him:
11 "But you hadn't even by this stage commissioned your
12 report, had you? All you had was the bare figures from
13 Dr Foster, which put this trust among the worst in the
14 country.
15 "Answer: Well, the worst in the country on a
16 particular indicator was my recollection.
17 "Question: Did you seriously not consider whether
18 you ought to put anything about mortality figures in
19 this box to alert the Secretary of State to that as an
20 issue?
21 "Answer: Well, we would -- we would have considered
22 it because it had been discussed at length, and I can't
23 ... I can't remember why but we didn't include it, but
24 we did flag it as an ongoing risk going forward.
25 "Question: I am sorry [I asked him], are you saying



1 that on reflection that should have made an appearance
2 here?
3 "Answer: Yes. Yes."
4 Sir David Nicholson described how the Mid Staffs
5 application was made at a time when there was a strong
6 impetus from the government to increase the number of
7 foundation trusts. The hospital was nominated to apply
8 by the SHA in December 2006 for the fifth wave, and the
9 DH's applications committee, chaired by Andrew Cash,
10 reviewed the application on 7 June 2007.
11 At the time of the application, what was of concern
12 to David Stocks of the Department assessment team was
13 the trust's long-term financial model. It seems clear
14 from his assessment that he had real concerns about
15 supporting this application, and his assessment document
16 said this:
17 "The trust has produced a good IBP based upon
18 reasonably sound agreements with its principal
19 commissioner and a long-term strategy is supportable.
20 Unfortunately, the financial requirements are lacking
21 and the trust had to submit revised LTFM after the
22 closing date following extensive reworking upon advice
23 from the Department's lead adviser. The HDD [you'll
24 remember the historic due diligence] also identifies
25 significant improvements that are necessary and taken

together it adds up to a less than convincing case that makes the application difficult to support."

Mike Gill of the applications committee felt that he could advise the trust on what it needed to do make the financial model acceptable to Monitor.

Summing-up the committee's thought process, Warren Brown said:

"The committee decided that Mid Staffs was a marginal case. Having taken David Stock's advice as well as the advice of others, the committee concluded that the Mid Staffs' application was just about acceptable and it could be made to work."

What was the minister told about this application? This is the note he received, it was just four lines:

"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 Monitor."

Sir David Nicholson was asked about this note, whether in light of it the minister was provided with adequate information. He told the inquiry:

"... I think you would expect, in these circumstances, for 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."

Mr Andy Burnham told the inquiry that he had to have faith in the applications committee. I asked him:

"It sounds as if you were only happy to put your signature on the piece of paper because you believed that the wider and more detailed scrutiny by Monitor, which you keep telling us about, incorporated a scrutiny of the quality of care provided; is that right?

"Answer: Mmm.

"Question: And I asked you little while earlier about when you talked about turning trusts upside down. Did you really think that Monitor was turning trusts upside down in terms of quality assessment or simply financial and you said both; yes?

"Answer: Correct."

Andy Burnham was not shown the note prepared for the applications committee which revealed that the application was regarded as one which was difficult to support. That note was put to him in questioning here, and he was asked whether he wished he'd had that information.

His reply was:

"Yes, of course ... if there was more information in



that submission, the more they gave me, the more likely it is I would have asked questions about it. That was the kind of minister -- that was the way I went about my ministerial duties."

In his statement he told the inquiry:

"The effect of my decision to support the application was to open the trust to wider scrutiny by Monitor and so in some respects it could be seen that the risk of not putting them through a rigorous assessment could have been greater."

With respect to him, there are obvious fallacies to that argument, not the least of which is that it is now widely accepted that the trust was not subjected to any sort of rigorous testing of the quality of its provision of care and, secondly, he later accepted in evidence that had the trust been rejected, it would have been the focus inevitably of considerable scrutiny to discover why.

The evidence brought into focus the question: what was the process of gaining the Secretary of State's support for the foundation trust application actually for? Was it, in reality, any assurance that a trust that subsequently gained foundation trust status would provide good quality care? It was in effect, in our submission, simply another financial filter, but you



might conclude that it was not a very effective one, and Monitor was going to do that job anyway.

Warren Brown's evidence suggests that the DH stage of the process only provided very limited assurance in relation to quality of care. His view was that the point of the Department of Health stage was simply to judge whether the trust had a good chance of being authorised by Monitor.

Andy Burnham denied that by passing the application for submission to Monitor he had done anything more than:

"... confirm that there was no reason that I knew of that Mid Staffordshire should not have a chance to go forward to Monitor's application process which would seriously test and inspect them and subject them to higher scrutiny to flush out any sues."

Well, perhaps the documentation suggests a degree of buck passing when it came to the responsibility for the authorisation of Mid Staffs as a foundation trust. Indeed, in an email to Nigel Fisher in late February of 2009 when the HCC's report was imminent, John Holden stated that he had spoken to Tim Young, head of the NHS Business Unit, and reported:

"I get the sense they want to drop Monitor in it."

However, it may be apparent from the paragraphs





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1 above that there were de facto serious limitations to
2 the extent to which anybody should have relied on the
3 fact of the Secretary of State's support for an
4 applicant to provide assurance that the organisation was
5 providing safe and good quality care to its patients.
6 Neither the SHA filter nor the Department of Health
7 filter achieved that effect, and after the break I am
8 going to turn to Monitor. It also reveals, we submit,
9 the difficulties which arise when you try to separate
10 finance from the quality of care which a trust is
11 required to deliver.
12 Perhaps I could turn to Monitor after a short break.
13 THE CHAIRMAN: You have certainly earned it. Ten minutes or
14 a little longer?
15 MR KARK: No ten minutes is fine.
16 THE CHAIRMAN: We'll come back at about half past.
17 (11.20 am)
18 (A short break)
19 (11.32 am)
20 MR KARK: Sir, I was going to turn to Monitor's assessment.
21 In terms of the application process, there was
22 consistent denial from those within Monitor and from
23 witnesses for the Department of Health that there had
24 been any pressure upon Monitor to approve the Mid Staffs
25 trust application. Although there was undoubtedly



1 pressure within the system to ensure that the
2 government's programme was met, there is no evidence to
3 demonstrate conclusively that this trust was given
4 foundation trust status by reason either of direct or
5 indirect government or Department of Health pressure.
6 It was also consistently denied that the application
7 process itself and the subsequent authorisation of this
8 trust caused the problems at Mid Staffs hospital.
9 However, it is legitimate to enquire, as we have done,
10 whether the efforts put into the application process,
11 which was, of course, considerable, may have diverted
12 those in management positions at the trust from focusing
13 on the quality of care which the hospital was providing.
14 In particular, we enquire whether the stress laid upon
15 good financial governance, without which no trust could
16 achieve this status, may have caused the trust to take
17 financial measures which it was unequipped to bear in
18 personally. The application process, if properly
19 focused, might, of course, have been an opportunity to
20 identify poor care, but it wasn't and it didn't.
21 According to Bill Moyes, it was up to Monitor to
22 decide on the process of authorisation as well as the
23 criteria for assessment. And it's reflective perhaps of
24 the make-up of the Monitor team that the processes
25 focused on finance rather than the quality of care.



1 Dr Moyes told the inquiry:
2 "Had Monitor decided to play a role in assessing the
3 quality of care provided by FTs it would have had to
4 take on experience clinical staff. Given that Monitor
5 have access to the expertise of the HCC and any external
6 advisers it needed, it seemed unnecessary and wasteful
7 to employ permanent clinical staff and, in any case, to
8 be extremely unlikely the [Department of Health] would
9 have agreed a budget for Monitor which would have
10 included such staff."
11 Adrian Masters' impression of the relationship was
12 that there was sometimes tension within the Department
13 of Health with regards to its policy on the status of
14 FTs in that it recognised the independence of these
15 bodies but had an instinct to involve itself in the
16 resolution of specific problems of a high profile
17 nature.
18 That instinct we have seen in the way in which the
19 Department of Health reacted with Monitor following the
20 publication of the HCC report. The instinct is perhaps
21 a natural one and one which inevitably follows from
22 ministerial accountability to Parliament for the NHS as
23 a national organisation, paid for from taxpayers' money.
24 Bill Moyes told the inquiry that in his view
25 Monitor's role was not well understood by the Department



1 of Health. He had suggested a series of roadshows and
2 seminars to explain the role of Monitor, but it didn't
3 happen:
4 "Monitor's relationship with the Department of
5 Health was never, in my personal experience [he said],
6 an issue 1. My impression was that me people at the DH
7 were hostile to the idea of foundation trusts and
8 consequently sceptical of Monitor. The Department also
9 had an ambiguous remit. In the case of NHS trusts, it
10 took the lead, whereas in the case of FTs it had to be
11 hands-off."
12 Bill Moyes in particular was protective not only of
13 Monitor's independence but also the autonomy of
14 foundation trusts. When David Nicholson wrote to all
15 trusts, including foundation trusts, in 2007 in relation
16 to deep cleaning, it generated discussion in a series of
17 letters between David Nicholson and Bill Moyes about the
18 appropriateness of the DH writing directly to foundation
19 trusts in that way.
20 Bill Moyes expressed his "discomfort" with the fact
21 that the David Nicholson had in effect given
22 instructions to foundation trusts for which he and the
23 DH were not directly accountable.
24 That striving for independence may, however, have
25 deprived Monitor of relevant information, even given due

weight to the fact that some of the information will have been historic by the time of the Monitor assessment. Monitor was also unaware of the internal debate within the Department of Health in relation to this application.

Neither Bill Moyes nor David Hill or indeed anyone else at Monitor were aware that the Department of Health assessors had advised in a note dated 14 June that the business model for Mid Staffs was marginal.

That note was put to him, and I asked him:

"Now, again, do you not think that that is the sort of information that your assessment team should have, if one is going to have a transparent, open and proper process?"

He said:

"Well, I would go further. That trust shouldn't have been referred to us. If that was the Department's assessment, then I would say the Department was mistaken in putting that trust to us. And certainly, you're absolutely correct, that if the Department had got to the point putting marginal cases to us, it would have been nice if they'd told us. But I don't think they did, to the best of my knowledge."

David Hill, from the Monitor's assessment team, was aware of the issue of poor coding at the trust, which



was said to create two problems: inflating mortality rates and an unfair reduction in the amount paid to the trust by the PCT.

The trust had relied on a report from CHKS to demonstrate that its clinical coding was poor. The assessment team was aware of Dr Foster's publication of the trust's standardised mortality rate of 127, which was the fifth worst in the country.

Bill Moyes told the inquiry:

"Monitor's assessment team was aware that the trust was recorded as being among the ten hospitals with highest mortality. This was unusual and certainly sounded an alarm bell as an issue for Monitor to investigate."

But according to David Hill, despite the poor mortality figures, Monitor took comfort from the following:

A letter from DFI dated 29 June 2007 apparently confirming that crude mortality rates were below the national average;

A memo from the trust detailing actions taken by the trust and an action plan;

The appointment of CHKS;

A meeting with the SHA and Dr Foster to follow-up concerns;



The trust setting up a mortality group;

Ongoing monitoring of Dr Foster Intelligence real-time monitoring tool;

And the DFI real-time monitoring tool which demonstrated apparently that the mortality rate had dropped to 107 for April 07 to August 07 and to 101 over the period May 07 to August 07.

Results of the CHKS coding review, dated 5 March 2007, which found that there was recorded a lower number of patients with complications in medicine than peer group trusts, documentation in case notes was poor, that there was a high number of episodes per clinical coder, the number of diagnosis recording was lower than peer group hospitals, and the coding manager at the trust had a low profile. In other words, all issues which pointed to poor coding.

Monitor was told specifically that the trust was under-recording co-morbidities, and they were aware that the University of Birmingham was carrying out research into the figures, although the results of that research weren't published until after the assessment was complete.

None of the specific mortality alerts in 2007 were made known to the Monitor assessment team, either by the Healthcare Commission or by the trust itself, despite



the fact that they were effectively contemporaneous with the assessment. In light of these, it is surprising that Helen Moss at the Monitor board-to-board felt able to give the limited explanation which she did to Monitor and that those who attended the meeting with Monitor on behalf of the trust were able to be quite so optimistic about the quality of care being provided.

What of the HSMR statistics published in April 2007? Why, we ask rhetorically, wasn't more attention paid to them?

On 29 May 2007 Dr Shukla and Mr Blythin presented a report to the West Midlands SHA board on the Dr Foster figures, under the heading "Actions to date". The report stated:

"... 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."

The report summarised the issues raised by all five trusts as ones of coding methodology with reference again to CHKS, and the lack of availability of palliative care in the community. And it then set out its next steps, that:

"The SHA will commission an independent analysis to determine whether there are indeed excess deaths in

1 hospitals in the West Midlands."
2 It was proposed that the analysis should address the
3 effect of the following factors: coding; the
4 availability of palliative care in the community; the
5 methodology used by Dr Foster Intelligence; and any
6 association between particular features of hospital
7 governance systems and lower in-hospital mortality.
8 It was not proposed at this stage that the analysis
9 should attempt to test the hypothesis implicit in the
10 DFI's publication and presentation of the HSMR figures
11 that they reflected the quality of care provided by the
12 trust.
13 The SHA board agreed that the independent analysis
14 should be carried out and they should receive a further
15 report on 22 January 2008, eight months later.
16 On 15 June 2007 the trust shared with the SHA three
17 documents: a report on work carried out in relation to
18 the HSMR figures, with an accompanying action plan;
19 a clinical audit annual plan; and a patient and public
20 partnership plan.
21 The starting point of the trust's report into HSMR
22 was as follows:
23 "Mortality rate.
24 "In order to establish if the trust had a potential
25 overarching clinical problem a simple analysis was



1 undertaken of the trust's raw data to establish an
2 overall trust mortality rate."
3 The report went on to identify the overall crude
4 mortality rates in 05/06 and 06/07 as 1.9 per cent and
5 1.8 per cent respectively, and said the national range
6 of an overall trust percentage is 1.5 per cent to
7 3 per cent, with an average of 2 per cent as identified
8 by CHKS.
9 And it carried on:
10 "It appears that the trust's overall mortality rates
11 are at the low end of the national benchmark. The trust
12 can therefore be assured that there are no obvious major
13 underlying problems in terms of the overall mortality
14 rates."
15 Professor Cumming accepted in his evidence that with
16 benefit of hindsight the trust's approach was very
17 clearly wrong. He went on to accept that it might have
18 been said to have been wrong even without the benefit of
19 hindsight. But at the time, the SHA didn't challenge
20 the trust's assumption about the significance of the
21 crude mortality statistics in relation to the HSMR.
22 A close reading of the evidence suggests that having
23 spoken to the trusts affected in May of 2007 the SHA
24 accepted their assurances and in commissioning the
25 Mohammed report had already decided that there were no



1 significant problems with quality of care underlying
2 those statistics.
3 The trust's board recorded comments on receipt of
4 the Mohammed report a year later in June 2008 suggest it
5 considered that the report had confirmed that there were
6 no problems with the quality of care at the trust with
7 high HSMR and that the issue was effectively closed.
8 That was not what the report on any construction did.
9 It was another example, perhaps, of trust spin, which
10 seems to have been accepted by some.
11 The trust's report also contained a detailed
12 description of work done to interrogate the diagnostic
13 coding behind certain elements of Dr Foster HSMR, and it
14 also contained a section on apparent duplication in
15 diagnosis group codes used by Dr Foster which, if
16 discounted, appeared to the trust to lead to the trust's
17 score being significantly below rather than above the
18 median score of 100.
19 Well, the evidence indicates that the SHA had no
20 independent means of testing what they were being told.
21 Dr Shukla considered that the plans provided by the
22 trust were reasonably robust and better than others
23 received by the SHA. In her statement she said that she
24 had no reason to believe that the trust was not
25 following through on them.



1 However, she added that if encountering the same
2 circumstances again, she would now consider the
3 information collated in the SHA's clinical quality
4 dashboard and would review the clinical audit plan
5 against national standards on audit and seek assurance
6 that the trust board understood the importance of
7 clinical audit. She would make enquiries about the
8 leadership and culture of the trust, matters in which
9 she hoped the SHA's recently devised appreciative
10 enquiry scheme would assist.
11 Mr Blythin remarked:
12 "While the accounts given by different trusts were
13 variable, what we did see is that Mid Staffs gave a good
14 account of what they were doing. What we did not do was
15 to check that the strategy in the clinical audit plan
16 were actually in place and being enacted. We expected
17 that where actions had been agreed they would have been
18 followed through."
19 Well, what has all of that got to do with Monitor?
20 On 15 October 2007 David Hill and Craig Watson of
21 Monitor met Mr Shanahan to discuss the trust as
22 a routine part of the assessment process. The three
23 discussed the performance of the local health economy in
24 general and the trust in particular, and the notes of
25 the meeting included the following comment:

1 "Quality. No concerns regarding quality."
2 In effect, Monitor received no assistance at all
3 from the performance manager, because the performance
4 manager was unaware of the inherent quality issues
5 within the trust. Given that quality of care was in
6 fact mentioned in the meeting between Mr Shanahan and
7 Monitor, it is striking that the matter of the trust's
8 HSMR does not appear to have been discussed at all, even
9 if only to be dismissed as an issue. The lack of
10 involvement of Dr Shukla as medical director is also
11 notable.
12 The minutes of the 5 December 2007 Monitor
13 board-to-board meeting reveal the broad outline of the
14 areas probed with the trust. Of the total number of 46
15 questions asked, just nine focused on clinical issues
16 and both the questioning and responses as recorded were
17 relatively superficial.
18 Sir, it is important to remember that it was
19 underlined by a number of witnesses that the minutes
20 didn't record every question asked or answer given, and
21 we must read the document with that in mind. However,
22 some of the answers do appear to be extremely
23 superficial, one example having been identified during
24 the inquiry being Helen Moss's response to the following
25 question:



1 "How will you ensure that you don't compromise
2 quality while cutting costs?"
3 Answer:
4 "With the systems we have in place and constant
5 monitoring. Quality is what drives our business and
6 makes people want to come to us."
7 Many might think this answer was meaningless and
8 shows up the relative superficiality of the process.
9 Another example:
10 "What clinical departments are you most concerned
11 about?"
12 Ms Brisby said:
13 "A&E gets a lot of attention at board level."
14 Well, this answer clearly required closer scrutiny.
15 However, the reality is that this interview was never
16 intended, nor expected, to identify serious clinical
17 weaknesses which ought to have been identified prior to
18 this meeting, had there been much closer cooperation
19 with the Healthcare Commission at all levels.
20 Miranda Carter told the inquiry that had the
21 specific mortality outlier issues been known to Monitor,
22 or the likelihood of an investigation by the Healthcare
23 Commission, "We", she said:
24 "... would not have proceeded to authorise the
25 trust."



1 It is difficult now perhaps, given all that's known
2 about the trust, to say one way or the other what
3 Monitor would in fact have done had they known of those
4 lower clinical difficulties.
5 Bill Moyes defended the board-to-board process in
6 his statement, and he denied that if Monitor had
7 genuinely probed the trust at the board-to-board meeting
8 it would have been apparent that the trust wasn't ready:
9 "I don't think that suggestion is justified."
10 If he is right about that, no amount of probing
11 would have revealed the problems, one is entitled to
12 enquire, what was the point of the board-to-board if it
13 was incapable of identifying serious issues which were
14 by this stage apparent to the Healthcare Commission and
15 to the trust itself?
16 Consideration was given, according to Mr Hill, to
17 the poor staff survey of 2007, in which just under
18 50 per cent of the trust staff said they would not want
19 to be treated or cared for at the hospital. The trust
20 has claimed that this was incongruous, given to the high
21 rating give to the trust by 88 per cent of patients.
22 As Mr Hill admitted:
23 "I don't think we focused on the results of this
24 review as much as we could have and under our new
25 quality governance approach we would look at the



1 outcomes from surveys in a more systematic way."
2 He was asked:
3 "Did you read the staff surveys or not?
4 "Answer: No, we didn't specifically download the
5 staff surveys or request them from the Healthcare
6 Commission and review them as part of the assessment.
7 "Question: Can you explain why not?
8 "Answer: It wasn't part of our process at the time.
9 "Question: Did you read the patient surveys?
10 "Answer: Likewise, it wasn't a standing part of our
11 process at the time."
12 He said.
13 Bill Moyes told the inquiry that he accepted, with
14 the benefit of hindsight, that authorising the trust was
15 a mistake, but he said:
16 "It needs to be seen in context. Almost every
17 applicant had problems and several had a number of
18 problems. Most had also recently implemented a cost
19 reduction plan. It is possible for a CIP to be achieved
20 without compromising patient care ... I accept it was
21 open to Monitor to ask more questions about [staff
22 reductions], and press the trust board harder to see if
23 they had considered fully the implications in staffing
24 levels which were made."
25 The reality, however, seems to have been that there

was in fact an almost complete absence of focus by the Monitor assessment team about the fundamental purpose of the hospital which they were assessing, which was not simply to balance its books by ensuring it didn't spend more than it was given in income, but which was to provide high quality care to its patients. This focus may have been the inevitable consequence of the structure of Monitor and the background of those it chose to employ to conduct its assessments, all of whom perhaps understandably had backgrounds in finance and management, and none of whom had any clinical training or professional experience. Even without knowing about the impending investigation by the HCC, the Monitor team were provided with a number of indicators, which to an alert assessor with clinical experience might have identified clinical concerns, but they were not picked up by the assessment team whose focus was elsewhere.

The authorisation itself was signed by Dr Moyes and dated 1 February 2008, and it's right to say that conditions were imposed with the authorisation. Condition 5 required the trust to ensure the existence of appropriate arrangements to provide representative and comprehensive governance in accordance with the Act and to maintain the organisational capacity necessary to deliver the mandatory goods and services referred to.



Condition 6 of the authorisation required the trust to put and keep in place and comply with other arrangements for the purpose of monitoring and improving the quality of healthcare provided by and for the trust.

On 6 February Monitor sent the side letter, addressed to Toni Brisby, pointing out that the trust was behind trajectory on its MRSA target as well as having breached the A&E target in December 07 and there was also concern about the trust's ability to meet the thrombolysis target. The trust was notified that it had achieved an amber governance rating.

Well, what about the relationship between Monitor and the Healthcare Commission?

Monitor's authorisation of the trust as an FT in ignorance of the HCC's concerns about mortality at the trust and the imminent launch of the HCC's investigation in 2008 revealed that there had been a fundamental breakdown in communication between these two bodies. In that light, the inquiry was concerned whether there was anything about the relationship between these organisations or the context in which they operated that led to that situation.

Part of the memorandum of understanding between the Healthcare Commission and Monitor stated that as part of Monitor's application authorisation process there would



normally be a meeting arranged with the HCC's area manager to discuss relevant issues about the applicant trust.

The HCC at regional level was clearly aware that this trust had applied for foundation trust status, but the HCC was not aware at a national level until it cropped up in conversation between Anna Walker and Elaine Murphy, non-exec director of Monitor, in March of 2008.

Shelagh Hawkins told us:

"I was aware that the trust had applied for this ... [status] and at this time there was a drive for all trusts to become foundation trusts. I wasn't aware of the timing of the application ... I wasn't involved ... no one asked me whether I had an opinion in relation to the trust's application."

This plainly demonstrates a failure of communication on a number of levels within the HCC itself. It demonstrates a failure by the regional staff to alert headquarters, it also demonstrates that the HCC at national level was failing to keep up with information which was actually publicly available.

In what might be regarded as a further failure of communication, neither the SHA nor Monitor were copied into the 2007 alert letters sent to the trust.



Bill Moyes was of the view that the information contained in the alert letters, coupled with the investigation, would almost certainly have caused Monitor to delay at the very least the application process.

The specific roles of Monitor and the HCC, so far as foundation trusts and applicants to foundation trust status were concerned, were not as well defined as plainly they needed to be.

Stephen Hay told the inquiry:

"Our role was to look at finance and governance, and theirs was to look at quality. The area where there was with hindsight ambiguity was in relation to quality governance. Until we learnt the lessons from the failings at the trust, I do not think it was clear either to us or to the Healthcare Commission which of us was looking at the way in which the boards of foundation trusts assured themselves of the quality of care provided. That is an issue which we've now addressed."

There was no record between any discussion between Monitor and the HCC in relation to the trust's application for FT status. This was a startling feature of the evidence, given the admission by Monitor as to the focus of its assessment process.

Miranda Carter had a recollection of sending an

1 email, which she has since been unable to find,
2 suggesting that the assessment team contact the HCC
3 local office. Monitor did notify the HCC of the trust's
4 application at local level by email, dated
5 23 October 2007, and invited the HCC to contact
6 David Hill.
7 Dr Stephen Bennett of the HCC then wrote to Mr Hill,
8 informing him that he should contact the HCC's assessors
9 instead of the area managers. That was followed by an
10 email from Rupinder Singh on 24 October saying that both
11 Andrea Gordon and Lorraine Moore of the HCC were happy
12 to talk to him.
13 Mr Hill says that he spoke over the telephone to HCC
14 area managers, but he cannot remember who he spoke to,
15 nor did he reveal what if anything he was told.
16 By this stage the Healthcare Commission had been
17 writing to the trust about specific outliers, and it is
18 at least a realistic possibility that had contact been
19 made at the right levels, these concerns have been
20 revealed.
21 The inquiry also heard that by January of 2008 the
22 SHA was also aware of these letters. Dr Moyes was later
23 to claim in evidence that this information would have
24 prevented the application from progressing.
25 He said:



1 "Monitor was completely unaware that the HCC was
2 considering launching an investigation the month
3 immediately following the trust's authorisation as
4 a foundation trust. If the HCC or the trust had told
5 us, we would have stopped the assessment decision
6 immediately and deferred a decision on the application
7 until the results of the investigation were known. That
8 didn't happen. I do not know why that was."
9 It was, said Anna Walker, a combination of home
10 produced outliers and those produced by the DFU, which
11 had identified seven alerts in relation to the trust
12 where the rates of death from specific conditions were
13 statistically higher than the expected rate of
14 mortality.
15 According to Martin Bardsley, the HCC began a pilot
16 scheme for the mortality outliers programme in the
17 summer of 2007, and so this was a new process. The
18 process was that alerts or signals could be generated
19 from a number of sources. The difference in approach
20 between the DFU and the HCC was that the HCC used a more
21 generic case mix than the DFU and looked across a wider
22 range of patient groups. A number of alerts were
23 generated in 2007 both by the Dr Foster Unit and by the
24 Healthcare Commission's internal pilot scheme.
25 The four alerts produced by the DFU were in relation



1 to:
2 The operations on the jejunum. There were 11 deaths
3 as opposed to the expected 4.9.
4 Aortic peripheral and visceral artery aneurysms.
5 Peritonitis and intestinal abscess.
6 And other circulatory diseases.
7 Those produced by the HCC's own analysts were:
8 Diabetes.
9 Epilepsy and convulsions.
10 Repair of aortic aneurysm.
11 It might be noted in passing that four out of these
12 seven relate to surgical procedures.
13 The first alert was forwarded to Andrea Gordon by
14 the HCC informatics team on 11 July 07, which was
15 a response to a DFU alert to the trust of 3 July.
16 The mortality outliers team considered this alert on
17 21 August 07, and the Healthcare Commission's own
18 analysis suggested that the issue could be one of coding
19 of emergency operations and the high proportion of those
20 might be being performed out-of-hours.
21 The first alert letter sent to the trust was dated
22 23 August and related to deaths from operations on the
23 jejunum.
24 The trust replied on 3 September indicating they
25 were already aware of the alert and the fact that 11



1 deaths had been recorded between June 06 and July 07.
2 A report was promised by the trust, but no such
3 report was forthcoming and it was chased by the
4 Healthcare Commission on 17 September and 25 October.
5 A second alert was received from the DFU in
6 August 07 in relation to aortic peripheral and visceral
7 artery aneurysms, and a new alert letter was sent by the
8 HCC on 10 October.
9 Well, these alerts weren't disclosed by the trust to
10 Monitor, and the HCC didn't share them.
11 During January of 2008 the regional team of the HCC
12 were told that the investigation team was considering
13 taking action in relation to the trust. So although
14 there was later denial that a decision had been made at
15 this stage to launch an investigation, the reality was
16 that there was information within the Healthcare
17 Commission which might well have been of assistance to
18 Monitor.
19 On 15 January 2008 a call was made by
20 Nicola Hepworth, investigation officer, to Rashmi Shukla
21 at the SHA. This was followed up by a formal letter two
22 weeks later to the trust.
23 A letter was sent on 28 January 2008 from
24 Dr Heather Wood informing the trust of the potential
25 investigation and copied to the regional assessor for

1 the trust. That letter was sent to Rashmi Shukla at the
2 SHA, together with a request for information. The SHA
3 doesn't appear to have responded to this letter, but an
4 email was sent to Cynthia Bower by Rashmi Shukla on
5 29 January 2008 to alert her.
6 The letter wasn't copied to Monitor, for the simple
7 reason that Dr Wood didn't know that the trust was just
8 about to become a foundation trust.
9 Stephen Hay of Monitor told the inquiry:
10 "Neither the trust nor the SHA, nor the HCC, told
11 Monitor what was happening, which is disappointing and,
12 which I am confident, could not happen now. Had Monitor
13 been told that the HCC was considering launching an
14 investigation into the trust on 28 January 2008 the
15 trust would not have been considered by Monitor's board
16 and would not therefore have been authorised as
17 a foundation trust [he told us]."
18 Well, the inquiry will wish to consider not simply
19 the communication failure but whether as a matter of
20 principle the quality regulator and the financial
21 regulator ought to be separated as they currently are.
22 It may be thought that this case reveals that the
23 separation of the two regulators does not always serve
24 the NHS well.
25 We discussed a moment ago the trigger for the



1 Healthcare Commission investigation, which was in
2 essence the specific mortality alerts and in fact it was
3 also, I think, the trust's failure to respond
4 appropriately.
5 The formal investigation was announced on
6 18 March 2008, and I turn now to the investigation.
7 According to Sir Bruce Keogh, the Department of
8 Health was informed by the Healthcare Commission -- and,
9 sir, I am on paragraph 210 if that assists you -- of the
10 decision to investigate on 17 March 2008. Until the
11 report was published in March 2009, the sponsor
12 department's role was limited to briefing ministers
13 about the decision to investigate and ensuring that the
14 HCC was regularly invited to meetings to tell the DH if
15 there was any need for immediate action. And as, we
16 know, the Department of Health received the draft report
17 in December 08.
18 In a note written in March of 2008 at the beginning
19 of the inquiry, for the Secretary of State and Minister
20 of State for Health, two senior health civil servants
21 wrote:
22 "The very worst case scenario would involve 100 plus
23 premature deaths over a three-year period but the HCC is
24 anxious to stress this is not a given."
25 What perhaps is of interest about this note is not



1 the statistical assumption but what it reveals about the
2 approach of the Department of Health and the perceived
3 sensitivities to the political impact of such figures.
4 The note seems to focus on the potential political
5 implications of the report and not on the fundamental
6 issue of an early discovery of what was going on at this
7 trust. No urgent intervention was requested, nor did
8 the Department consider that the issues raised required
9 intervention. Had such intervention been necessary,
10 then by this stage the appropriate intervention would
11 have had to be conducted by Monitor under its section 52
12 powers. Section 66 of the NHS Act, which gives the
13 Secretary of State for Health power to intervene if an
14 NHS body is not performing its functions effectively,
15 specifically excludes foundation trusts.
16 The Department of Health was copied into some of the
17 correspondence between the Healthcare Commission and the
18 trust. The correspondence that the Department received
19 was as follows, according to David Flory:
20 The 23 May letter of 2008 in relation to accident
21 and emergency.
22 On 25 May that letter was forwarded to the chief
23 executive of the SHA to underline its importance.
24 Sir, if you'll forgive me, I am not going to go back
25 to the contents of this letter. You've read it so many



1 times, I suspect you almost know it by heart.
2 There was then the 7 July letter from the HCC to
3 Martin Yeates, and the 15 October letter to
4 Martin Yeates.
5 Those letters were sent to the Department of Health
6 for information only, but they added to the knowledge
7 held within the Department and, on one view, could have
8 themselves triggered considerations of intervention if
9 looked at with the right level of understanding and
10 concern.
11 It is noted that Sir Hugh Taylor in his statement
12 also accepted that even had he seen the May letter it
13 wouldn't have prepared him or, in his view, others
14 within the Department of Health for the report which
15 surfaced in February the following year.
16 This was in marked contrast to the reaction of
17 Sir Bruce Keogh, who, as a clinician, would have had
18 a quite different reaction. Sir Bruce hadn't seen that
19 May letter until he came to the inquiry to give
20 evidence. When confronted with it, he told us --
21 I asked him:
22 "Well, first of all, you've read that through, does
23 it, in your mind, raise quite serious issues about what
24 was going on in this trust?
25 "Answer: Without any shadow of a doubt."

1 David Flory told the inquiry that he met with
2 Anna Walker on a number of occasions during the currency
3 of the investigation and doesn't recollect any
4 expression of concern about the investigation into
5 Mid Staffs.
6 He told us:
7 "Indeed at no time prior to the issue of the draft
8 report was I made aware that the HCC had identified that
9 serious concerns were emerging in relation to
10 Mid Staffs."
11 It doesn't appear that he had read the letters
12 referred to above at the time of receipt. But it is
13 clear that nothing in the letters which he had read by
14 the time of the inquiry changed his view. He referred
15 to updates from the Healthcare Commission being
16 reassuring, and quoted a press release by the
17 Commission, which referred to the trust having responded
18 positively to concerns raised about the safety of
19 patients in Stafford Hospital A&E.
20 Nevertheless, one might have expected that anyone or
21 at least anyone with clinical experience working in the
22 DH would have read those letters with a high degree of
23 concern:
24 "I expected that, had there been any immediate
25 concerns about patient safety, the HCC would, in



1 accordance with its powers, propose that the trust be
2 placed under special measures", said Mr Flory.
3 It may be thought that the letters, particularly
4 that of 23 May did indeed reveal immediate concerns
5 about patient safety, and that no one at the Department
6 who read them seems to have been sufficiently alert to
7 realise that.
8 Sir David Nicholson was asked about the letter of
9 23 May, which had not been seen by him at the time.
10 I put to him:
11 "... Sir Bruce Keogh told us last week, if he had
12 seen that, as a clinician he would have been very
13 concerned.
14 "Answer: Yeah.
15 "Question: Perhaps it doesn't need a clinical eye
16 to look at that sensibly and realise that it raises
17 serious problems. But does it reveal, do you think,
18 a blockage in the Department of Health that it wasn't
19 shown Sir Bruce Keogh and it wasn't shown to you?
20 "Answer: I mean, clearly whoever read it didn't
21 understand the scale and nature of what was being said
22 in it."
23 Over the course of a year, from the beginning of the
24 investigation to the time of the publication of this
25 report, the dominant tone of the SHA internal and



1 external correspondence regarding the HCC's
2 investigation was one of scepticism. This was partly
3 because Mr Allen and Mr Shanahan appeared not to
4 consider mortality statistics to be reliable indicators
5 of quality of care.
6 In September the SHA sent the HCC the Birmingham
7 report on HSMRs. And on 17 September the HCC wrote back
8 criticising the report's conclusions.
9 On 29 September Andrea Gordon wrote to Anna Walker
10 and relayed concerns expressed by Peter Shanahan about
11 the manner in which the investigation was being
12 conducted. Again, it might be thought to be unfortunate
13 that there was what appeared to be a degree of tension
14 between the strategic health authority and the HCC as
15 well as a degree of a lack of cooperation.
16 Anna Walker was critical of the SHA's position at
17 this stage. She told us -- I asked her:
18 "You told us that this sort of correspondence isn't
19 uncommon. Did you think it was an appropriate stance
20 for the SHA to take? I asked you, perhaps it was an
21 inappropriate way of putting it, where you saw the SHA's
22 loyalties lying. How would you reflect upon it?
23 "Answer: Well, I suppose what really puzzled me
24 with these conversations, actually, was once the SHA had
25 satisfied themselves that we were conducting this



1 investigation with professionalism, then my view was
2 that surely what we were doing would be of as much
3 concern to them as it was to us. So that was why I was
4 so puzzled by the exchanges that were taking place. The
5 other thing which really puzzled me was that by the time
6 of this conversation, there was a draft report, and so
7 the issues that had taken place at the trust were being
8 laid bare in that draft report and still we didn't seem
9 to be getting concentration on the issues that needed to
10 be addressed."
11 As the investigation continued the HCC appears to
12 have received no support either from the SHA or Monitor
13 and there were attempts made by both organisations to
14 curtail the investigation.
15 According to Sir Andrew Cash, the Department
16 received the Healthcare Commission's recommendations on
17 20 February 2009, and those were shared with ministers
18 the following Monday, the 23rd.
19 The draft report appears to have first been
20 discussed at an investigation team meeting on
21 9 December 2008 the previous year, and a draft was sent
22 for comment to the trust to the Department of Health and
23 to Monitor on 18 December.
24 A second draft was sent in January, and both first
25 and second drafts received criticisms from the trust

1 saying that they had significant concerns.
2 Draft copies of relevant extracts of the report were
3 provided to a number of organisations, including an
4 extract being provided to the SHA. The SHA took
5 exception to the wording within the report critical of
6 the SHA, although in a letter dated 16 February the SHA
7 recognised that there were serious quality of care
8 issues. Nevertheless, they accused the HCC of data
9 dredging, which Nigel Ellis regarded as a serious
10 allegation, and when the HCC responded by letter the
11 HCC, according to Mr Ellis, failed to reply.
12 Monitor was also critical of the methodology of the
13 report, and the trust thought it was unfair because it
14 didn't reflect the changes which had taken place at the
15 trust. There was discussion between the HCC and Monitor
16 as to whether the HCC would recommend to Monitor that
17 they should take special measures, and this was
18 discussed at an HCC investigation meeting in February of
19 09.
20 Special measures were, however, avoided. There was
21 a body of evidence which suggested that the language
22 used in the report was deprecated by the new leadership
23 of the CQC, as the language was considered to have been
24 extravagant or florid. That was a view which certainly
25 seems to have been held by Baroness Barbara Young.



1 There was correspondence between Heather Wood and
2 Baroness Young in May of 09 on that issue, and
3 Baroness Young referred to the report as a blunt
4 instrument.
5 Neither Nigel Ellis nor Dr Heather Wood accepted
6 that description, nor did they accept that the report
7 was written in deliberately extravagant language because
8 the HCC had limited powers.
9 There is speculation as to whether or not a similar
10 set of problems arising elsewhere would now be
11 identified by the CQC, and it's perhaps not surprising
12 that each of the witnesses from the HCC investigation
13 department were very firm believers that an
14 investigation team is crucial.
15 Nigel Ellis told us this:
16 "Without a dedicated specialist investigations
17 function I am not sure how this [identifying another
18 Mid Staffs] would be realistically achieved. Without
19 investigations into a trust or a dedicated national
20 investigations team, I struggle to see how the CQC can
21 be confident that similar safety concerns will be picked
22 up and acted upon in the future. If we are to have
23 proportionate health and social care regulation, this
24 needs to be combined with an independent investigation
25 function that is able to look critically and in depth at



1 situations like the trust to get to the heart of the
2 matter and crucially not to be too easily convinced by
3 those who provide comforting yet a ultimately
4 superficial assurance."
5 Of course, all of that does beg the question of the
6 problems which arose because length of the
7 investigation, and there were many critics in relation
8 to that.
9 The question then arises: could Monitor have stepped
10 in sooner and should they, therefore, have taken action
11 during the course of the HCC investigation?
12 Monitor was also criticised for failing to act
13 divisively enough following publication of the report.
14 David Bennett told the inquiry:
15 "I think it's now clear that things only began to
16 improve when [David Stone and Eric Morton were
17 appointed]. To my mind this means that things would
18 have been better if Monitor had intervened sooner, but
19 I am doubtful as to whether it could have done so in the
20 specific circumstances it faced ... As I understand it
21 ... the view of Monitor's lawyers, in conjunction with
22 senior management, was that Monitor could only intervene
23 once the HCC had reached firm conclusions ... The
24 absence of a recommendation from the HCC served to leave
25 open the question as to the severity of the problems at



1 the trust."
2 With respect to that sentiment, you may conclude
3 there was ample evidence which could have justified
4 Monitor in taking steps earlier. Not only did they have
5 drafts of the HCC reports which describe substandard
6 care, Monitor had also received the 23 May 2008 HCC
7 letter and the subsequent alert letters in July and
8 October.
9 In the circumstances, Monitor can, in our
10 submission, be properly criticised for failing to act
11 decisively and blaming others for not doing so. Monitor
12 was not obliged to wait for a recommendation from the
13 Healthcare Commission, and indeed in due course when
14 Monitor did act it wasn't on the basis of any such
15 recommendation.
16 Dr Moyes was pressed upon this issue in evidence.
17 I asked him:
18 "Now, with respect, Dr Moyes, isn't that simply
19 misstating it, to say that in effect seven to eight
20 months were lost before Monitor good intervene because
21 the HCC hadn't given uni recommendations?"
22 He answered:
23 "Well, I still think that the way Parliament
24 intended the system to work in a case like this, [it]
25 was for the Healthcare Commission to make a clear

1 recommendation to Monitor that special measures were
2 needed and to be specific as to what those were, and
3 then for Monitor to use its powers of intervention.
4 I do believe that that was the intention."
5 I put to him:
6 "But you agreed with me yesterday, I think, that you
7 did not have to wait for the recommendations from the
8 HCC for Monitor to act.
9 "Answer: No, I mean, I accept that legally we could
10 have probably acted at this stage, but I felt at the
11 time and, as I say, with the benefit of hindsight you
12 may tell me that I made the wrong judgment, but I felt
13 at the time, and my colleagues felt at the time, that
14 the right thing to do was to ask the Healthcare
15 Commission to bring their investigation to a rapid
16 conclusion, give us clear recommendations and then to
17 intervene."
18 Bill Moyes claimed in evidence:
19 "Monitor ensured that the terms of the authorisation
20 of foundation trusts were drafted to enable these powers
21 [of intervention] to be used in circumstances of
22 clinical failure. This therefore contemplated the HCC's
23 legislation well. They had the power, the expertise and
24 the independence to identify clinical failure and draw
25 them to our attention. Monitor had the power to



1 intervene and both bodies were under a statutory duty to
2 cooperate."
3 Well, those were indeed the powers and roles
4 ascribed by statute, but the reality in practice appears
5 to have worked rather differently, as I have described.
6 On 23 May Ed Lavelle sent an email to Bill Moyes
7 referring to concerns that Martin Yeates appeared not to
8 be aware of some of the problems within A&E at the
9 hospital.
10 The purpose of that had been to prompt further
11 consideration from Stephanie Coffey and Yvonne Mowlds
12 ahead of a meeting with the HCC:
13 "We were told that it wasn't considered appropriate
14 to intervene at this stage, as the HCC was still
15 investigating and was expected to make recommendations."
16 Mr Lavelle admitted, however, that although Monitor
17 have limited evidence at this stage, it was aware that
18 although the trust was taking action it was not doing so
19 quickly enough.
20 Mr Lavelle told us that there was concern that
21 progress and improvement might be put at risk. One
22 wonders in passing why at is stage Monitor didn't become
23 more active if there was that realisation. Who at
24 Monitor had at the forefront of their mind the patients
25 who were still being treated at the hospital?



1 On 25 June 2008 there was another email to
2 Stephanie Coffey, who was Monitor's senior compliance
3 manage, from Ed Lavelle in which he stated that there
4 was a risk that:
5 "If the HCC just keep bashing on with their reviews,
6 the goods bits of the hospital would just decline as
7 there is a firefighting focus on the bad things to the
8 detriment of everything that was good in the hospital."
9 He went on to say:
10 "... enough evidence already that material action is
11 required and there is a need for an operational and
12 strategic review."
13 He explained in his statement that what he meant was
14 material action by the trust, rather than formal
15 statutory action by Monitor.
16 One might have thought by this stage there was
17 sufficient material for Monitor to take a far more
18 active role but they appear to have been waiting for
19 some sort of proof from the HCC.
20 Bill Moyes told us that he felt the HCC team took
21 a criminal-style approach and investigated everything.
22 He said:
23 "The HCC could have presented a convincing picture
24 of the hospital which needed reform without identifying
25 issues in each ward."



1 He said:
2 "I was frustrated because Monitor could not use its
3 statutory powers of intervention to help the trust deal
4 in earnest with its problems when the HCC stressed on
5 a number of occasions that its investigation was
6 incomplete and that it was not possible to make
7 recommendations."
8 This may now be a relatively easy line to take but,
9 with respect, it does appear that Monitor was trying to
10 absolve itself of its responsibility as an independent
11 regulator with its own autonomous powers of
12 intervention.
13 Throughout the period, Dr Moyes and others at
14 Monitor were in regular contact with Martin Yeates and
15 the senior management of the trust requesting
16 information as to the trust's reaction to the various
17 HCC criticisms as set out in the letters.
18 On 13 February 2009 Bill Moyes was to write to
19 Yvonne Mowlds in the following terms:
20 "I am not convinced that the HCC has a good
21 methodology that produces strong enough evidence to
22 satisfy a court if it came to that. We shall see."
23 In the same email he revealed that he was expecting
24 there to be pressure from the Department of Health to
25 act once the HCC report was published.





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He wrote:
"They [meaning David Flory and Alan Hall] were particularly interested in whether the HCC was likely to conclude that there had been a failure of leadership."
Bill Moyes did, however, reveal that the legal advice he was at this time receiving was that the evidence emerging from the HCC report indicated a breach of the trust's authorisation, which was significant and merited intervention.
The HCC did not, of course, design its investigation, nor its collation of evidence, around what Monitor might need. Nor does there appear to have been any agreement about what Monitor would need from the HCC by way of evidence for it to use its formal intervention powers. There was, it seems, something of a chasm developing between what the HCC was developing through its investigation and what Monitor in fact felt it needed by way of evidence.
On 2 March 2009 Toni Brisby called Dr Moyes to inform him that she had decided to resign and she planned to do so at a council of governors the following day.
And on 3 March the assessment team at Monitor did recommend that formal intervention was taken. In the meantime, David Stone had been lined up by Bill Moyes as



an interim chair.
By this date the chair, Toni Brisby, had already decided to step down. Martin Yeates had agreed to step aside, so the only formal intervention by Monitor was to appoint an interim chair. David Stone was then chair of Sheffield teaching hospital, and two days later Eric Morton was appointed interim chief executive. He was also at that time heavily involved with another trust, and he was the chief executive of Chesterfield.
Later attentions arose in relation to the appointments of full-time posts as chair and chief executive and there were, as we know, discussions between Monitor and the Department of Health in relation to the replacement of those interim posts.
Sir David Nicholson accepted that he suggested some names for a permanent role position, and he did so because Monitor had said they couldn't find anyone else. Antony Sumara was Sir David Nicholson's suggestion, and Monitor didn't come up with any alternatives.
The note by David Flory dated 7 July 2009 entitle "Options for further action" speaks of increasing pressure on Monitor to appoint full-time leadership and:
"Raising the stakes by threatening serious consequences if they did not cooperate or deliver."
That, according to Sir David Nicholson, was because



the Department felt that the action Monitor was taking would not secure adequate improvement within an acceptable timetable. Therefore, said, Sir David:
"... we were preparing to take action ourselves if that became necessary."
It is clear from certain internal emails within Monitor that some thought that the Department of Health ought not to be interfering in the appointment process. However, as Edward Lavelle himself pointed out in an email dated 9 March 2009:
"He [Mike O'Brien] is concerned that whilst Monitor can handle things when the wheel wobbles, when the wheel comes off, ministers need to be in a position to do something about it."
Bill Moyes attempted to put the emails into context. He told the inquiry:
"MPs and ministers were concerned about the forthcoming general election at around this time ... Several local MPs were pressing for faster action to put the trust right and were choosing to direct their pressure to ministers rather than to Monitor ... Ultimately I didn't have a better solution to offer Monitor's board in relation to the appointment of a permanent chief executive than the one the DH wanted."
Interestingly, at about the same time Mr Ken Lownds



was in correspondence both with Bill Moyes and with Ed Lavelle complaining about the lack of action and the fact that interim officers were less active than had been hoped. Poor care was continuing and there was an enormous amount of public concern and frustration.
Monitor also resisted interference by the PCT and again was seen to be protecting its turf, the turf being a foundation trust. We were told:
"Monitor took a different view of the scope of the PCT's role. Mr Poynor described a meeting with the trust and Monitor [including Bill Moyes] in March of 09 to discuss the immediate action required as a result of the ... report."
He said:
"It was Monitor's view that the PCT didn't have a role in monitoring the governance processes in the trust. They were insistent that the responsibility belonged to the trust board and that the PCT should take its assurance from the governance processes in place and trust board papers."
Mr Poynor asked for details of the nursing recruitment plan and raised concerns about management capacity at the trust, particularly the sufficiency of a part-time chief executive.
He said:

1 "Bill Moyes from Monitor was very challenging back
2 to me about my views and said he thought it was
3 inappropriate that I pass comment on it."
4 And Alex Fox told us:
5 "Dr Moyes then put Stuart Poynor and I firmly in our
6 place by making it clear that the PCT had no role in
7 monitoring the trust's quality assurance and it was for
8 the trust to provide the PCT with that assurance.
9 I refused to accept this and I told Dr Moyes so. I said
10 that the trust still had issues with patients that
11 Monitor was simply not addressing."
12 What appears to have been missing from Monitor was
13 the sense of urgency which having a relative in the
14 hospital receiving poor care clearly provided to members
15 of Cure and others.
16 There was, it might be thought, throughout the
17 evidence from the major organisations seemingly a lack
18 of appreciation that their actions and delays had a real
19 effect upon patients lying in beds in the hospital or
20 receiving treatment in A&E.
21 In any event, on 13 July, after five months of
22 interim leadership, the trust announced the appointment
23 of Sir Stephen Moss as its new chair from 1 August, and
24 Mr Antony Sumara was also appointed from that date.
25 Well, the reaction to the report in March of 2009 at



1 the higher levels of the CQC was poor, according to
2 Heather Wood.
3 She told us:
4 "... I would say that the reaction of the CQC to
5 this particular investigation, setting aside the matter
6 of the type, was that it was an embarrassment. I didn't
7 hear it myself but it was reported to me that
8 Baroness Young had said that she would never forgive the
9 Healthcare Commission for producing the report. So to
10 me it seemed very clear that certainly this specific
11 report was viewed with great disfavour by the leadership
12 of the CQC."
13 Baroness Young told us:
14 "... because of the length of these reports and the
15 fact that by the time they appeared and operated on
16 a very shocking level, one would have liked to have
17 hoped that in many cases that by then the hospital would
18 have been well on the way to delivering much better
19 care. Because one would have liked to have hoped that
20 as soon as problems were identified, there would have
21 been a robust discussion with the hospital about
22 remedying those as the investigation went forward. And
23 so to produce a report, 18 months later, that kneecapped
24 the place by exposing it and one might say quite
25 rightly, to huge press attention, to huge public concern



1 and to really make it a thoroughly challenging picture,
2 probably means that people don't want to go and work
3 there. That's the credibility of the people who by then
4 were trying to take it forward and would again be
5 undermined, and that the relationship with the public
6 that they may or may not have been trying to deliver
7 would be set back again. So it does seem to me that the
8 important thing for the public and for patients is that
9 whatever happens when there is poor quality, that it is
10 a very, very rapid process that produced well
11 evidence-based results rapidly, that the focus is on,
12 'How do we get this better for the future quickly?' And
13 not an extensive process that then makes it more
14 difficult to manage that process of improvement for the
15 future."
16 Well, sir, those comments take us neatly enough to
17 an examination of the Care Quality Commission, which
18 I can certainly start and then I'll choose a convenient
19 break, if I may.
20 Sir Liam Donaldson maintained that routine
21 inspection of healthcare providers was necessary.
22 He said:
23 "I think it's essential that planned reviews are
24 still carried out. It is a matter for the CQC as to
25 whether they have sufficient resources to undertake them



1 and if they do not, they should make their position
2 clear to government."
3 Whatever system there is for identifying danger
4 signals via the receipt of data its our submission, on
5 the basis of the evidence that we've heard, that
6 physical inspection is crucial. However, the inspection
7 in order to have value has to be conducted by people who
8 are properly trained and knowledgeable, people who know
9 either from clinical experience or from training who to
10 ask, what to ask, what to look for. There must always
11 be the assumption that something is wrong, and it just
12 needs to be found.
13 Sir David Nicholson told the inquiry:
14 "In relation to large-scale investigations into
15 trusts, both Mid Staffordshire and the investigation
16 into Maidstone and Tunbridge Wells were very important
17 to the NHS and they both had a massive impact in the way
18 that the NHS operates. However [he said], I was struck
19 by the length of time that the investigations took and
20 I query whether that was necessary. In my view, I think
21 a smaller investigation could have collated the same
22 information, produced the same outcomes in a shorter
23 period of time, resulting in the necessary interventions
24 and actions happening sooner, to be filtered around the
25 rest of the system. I do not underestimate the benefits

1 of these investigations, but I think they can be
2 achieved in a shorter timescale."
3 The inquiry heard a good deal of evidence about the
4 CQC. We heard from its current and its past chair, and
5 we heard from its chief executive twice in different
6 guises.
7 Given her previous role as the chief executive of
8 the West Midlands SHA between July 2006 and July 2008,
9 Cynthia Bower's continuing role as chief executive of
10 the CQC after the HCC report had been published was
11 regarded by some as controversial. Miss Bower had been
12 appointed in June 2008, following a competition, and
13 Baroness Young told the inquiry that she had reviewed
14 what had taken place and did not think it impacted upon
15 Cynthia Bower's ability to be chief executive of the
16 CQC.
17 Miss Bower described the HCC's main approach to
18 encouraging change as being to use high profile
19 investigations supported by high profile publicity.
20 This was not a categorisation which the witnesses from
21 the HCC accepted or recognised. Miss Bower went on to
22 say that the CQC's powers allowed it to adopt a more
23 low-key approach to the media, working at a local level
24 and delivering substantial local media coverage.
25 Sir, I am not going now to try to talk about the



1 systems employed by the CQC to try to identify danger
2 signals within the system. The validity of the QRPs has
3 been questioned, of course, by Cure, who describe the
4 result as a food mixer of different colours.
5 We submit that when evaluating the risks in such
6 a complex system, the method used to do so is probably
7 going to have to be quite complex itself. We do not
8 criticise the concept of the QRP system, but there are
9 serious concerns, which I shall come to, as to its
10 ability to identify the danger signals effectively.
11 No matter how much tinkering there is in relation to
12 the relative value and weight to be placed on pieces of
13 information, the system can only be as good as the
14 information fed into the system, and it seems to us that
15 there are at least two significant issues in relation to
16 the way in which the QRPs work and the basis upon which
17 action is taken by the CQC. One is the quality of the
18 regional information being fed into the system. The
19 second is the quality of the training of inspectors,
20 upon whom the system seems heavily reliant.
21 The focus of judgment, the inquiry was told by
22 Richard Hamblin, lies much more with local inspectors.
23 Decisions about individual providers and what regulatory
24 intervention and judgment is required is taken by the
25 compliance inspectors in conjunction with their managers



1 and other colleagues.
2 Amanda Sherlock was asked about this level of
3 autonomy by you.
4 You put to her:
5 "So does this mean for these purposes the inspector
6 is almost an independent entity whose decision is
7 invariably respected, except, I suppose, if there was
8 some manifest impropriety, which is, I am sure, rare."
9 She said:
10 "One of our principles, when we were doing our
11 workforce design and coming up with the roles and how we
12 would discharge our response builds, is that we wished
13 the front-line inspector to have as much professional
14 autonomy in the way they regulate the services on their
15 portfolio as possible, with professional checks and
16 balances to ensure that you didn't have regulatory
17 capture or you didn't have overzealous regulation of
18 individual providers."
19 Again, there may be concerns that this leaves
20 a great deal in the hands of local inspectors and,
21 therefore, subject to his or her individual judgment.
22 Ms Sherlock made this admission in her evidence:
23 "Firstly, I would say that, given the scope of
24 organisations that the CQC regulates, it's simply not
25 possible with the resources available to have sufficient



1 inspectors who are experts in each type of organisation.
2 However, the inspectors are professional regulators."
3 If there is no sensible audit made of inspectors'
4 decisions, then there's plainly considerable room for
5 differences of approach as between individual inspectors
6 and separate regions.
7 The central system through which CQC staff access
8 the range of data it holds is via the customer
9 relationship management system, the CRM. This is
10 organised around the registered providers allowing
11 inspectors to add information and access it in relation
12 to each location. The QRP system is also accessed
13 through the CRM. New information received on the system
14 should be passed to a local inspector via an alert, but
15 there's evidence, however, that this has not to date
16 been working satisfactorily.
17 It's critical that inspectors record information
18 which they receive upon an engagement form. Now I think
19 it's called a Share Your Knowledge form, which is
20 supposedly better. That's then saved within the CRM
21 against the relevant organisation and will be accessible
22 to other staff.
23 It follows that a failure to record relevant
24 information via engagement forms could have
25 a significant effect upon the efficiency and indeed the

1 viability of the system. In the provisional statement,
2 the CQC claimed to have undertaken over 13,000
3 inspections in 2009/2010. The vast majority were said
4 to be unannounced. Inspection, the inquiry was told,
5 involves talking to patients and people using services
6 as well as staff. This is not merely an interaction at
7 corporate level.
8 The number claimed were, however, undermined by
9 further evidence from Amanda Sherlock that the CQC
10 annual report for 2010/2011 was incorrect by about
11 50 per cent. The report stated that were 15,220
12 inspections and reviews, but the correct figure was in
13 fact 7,368.
14 This was described as an error as a result of
15 a mistranscription of some data, and the CQC will have
16 to notify Parliament of the correction. This is
17 a surprising and significant mistake to have made and
18 one which it is difficult to fathom were there proper
19 governance systems in place.
20 Amanda Sherlock also qualified in evidence what the
21 term "inspection" means when she was pressed upon this.
22 She was asked:
23 "You say:
24 "'Under the current scheme of full registration
25 under the 2008 Act, ongoing compliance with



1 regulation 12 of the Health and Social Care Act ...
2 [which relates to cleanliness and infection control] is
3 now inspected under outcome 8 of the Essential Standards
4 as part of the CQC's planned programme of planned and
5 responsive reviews.'.
6 "What does the word 'inspected' means in that
7 sentence?
8 "Answer: In this sentence it means looked at,
9 reviewed.
10 "Question: 'Looked at' does not, therefore, mean an
11 on site visit?
12 She was asked:
13 "Answer: Not in the context of this sentence.
14 "Question: Right. Elsewhere where you've used the
15 term 'inspection', is it used in the same way or in an
16 different way?
17 "Answer: We would need to look at the specific
18 context around the paragraphs.
19 "Question: Right, so an inspection doesn't mean
20 what members of the public might think of as an
21 inspection. It may simply mean locking at the systems
22 and the paperwork; is that right?
23 "Answer: It may."
24 Amanda Sherlock has provided further evidence as
25 recently as Tuesday of this week, for which the inquiry



1 is grateful, and in it she points out that the CQC
2 itself has moved forward in respect of external
3 whistle-blowers, particularly since the
4 Winterbourne View scandal and has set up a devoted
5 whistle-blowing team based in Newcastle upon Tyne.
6 She has also given up-to-date figures for the
7 recruitment of compliance inspectors, which reveals that
8 all of the previously vacant posts have been filled
9 except for 25, and there is a commitment to filling
10 those.
11 The CQC has also received further funding from the
12 Department of Health, which together with efficiency
13 savings apparently should allow it to meet a requirement
14 for 955 compliance inspectors which will have
15 a concomitant effect on reducing the current inspectors'
16 portfolios, all of which will no doubt be good news to
17 the likes of Amanda Pollard, to whose evidence I will
18 shortly turn.
19 A separate issue which the inquiry has had to
20 consider is the transparency and openness of the CQC
21 itself and its cultures within the working place.
22 Early staff surveys within the CQC were disparaging
23 of the organisation. Miss Bower was asked about this:
24 "In the staff survey it was revealed that only 18
25 per cent of employees within the CQC felt it was safe to



1 challenge the way that things are done. Isn't that
2 something of an indictment of the culture within the
3 body of which you have been the chief executive since
4 its inception?"
5 She answered:
6 "Yes, of course, the staff survey wasn't a good
7 survey. I am not pretending that it was. But, again,
8 in my experience it's not out of the ordinary for
9 organisations that have gone through the sort of turmoil
10 the CQC did, in order to bring it into existence, to
11 have quite negative staff surveys so early in their
12 life."
13 It was brought to the inquiry's attention that
14 employees who had left the CQC did so under compromise
15 agreements, which included clauses preventing the
16 disparagement of the CQC itself or so-called gagging
17 clauses. As a result, a number of witnesses were
18 required to give evidence by way of a direction order
19 issued by you.
20 Cynthia Bower told the inquiry that she had been
21 advised that such clauses were entirely standard in both
22 public and private sector. It was also made clear that
23 a specific clause in the compromise agreement did not
24 prevent witnesses speaking freely to the inquiry,
25 although the wording of those clauses could have been

slightly less ambiguous than they were.
Both Dr Heather Wood and Roger Davidson were subject to confidentiality clauses in their compromise agreements when they left the CQC.
It was of some concerns to the inquiry that these clauses were felt necessary, given the particular role of the CQC. Those concerns were heightened when between July and August of this year, while the inquiry was in recess, the existence of an internal document was made known to the inquiry by an anonymous source. This led to further investigation and the taking of a number of further witness statements.
It was unfortunate, and perhaps indicative of a culture within the CQC, that an individual had felt that the only way of revealing the existence of the document was by doing so anonymously. It was very unclear from the evidence which then followed that it had ever been the intention of the CQC to share with the inquiry what was in fact an important internal review, which compared the evidence given by CQC witnesses in May to the inquiry with the reality of how the process worked on the ground.
It would, in our submission, have been unfortunate if the document had not been revealed to the inquiry, and potentially the inquiry would have been denied an



important insight. Of perhaps most significance was the fact that the evidence which arose from the revelation revealed a significant lack of governance within the CQC into the effectiveness of its own processes.
The significant concerns which were raised through Mrs Bryce and Ms Goodman's response in the document were as follows:
There was evidence that local intelligence was not being routinely recorded on engagement forms by local inspectors.
RIEOs, if you'll forgive the term, do not complete engagement forms. This would mean that local intelligence was not finding its way into the QRPs and, therefore, would not be affecting the risk ratings.
Information from LINks was not being routinely recorded on engagement forms and so local information was being missed.
RIEOs did not routinely or regularly review the contents of the CRM database, so would not be aware of information recorded outside the QRPs.
RIEOs only became aware of complaints made to the CQC if they're recorded on an engagement form, otherwise they will be unrecorded and so will not fall into the QRP database, although we understand they would be on the CRM.



Regional risk logs, which may contain local information derived from local intelligence, is not submitted for inclusion in the QRPs.
Notifications from the NPSA are not routinely reviewed by RIEOs, and they do not have capacity to do so.
Ms Goodman said specifically about this:
"It is not part of a RIEO's role to look at each individual notification in detail. Given the number of trusts and care homes that I have in my portfolio, this would not be possible ... [that's] a role which should be undertaken by inspectors however."
We were told that RIEOs do not have the capacity to update information in the QRP through filling in engagement forms, and RIEOs would be surprised by the suggestion that they did so.
Decisions made by inspectors in relation to safeguarding alerts are not reviewed by RIEOs or their managers. There is, therefore, no audit of inspectors' decisions to ensure consistency of approach.
Ms Goodman made it very clear that RIEMs do not have a role of performance managing inspections. It had been suggested that inspectors feed back if they have acted on the alert and the judgment behind that, which is then reviewed by RIEOs and my favourite phrase of the



inquiry, the double-loop feedback.
According to Ms Bryce and Goodman no such feedback occurred in reality. Ms Goodman's document reveals:
"We do not write reports about what inspectors have done -- I think I can safely say my region would be shocked if we found out we were supposed to be."
Where there's a change in the risk estimates or when there is significant information an alert would be sent to an inspector. Although inspectors are alerted RIEOs are not.
Lauren Goodman revealed in her response to Ms Bryce that when RIEOs are less busy they will look at this proactively, otherwise it would have to wait for there to be a request.
Well, of course there was concern within the CQC about the leaking of that document and we know that Rona Bryce was called into a meeting on 8 August with Richard Hamblin and was informed that an investigation was taking place.
Of course, any organisation is entitled to expect a degree of confidentiality from its employees, but this episode demonstrated that it may never have been the intention of the CQC to share this internal audit. This is reflective, we respectfully submit, of an unhealthy organisational culture, and that impression was given

1 greater weight by the recent evidence of Kay Sheldon,
2 which demonstrates, if that evidence is accepted, that
3 the culture goes to the top of the CQC.
4 There is a third significant issue in relation to
5 the CQC and that is while it purports to measure the
6 quality of governance in providers within the health
7 service, there is an apparent inability to apply proper
8 governance to itself. We heard that there's a lack of
9 strategic planning, and that the organisation works in
10 a reactive way to events. If that's right, then it's
11 plainly unacceptable, in our submission, that the single
12 quality regulator of the National Health system lacks
13 a strategic plan and a clear vision of how it intends to
14 regulate the system, not just in the weeks to come, but
15 planning year on year.
16 The suggestion that the organisation is merely
17 reactive to those events which hits the headlines is,
18 frankly, worrying. What is more, it appears that at
19 least some of what we heard in May of this year about
20 how the CQC regulates was in reality an aspiration as to
21 how it would like to regulate, and those aspirations are
22 not necessarily turned into reality on the ground by
23 those responsible for the system at regional level.
24 It was a truly surprising feature of the evidence of
25 the CQC that we heard from not one, but three witnesses



1 who might properly be described as whistle-blowers from
2 within the organisation, witnesses who came forward
3 because they were unhappy about the evidence given to
4 the inquiry by the senior management team. All of those
5 witnesses appeared to be frightened of the consequences
6 of giving oral evidence, and that fear was on each
7 occasion palpable in this room.
8 Sir, I can finish what I have to say about the CQC
9 in the next couple of minutes if that's acceptable.
10 I am going to turn briefly to the evidence which we
11 heard on Monday of this week. Although it was
12 undoubtedly important evidence from both witnesses, it's
13 also plainly important not to give it undue weight
14 merely because of the circumstances in which we found
15 ourselves in possession of it. Also, and particularly
16 in the case of Amanda Pollard, we must bear in mind that
17 it is just one view from one compliance inspector,
18 although you may think that it is very unlikely indeed
19 that her experiences are particular and unique to
20 herself. Not only must it have taken some considerable
21 courage for her to contact the inquiry as she did and
22 then to give evidence, it is inconceivable, in our
23 submission, that she would have done so unless she had
24 good grounds to believe herself to be representative of
25 a body of opinion at her level of the CQC.



1 And, if I may, I am simply going to summarise the
2 concerns which she expressed:
3 The registration process did not test the
4 registrants in any real way.
5 It was a tick-box exercise or rubber-stamping
6 exercise, which simply diverted resources away from what
7 may have been more viable inspections.
8 It was not a robust assessment, as Cynthia Bower
9 claimed in evidence.
10 The role of the HCAI teams was a significant loss to
11 the safety of patients in the NHS.
12 In relation to a new role, which she began in
13 October of 2010 as an inspector mainly of care homes,
14 nursing homes and ancillary services, she described the
15 training as appalling and the training, as described by
16 Dame Jo Williams, to the inquiry simply didn't happen.
17 The training she did receive was arranged by herself
18 and took the form of shadowing another more experience
19 inspector.
20 The management of the CQC have ignored her pleas and
21 those of others for training in their field of
22 inspection.
23 That inspections themselves had, therefore, become
24 relatively valueless -- those are my words -- and she is
25 concerned that there's every possibility that she and



1 other inspectors will miss significant issues in
2 providers which they are inspecting.
3 That there's no proper oversight of her decisions or
4 those of other inspectors, and there is no significant
5 attempt by management to ensure uniformity of approach
6 to decisions or judgments.
7 Team meetings which might assist this process have,
8 at least in Miss Pollard's area, apparently been
9 abandoned.
10 There is constant management pressure to meet
11 numeric targets at the expense of quality assessment.
12 The latest direction being to inspect 75 per cent of all
13 providers by March of 2012. And in order to do so,
14 inspectors have been told to inspect for as many or as
15 few outcomes as they choose.
16 Follow-up visits where an inspector has concerns are
17 subtly discouraged because of the pressure on meeting
18 inspection targets.
19 Because of the pressure of the targets being set,
20 there's strong disincentive to issue a warning notice.
21 The organisation appears to be driven by
22 reputational management rather than long-term strategy.
23 Mrs Sheldon came to the CQC with impressive
24 credentials, having been a Mental Health Act
25 commissioner and a board member of the Mental Health Act

1 Commission. She is a commissioner and board member of
2 the CQC.
3 She had come forward out of concern in relation to
4 the direction of the CQC and the culture of its
5 management. You're entitled to take her evidence into
6 account, insofar as it falls within your terms of
7 reference, among which is the identification of lessons
8 to be learnt in respect of how in the future the bodies
9 which regulate the NHS can ensure that failing hospitals
10 are identified and have regard to how the regulatory
11 system is now.
12 Rather than simply repeating the evidence which you
13 heard only a few days ago, it may be more helpful if
14 I try to identify the themes of her concerns.
15 It's fair to say that the CQC in the little time
16 they've had to respond have identified documentation
17 which seems to point to a degree of consultation over
18 the changes which were made at the CQC and a discussion
19 at board level of strategy. You will no doubt take that
20 documentation into account, as you will any board
21 minutes which the CQC send the inquiry which you've
22 asked for. But Mrs Sheldon's concerns were
23 fundamentally these, with apologies to her for
24 shortening what she said more eloquently.
25 There is no proper strategic approach by the CQC as

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1 to how it intends to regulate.
2 There's no understanding at senior levels of the CQC
3 as to what that regulatory model should look like on the
4 ground.
5 There's a lack of leadership on strategic issues.
6 The organisation's approach is relative, led by
7 reputational management.
8 The board doesn't govern or lead the organisation in
9 any real sense.
10 Little consideration is given as to the capacity of
11 the organisation to deliver what does purport to be its
12 strategy.
13 Strategic decisions appropriate to be made at board
14 level are not made by the board but by the executive
15 with an expectation that those decisions will be
16 approved.
17 Challenges at board level are sidestepped and not
18 dealt with appropriately.
19 There is no proper debate about issues and board
20 decisions are neither made nor minuted.
21 Personal experience of inspection reveals that
22 inspectors are inadequately trained for the roles they
23 are given, and inspections are consequently inadequate.
24 There is a culture of bullying in the organisation,
25 even at a high level.

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1 There is a lack of internal governance, and the
2 treatment of external stakeholders whose input is
3 important has been poor and a number of stakeholders
4 have been excluded without proper consultation or board
5 involvement.
6 Whatever view you take of the evidence you heard
7 from those two women, it undoubtedly took considerable
8 courage for them to come forward and express their views
9 and, in my submission, the inquiry would have been
10 poorer without their insight.
11 Based upon the evidence the inquiry has heard, you
12 may wish to consider the following issues among others
13 in relation to the CQC.
14 Should the CQC take urgent action to ensure that the
15 quality of data collection throughout the organisation
16 is improved and homogenised?
17 Should there be a system of independent audit of the
18 effectiveness of the CQC systems for spotting and
19 reacting to failures of service provision?
20 Is the leadership of the CQC sufficiently open to
21 internal criticism from which the organisation might
22 learn to improve its systems and behaviour.
23 Are the working systems of the CQC sufficiently
24 transparent, both to the organisations which it
25 regulates and to the public in relation to how it does

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1 so?
2 Should specific action be taken to ensure that
3 inspectors across the system are acting in a consistent
4 and homogeneous way, both in the recording of data and
5 in relation to trigger levels for compliance visits?
6 Peer review by inspectors from different regions and
7 a consistent training programme might mitigate the
8 risks.
9 The training system for compliance inspectors may
10 need urgent review and potentially validation by
11 a source external to the CQC.
12 Should consideration be given by the CQC to identify
13 inspectors with suitable backgrounds or training which
14 would equip them for the role of inspecting the
15 providers they are asked to inspect, rather than generic
16 model of so-called expert regulators?
17 Sir, the focus of the CQC must not merely be on the
18 number of inspections that it can perform in a given
19 period but rather upon the quality of the inspections
20 and the likelihood that each inspection has the capacity
21 to discover faults in the provider.
22 Sir, I am going to move on to other issues.
23 I wonder, since I am probably the one most affected,
24 whether I could suggest a slightly shorter lunch break.
25 I am slightly beyond halfway through.

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1 THE CHAIRMAN: What's your estimate for the time of arrival
2 at the point marked "the end"?
3 MR KARK: Well, can I put it this way, if we were to start
4 at ten to 2, there's a better chance that I'll finish by
5 around 4.30.
6 THE CHAIRMAN: Right. Very well. We'll start again at ten
7 to.
8 (1.05 pm)
9 (The short adjournment)
10 (1.50 pm)
11 MR KARK: If it's of any comfort to anybody, I am slightly
12 more than halfway through.
13 THE CHAIRMAN: We want you to go on and on and on.
14 MR KARK: Sir, I am going to turn as a discrete issue to the
15 role of the National Institute of Clinical Excellence.
16 Before I turn to the commissioners, it might be
17 appropriate to do so, having just looked at the role of
18 the HCC and the CQC and, of course, the core standards
19 or outcomes which they tried to apply.
20 Una O'Brien stated that she had read
21 Sir Liam Donaldson's evidence and agreed with him on the
22 importance of individual clinical teams using a range of
23 measures to assess their performance and seek to
24 improve. Nonetheless, some national standardised
25 outcome measures were required to ensure consistency



1 across the NHS.
2 She said:
3 "What we're always trying to seek here is we want
4 standardisation of the right things, but not
5 over-standardisation, such that it undermines the right
6 level of engagement and the participation of clinicians.
7 And I think this is always a hard place to sort of work
8 out where to draw the line.
9 "On the broader point, if you were to say to me, do
10 I think it's right for there to be more clearly
11 articulated outcomes for patients, for example, with
12 cancer or stroke? Yes, I do. I don't think that there
13 can be something that can be worked out separately in
14 every separate part of the NHS, because that leads over
15 time to too much variation and that's unacceptable.
16 "So I think we need to have national standards and
17 national goals for outcomes."
18 Well, the careful process by which clinical
19 guidelines are produced must be crucial to their
20 credibility, and the prospects that they will be taken
21 up within the NHS, and that, I suppose, comes back to
22 the theme of clinical engagement.
23 Sir Andrew Dillon explained the process. The
24 guidelines, he said, are produced by independent
25 advisory bodies comprised of people who do not work for



1 NICE but are in clinical practice, have some other role
2 in the NHS, have evaluative skills or represent
3 a particular interested constituency. The guidelines
4 are based on a comprehensive review of evidence from
5 published studies as well as evidence from practitioners
6 and the experiences of patients. Once draft guidance is
7 agreed, it's published on the NICE website and it
8 becomes part of public consultation. We were told that
9 it takes approximately two years to produce a new
10 clinical guideline.
11 Aside from technology appraisals, NICE guidance is
12 advisory and not mandatory. That, we were told, is for
13 good reason.
14 Sir Andrew told us:
15 "Once NICE guidance is published, health
16 professionals [and organisations who employ] them are
17 expected to take it fully into account when deciding
18 what treatment to give people. However, NICE guidance
19 does not replace the knowledge and skills of individual
20 health professionals who treat patients; it's still up
21 to them to make decisions about a particular patient in
22 consultation with the patient and/or their guardian."
23 In other words, there may be circumstances where
24 it's appropriate to consider but not to follow the
25 guidance. Hence the general expectation that clinicians



1 should have regard to it, rather than a mandatory
2 requirement tight must be followed.
3 Sir Andrew said that the only way to assess
4 independently whether NICE guidance was being
5 implemented in a healthcare provider would be through an
6 audit, and he also said if it were deemed appropriate
7 for any organisation to review systematically the
8 implementation of NICE guidance, it would be logical for
9 this to be done by the CQC, given its powers to
10 encourage or enforce compliance.
11 Professor Sir Bruce Keogh offered an insight into
12 the Department of Health's view of the value of the
13 quality standards. Sir Bruce clearly saw great value in
14 NICE, an organisation with an international reputation,
15 and good experience of developing evidence-based
16 guidelines and producing statements of what good looks
17 like for the treatment of a range of conditions.
18 He explained in relation to the way in which the
19 Department of Health took forward Lord Darzi's
20 recommendations on quality standards, he said:
21 "It was quite clear that there were numerous players
22 on the healthcare scene who claimed to be writing
23 standards. There were Royal colleges, there were
24 specialist association, there were patient groups, there
25 were other organisations, there was the Department of

1 Health, there was NICE ... all we had, frankly, was an
2 alphabet soup of standards that was creating confusion
3 in the system. So the problem that we're trying to
4 solve here was, how do we let people know what the real
5 standards for the NHS are?"
6 But they are not, as Sir Bruce explained, a form of
7 standard operating procedure. They're a means of
8 setting out on the basis of the best evidence a document
9 that said:
10 "If you do these eight or nine, ten things, you're
11 likely to get the best outcome for your patients."
12 Sir Bruce was asked how it was proposed that
13 clinicians would be persuaded to use the standards, and
14 he said that the key factor was that the way in which
15 the standards are created means that clinicians are
16 intimately involved in drawing them up and have a sense
17 of ownership, which means that they will be used. There
18 is no other incentive currently, although the Department
19 of Health is looking at ways of putting incentives in
20 place to encourage their implementation. He anticipated
21 that commissioners would use the standards, and would be
22 engaged in auditing implementation. He also envisaged
23 that the NHSLA would monitor compliance with the
24 standards insofar as they related to risk.
25 The inquiry may well conclude on the basis of the

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1 evidence set out that NICE guidance and its quality
2 standards provides an extremely valuable way of
3 promoting safe and good quality care across the board
4 within the NHS. Its implementation tools also provide
5 helpful means of monitoring of take-up at local level.
6 You may think that it's essential to ensure that
7 commissioners and regulators are able to evaluate the
8 implementation of the guidance and/or compliance with
9 the quality standards, and in that regard liaison
10 between those setting the standards, those collecting
11 data by which standards may be measured, and those
12 charged with evaluating data and regulating healthcare
13 providers is, in our submission, crucial.
14 Not only will it assist the CQC in measuring good
15 outcomes, but the standards should help the CQC to
16 identify potential risk if the guidelines are routinely
17 being ignored, as we heard on occasion at this trust
18 they were.
19 NICE guidelines should also be a significant factor
20 in effective commissioning, and it is to the role of the
21 commissioners that I now turn.
22 Una O'Brien identified putting clinicians at the
23 heart of local commissioning process and thus in
24 a commanding role in holding providers to account as one
25 factor in the government's White Paper that was designed

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1 to avoid repetition of Mid Staffordshire.
2 In oral evidence she explained that commissioners
3 should use information available to the quality
4 regulator and be hands-on in gaining an understanding of
5 the care they commissioned.
6 She said this:
7 "I think that any good group of commissioners would
8 want to be hearing from the regulator to be satisfied
9 that the regulator has got no concerns or that the
10 concerns that are known about are being understood and
11 highlighted back to the trust. So far as the quality
12 and risk profile develops -- and there's more work to do
13 on it to refine it -- my clear expectation is that those
14 will be available to commissioners. And ... the other
15 thing that I would say is they need to -- commissioners
16 need to get out there ... they need to see, feel and
17 hear what services are like."
18 Well, how did those sentiments which were, of
19 course, expressed long after these events, translate
20 into reality in commissioning at this trust?
21 I cannot here embark upon a close analysis of the
22 work of the PCT, nor the changes in commissioning which
23 took place after World Class Commissioning was
24 published. But it is worth making some short bullet
25 points.

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1 Commissioning, obviously, should be a tool to ensure
2 cost-effective high quality care. It plainly failed in
3 this case, and there is an acceptance by the PCT that
4 during the relevant period it was neither capable nor
5 configured to use the tool appropriately.
6 SSPCT simply didn't have the mechanisms for
7 obtaining and analysing information in place prior to
8 the HCC investigation that would have been necessary to
9 identify the type of problems that were in fact
10 occurring. However, the witnesses were unanimous in
11 emphasising that the SSPCT was no different from other
12 PCTs across the country in that regard.
13 There appears also to have been recognition by the
14 Minister for Health, Ben Bradshaw, in 2007, that the
15 quality of commission as a quality driver was not as
16 effective a tool as it should have been across the NHS,
17 although he did point to examples within his own
18 knowledge of successful commissioning practices.
19 He was asked:
20 "Did you recognise when you came into your role the
21 PCTs in fact had very limited scope for ascertaining the
22 quality of the services that they were commissioning?
23 "Answer: Oh yes. I think that's why we introduced
24 World Class Commissioning because ... I was conscious,
25 not just from my own experience as a Member of

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1 Parliament, but also anybody looking at the HCC's annual
2 health check and the relative performance of PCTs
3 vis-a-vis hospitals could see that while, in general,
4 hospitals were improving, in most cases significantly,
5 PCTs were not performing or improving as well, and that
6 was an issue of concern ..."
7 Mr Griffiths of the PCT stated:
8 "In 2006-08 we were doing the same as all other
9 PCTs, but what became apparent in 2008 was that what we
10 were doing was not getting us the right answers in
11 relation to identifying the care issues at the trust."
12 He also said this:
13 "I don't think our approach to commissioning was any
14 different to other PCTs in the country. It is not the
15 case that everyone else was way ahead of us. However,
16 it is undoubtedly true that what we were doing in 2008
17 was insufficient."
18 Well, that evidence was mirrored by Stuart Poynor:
19 "The PCT recognises [he said] that there are areas
20 where it could have been more proactive in 2000 and
21 early 2008 in assessing the quality of services
22 delivered at the trust. If the PCT had been more
23 proactive and gone beyond the expected levels of
24 commissioner assurance at the time, the poor quality
25 care delivered at the trust might have been uncovered



1 earlier."
2 The evidence as a whole demonstrates that the job of
3 monitoring the safety and quality of services purchased
4 by the predecessor PCTs and SSPCT was very much a work
5 in progress throughout the period under scrutiny and
6 remains so. Of course, PCTs had only existed from
7 around 2002 and their role evolved over time. From 2005
8 to 2007 there was still very few if any means beyond
9 national performance measures and the HCC's annual
10 assessments used by the predecessor PCTs to obtain
11 information in this regard.
12 What information was available at a local level that
13 might have revealed problems earlier, such as the
14 details of complaints, adverse incident reports, staff
15 and patient surveys and peer reviews were not harnessed
16 by the PCTs in any meaningful way prior to the HCC
17 investigation. This led Dr David Colin-Thome, in his
18 April 2009 report, "A review of lessons learnt for
19 commissioners and performance managers following the
20 HCC's investigation", to comment that PCTs and SHAs past
21 and present:
22 "... do not appear to have taken notice of signs
23 that were present in the survey data and in complaints
24 that indicated poor quality care. They also fail to
25 take a proactive approach to gathering soft data, which



1 could have helped them to hear the concerns of patients
2 far earlier and louder."
3 Again, while the PCT accepted this analysis,
4 Stuart Poynor emphasised again that the SSPCT's conduct
5 must be seen within its national context and the context
6 of change over time.
7 Mr Price was highly critical of Shropshire and
8 Staffordshire SHA in terms of the pressure it exerted to
9 emphasise the need for financial balance. He refers to
10 the financial position of the PCT in September 05, when
11 an end of year deficit of around GBP 2 million was
12 forecast by that organisation.
13 He said:
14 "I recall the SHA was made aware of the financial
15 position and the minutes [of the PCT board in September
16 05] record that it had been emphasised by the SHA at
17 a meeting to discuss the position that we needed to
18 break-even financially and continue to focus on both
19 finance and targets. This was a typical SHA response.
20 I don't recall we received any guidance on how this
21 would be achieved."
22 And Susan Fisher stated:
23 "The SHA's performance management of the PCT was
24 very financially driven."
25 The PCT has been upfront about its failures. The



1 fact that they were unable to perform as they should
2 have done is, of course, no comfort to the patients and
3 their relatives who were let down by the hospital from
4 which they commissioned services. It also reveals
5 a deeper issue, and that is the willingness or
6 unwillingness to ask for help when help is needed from
7 the Department of Health.
8 Both the SHA and the PCT have now relied upon, among
9 other issues, lack of staff and resources to do their
10 statutory jobs properly. But at no stage have we heard
11 any evidence that either organisation sought help from
12 the Department of Health. That may, of course, be a
13 reflection of a wider culture in the health service that
14 a plea for help is an admission of failure or weakness.
15 It's also a reflection that at the time they thought
16 that they were doing what everyone else was doing.
17 Both organisations gave insufficient thought, we
18 submit, to protecting the patients under their care.
19 It may be no comfort for those receiving care when
20 the NHS is about to face another upheaval to know that
21 the regulatory and commissioning organisations may claim
22 in the future, should another Mid Staffs occur, "our
23 focus was upon reorganisation and we lost focus upon
24 patient care and safety. The number 1 priority, we
25 submit, is 'how will my actions today affect the

1 patients for whom I have responsibility?'."
2 While appreciating the frankness of the PCT, and the
3 sensible way in which they have conducted themselves
4 here, they know, as we know, that the loss of focus on
5 patient care is not excusable.
6 The HCC investigation, its report and the
7 realisation within SSPCT that there were serious
8 problems with the quality of care provided by the trust,
9 led to a level of intervention and scrutiny by the PCT
10 over its provider which was both (a) helpful in
11 demonstrating some of the ways in which commissioners
12 may effectively monitor quality, but also (b) atypical
13 and most likely unsustainable in the long-term across
14 the country.
15 This evidence highlights, in our submission, the
16 continuing need for commissioners to develop or to be
17 provided with effective and workable measures of safety
18 and quality that can be used in a systematic way and
19 meaningfully enforced if commissioning is really to
20 provide a safeguard against the type of failings found
21 at the trust.
22 One issue which again reared its head in relation to
23 the PCT, as with other organisations, was the lack of
24 clinical knowledge at board level. Stuart Poynor
25 explained that the degree of clinician involvement on



1 the PCT board was comparable with other PCTs. There
2 were three clinicians on the board, Yvonne Sawbridge was
3 a registered nurse, a locality director was a
4 physiotherapist, and the PEC chair was a local GP.
5 However, the non-exec directors had no clinical
6 experience. This was the same story both at the SHA and
7 the DH.
8 At Monitor, they didn't have a single clinician on
9 the board. We submit that this lack of clinical
10 expertise has a number of disadvantages, the most
11 obvious of which is a lack of patient-doctor focus when
12 systems are designed and operated, and this is a theme
13 which arises frequently in our written submission.
14 It has been a constant surprise that organisations
15 tasked with supervising and regulating the health
16 services are very often made up of people with financial
17 or management backgrounds. In order to get clinical
18 focus into the decision-making, we submit that there
19 needs to be far greater use of clinicians and those with
20 patient experience.
21 Alex Fox stated that the PCT's non-exec directors
22 were intelligent and talented people, including three
23 ex-financial directors, a retired deputy chief constable
24 and the worldwide contract director of Rolls-Royce.
25 However, no candidates with clinical experience had come



1 forward.
2 Clinical advice was provided to the PCT board
3 between September 06 and April 07 by the interim PEC,
4 made up of the four predecessor PEC chairs but, we were
5 told, they did not appear to be very engaged.
6 It took until September 07 for the PCT to appoint
7 a medical director in the form of Dr Phil Ballard. When
8 it did, this was not a move that improved the assessment
9 of quality at the trust.
10 Dr Ballard told us:
11 "At the time, I didn't have any responsibility for
12 quality of care in acute trusts. This was not on the
13 horizon for medical directors at this point. The main
14 driver for commissioning at the time was financial."
15 Why, one asks again rhetorically, hadn't the PCT
16 picked up on these problems that there were at the trust
17 via its GPs?
18 The PCT witnesses to some degree blamed the local
19 GPs for failing to make use of the opportunities that
20 the PCT afforded them to raise their concerns.
21 Stuart Poynor said:
22 "I think it is a reasonable expectation that if
23 you're remunerating clinicians to be part of a system
24 where quality is being developed, you would expect them
25 to raise with us and their commissioning boards if they



1 had concerns."
2 One problem may have been that despite the PCT's
3 efforts there remain a low level of GP engagement in the
4 commissioning process.
5 Geraint Griffiths said:
6 "GP engagement within the south Staffordshire area
7 is reasonably low, and this is by no means unusual
8 compared with the rest of the country. I can name fewer
9 than ten GPs in the PCT area who are real leaders in
10 terms of taking commissioning forward, but that is not
11 unusual."
12 The local medical committee, in the PCT's view,
13 appears to have been concerned predominantly with
14 matters affecting conditions for GPs, rather than any
15 concerns they might have had about other providers of
16 healthcare.
17 Mr Griffiths told us:
18 "The LMC is effectively the trade union for GPs as
19 providers and the LMC has a statutory function in
20 relation to this. The LMC are made up of the more
21 traditional GPs."
22 He said:
23 "The GPs on the LMC are not necessarily at the
24 cutting edge of service redesign. They are more likely
25 to be the GPs who see their patients in practice and are

1 more focused on GPs providing services than being
2 commissioners."
3 Dr Phil Ballard said this of the LMC and the PCT's
4 attitude towards it:
5 "In effect it was a trade union. Its main role is
6 to look after GP members. The LMC is often not helpful
7 in the way that it interacts with the SSPCT. However,
8 I also feel that on occasion there is a degree of
9 reluctance amongst the PCT directors to take the LMC
10 seriously. As a result the PCT tends to just regard
11 practice-based commissioners and the PEC as its main
12 mechanism to engage with GPs."
13 A central point raised by the evidence of the PCT
14 witnesses is that during this period GPs simply did not
15 recognise that the PCT offered a route for the
16 resolution of their individual concerns. They would go
17 direct to consultants at the trust, without necessarily
18 realising that the experience of their patient was
19 a sign of greater malaise. That meant that no one
20 outside the trust had an overall view of the problems
21 which the GPs were coming across.
22 As to the trust's annual health check declaration,
23 Yvonne Sawbridge produced a letter from her to
24 Helen Moss following a meeting between them in April 08
25 in which they discussed the trust's intention to declare



1 compliance with the core standard 13A relating to
2 dignity and respect. By that stage the PCT itself was
3 aware of complaints raised by Cure the NHS and the HCC
4 investigation.
5 But Mrs Sawbridge told us:
6 "When I raised this with Helen Moss, she assured me
7 that she discussed this in detail at the trust's audit
8 committee, which felt there was sufficient evidence to
9 ensure that the trust complied with the standard.
10 I made the point that it was a judgment call for the
11 trust to decide whether they were compliant or not ...
12 It's not within our remit to check every response given
13 to the AHC, rather than to ensure that the organisations
14 we commissioned from had a system in place to ensure
15 compliance."
16 This raises the question of whether it was realistic
17 to expect the trust to be open and honest about its
18 problems with the PCT in view of the commercial
19 relationship between them. On one view that
20 relationship could make such honesty very difficult,
21 supporting the need for specific safety and quality
22 measures and information flows in order for
23 commissioners to be assured of receiving the information
24 that they need.
25 Give me a moment, sir. (Pause).



1 Mr Griffiths said:
2 "Whilst I would have been able to have more open
3 conversation with other trust I worked with, [this]
4 trust [he meant] was very different and as far as
5 Mike Gill at the trust was concerned, matters within the
6 trust were not for discussion with the PCT. The
7 contractual relationship stalled as the trust would only
8 respond to specific questions based on the wording of
9 the contract, but would never provide enough detail for
10 the commissioners to understand the issues well enough
11 to be able to specify the exact problem."
12 He said:
13 "Out of all the trusts I have worked with, I had the
14 least amount of information from the trust in the past
15 four years of dealing with them."
16 Well, sir, it's easy now to say this should have
17 alerted the PCT to problems, which they ought to have
18 been exploring. But to use that much maligned phrase in
19 this inquiry, I accept that that's a comment made with
20 the benefit of hindsight.
21 All of the PCT witnesses emphasised the importance
22 of ensuring that the valuable lessons learned by the PCT
23 through experience are not lost in future reforms.
24 Alex Fox said this:
25 "At present, not enough GPs are engaged in shaping



1 the new order and I doubt that they'll have the capacity
2 to embrace that the PCTs do now. This can only be
3 addressed if PCTs, whilst they have any influence, move
4 quickly to create the right sort of management capacity
5 for GP consortia to be successful. My view is that all
6 of the collective experience and knowledge that has been
7 built-up will be lost if we cannot relate the corporate
8 knowledge into the GP consortia."
9 I am going to turn to the SHA, but can I say, if
10 it's a relief to anybody sitting at the SHA table, that
11 I am going to do so very shortly.
12 The SHA has been the focus of considerable criticism
13 throughout this inquiry, not only, I hasten to add,
14 through the questioning of witnesses by counsel to the
15 inquiry, but by a series of witnesses. And, of course,
16 we accept Ms Smith's assurance that the SHA is not
17 staffed by uncaring people or people who do not want to
18 do good or people who are not hard working.
19 We accept also the difficulties that the SHA faced
20 following reconfiguration and the limitations imposed
21 upon it by its staff numbers. And, of course, we also
22 accept, so far as the SHA was concerned, this trust was
23 not the sole or central focus of its attention.
24 However, we do submit that there's substantial
25 evidence to support the suggestion that the SHA was very

much finance focused and that it did fall into error in supporting the trust in the face of mounting evidence that this was a trust which needed some careful and intensive management support and performance supervision, which it did not receive.

We've already discussed the SHA's actions through the period of application for the FT status, and also when discussing the relationship with the Department of Health, and it would be unfair to focus again on the SHA and indeed give their role undue attention. However, there are some issues not so far discussed which I should raise if only in bullet point form.

The particularly pertinent issues you may think which go beyond that already discussed are as follows:

The SHA did nothing to the trust's clinical risk assessment of the 06/07 CIP insofar as it existed. The approach of SASSHA would have simply been to check that the CPI had been risk assessed by the trust not to ask to see any documents relating to that or to go behind it.

The WMSHA witnesses were clear that it was not the responsibility of the SHA to enquire into the clinical risk arising from the CIP. The only proper question for the SHA was whether the trust was capable of achieving the CIP so that regional financial balance could be



regained or maintained.

Was it correct, we query, for these supervisory bodies to take this approach effectively trusting the trust board?

Peter Blythin, who, if I may comment, was clearly an experienced and caring individual as WMSHA's director of nursing and workforce, took a particular interest in Helen Moss's workforce review at the trust. He was aware of the process and the time it was taking. However, he apparently failed to inject any urgency into the holding of that review, so that the time lag between Helen Moss first expressing to him her concerns about nurse staffing and her presentation of the review to the trust board was about eight months. We ask, should he not have been more proactive than he was?

I turn to the role, briefly, of the postgraduate dean. No one at WMSHA, including Mr Blythin, thought to share the Healthcare Commission's letter of 23 May with the postgraduate dean, despite the presence of medical trainees in the trust's accident and emergency department.

It took Dr Chris Turner's JEST survey to make the dean realise the extent of the problems. The deanery managed to carry out an inspection of the trust in May 2008, without realising that the trust was under



investigation by the HCC. Thereafter, when the dean was interviewed by the Healthcare Commission she misunderstood her obligations to them and also believed herself to be bound not to reveal anything about the problems at the trust to the national regulator to which she was responsible, the PMETB, and so didn't mention to them in her deanery report, which was specifically designed to include such information.

This is reminiscent of the peer review team's ignorance of the HCC's investigation when they visited the trust in June 2008, producing a very critical report in relation to A&E that was very similar in tone and content to the 23 May letter. It suggests a total disconnect between those parts of the NHS considered to have a developmental function, peer review, or a educational function, the deanery, and the quality regulator. In short, there was a complete lack of joined-up thinking, even though in this case the deanery was situated in the same building as the strategic health authority.

There was no detailed handover between SASSHA and WMSHA in relation to the trust or indeed any other provider. There was no clearly defined procedure for handover, as the variation between different areas of responsibility showed.



Financial matters were dealt with in a letter by Phil Taylor and a very short summary of the position on each organisation.

Non-financial performance had no equivalent document.

Clinical governance and safety issues were dealt with in two documents of about page and a half in length, referring to a few exceptions across the SASSHA patch.

Although the evidence was that there were meetings, discussions, et cetera, there was clearly no systematic approach to risk in NHS organisations in the West Midlands, and WMSHA witnesses generally accepted that there should have been.

Sir, the role of the SHA is dealt with in detail in the written submissions, but at this stage that is my short summary of the issues.

Having looked briefly at the regulators and the performance managers of the trust, I now turn briefly to those who were meant to be providing on behalf of the local public the public voice and the scrutiny of the trust.

Sir Liam Donaldson told us this:

"I think it would greatly reduce the risk of another Mid Staffordshire-type disaster if we managed to achieve

wholesale involvement of patients and their families in how our hospitals are run."

His view was that the formal representation of patients historically had not worked very well. He believed the patient voice was far more effective if embedded within the organisational structures of a trust, for example, by putting patients on the hospital's main governing committees, getting them to advise on the running of services, and involving service users and the kinds of reviews of service provision that would normally only be undertaken by professionals.

When asked about whether the public should be more embedded in the governance structure of hospitals, as Sir Liam Donaldson had suggested, Una O'Brien stated that more needed to be done to give teeth to governors of foundation trusts, and to enable them to work more effectively.

She said:

"I think the government has indicated its intention to support more training for governors. I myself have been a school governor and I was very struck by the degree of support and backup you get to undertake that role, albeit it is different in responsibility terms from being a governor in a foundation trust. So I certainly think in the level at institutions there



must be patient involvement at every level. And I agree with what Sir Liam said clearly embedding people -- enabling them to be engaged in how organisations are run is fundamentally important."

And Una O'Brien identified HealthWatch with its role of giving greater powers to local communities to scrutinise the NHS and act on the concerns of patients, as a key way that the government envisaged preventing another Mid Staffordshire.

Whilst the precise way in which it would function was still being debated, she stated that it was important that HealthWatch should be independent in making its own judgments on the organisations it scrutinised. It was important also that it should be part of a national structure in order that themes across the country could be identified and voiced. It was a particular strength that this unified patient voice would be tied into the quality regulator, the CQC.

HealthWatch would have the power to inspect services in the same way that LINks could. On the point of inspection, the inquiry has heard evidence about the limitations of what lay people could achieve in such exercises.

Ms O'Brien, interestingly, mentioned that the CQC were currently starting to involve residents of care



homes within their inspection teams for other care homes, in to order have a combined expert and lay perspective. She thought this was something that may well be worth considering further.

It's clear from the substantial evidence that we heard in relation to the effect of the patient and public voice that there will always be an imbalance of power between an organisation of volunteers, many or all of them without healthcare sector or NHS experience, and an organisation such as an acute trust. In the case of the trust and the PPIF, this appears to have resulted in the fixation of the forum's leadership on the maintenance on the forum's relationship with the trust. Anybody charged with ensuring public involvement with the NHS needs to address this issue.

Leaving aside the controversy between Mr Deighton and the forum leadership, the forum's approach to the trust's A&E shows the limitations of what a non-expert body of volunteers can achieve in scrutinising a body as relatively complex as the trust. The real danger in A&E lay not only in poor hygiene, but in understaffing, the lack of governance and learning and training. The forum's overwhelming focus was on cleanliness and hygiene. Those issues were easy for a layperson to understand and had a high profile in the mid-2000s



through media reporting of HCAI. The PPIF appears to have been almost overwhelmingly supportive of the trust and of its chief executive.

It's easy to lay blame at their door, but it's also unfair. The failure of the local PPIF you may think was a cultural one and not an individual failure.

The lack of prescription from the Department of Health as to the structure and constitution of LINks was a serious failing, notwithstanding the good intention behind it to create independent, non-bureaucratic local networks.

In Staffordshire uncertainty about the nature and role of the LINk meant that a disproportionate amount of time and resources were devoted to the establishment of governance and other procedures. The local consultation process for the establishment of the LINk resulted in a structure that was unwieldy and ultimately unworkable; nine committees covering Staffordshire with potentially 128 members all to be administered by three or four part-time host employees.

Although guidance or diktats from the centre might themselves produce such a result, the right kind of guidance might have helped to avoid it.

The lack of guidance from the centre and a lack of a body corresponding to the Commission for Patient and

1 Public Involvement in Health in the earlier arrangements
2 meant that there was no arbiter in disputes between
3 members or between the host organisations and members.
4 This lack of guidance also made such disputes more
5 likely, as, with no template for what a LINk should look
6 like or how it should be run, there were more areas
7 about which host organisation employees and volunteers
8 could and did potentially disagree.
9 All are agreed the LINk was wholly ineffective in
10 this area and the Department of Health has to take
11 a degree of responsibility for that failure.
12 I turn to the role of the overview and scrutiny
13 committee.
14 You may have formed the view that the borough
15 committee members primarily viewed their role as one of
16 overview rather than scrutiny. This was reflected in
17 the reliance of the borough committee witnesses on the
18 Department of Health guidance for OSCs where that
19 guidance emphasised the overview component of their
20 role. However, the committee effectively ignored the
21 part of the guidance that stated that anonymised
22 complaints data would be a crucial source of information
23 for it.
24 The approach of both committees was characterised by
25 over-reliance on information from trust's executives.



1 Borough council committee members considered themselves
2 more or less bound to accept what they were told by
3 trust executives. The evidence of the borough committee
4 members was vague on the significance to be attached to
5 the findings of other bodies, such as the HCC. There
6 had been some reliance historically on the fact that the
7 trust had been a three-star trust but one member of the
8 committee had not even read the Healthcare Commission
9 report into the trust or even a summary of it.
10 Patient relatives felt that the committee's
11 bureaucratic approach hampered public participation.
12 The interaction between the committee and the PPIF
13 appears to have related solely to the issue of
14 cleanliness at the trust. There were many other aspects
15 of the patient experience, and many other issues about
16 which patients might have views. The interaction might
17 reflect the limitations of the PPIF, but the OSC had
18 a duty to engage with patients more than it did.
19 There is good evidence, we submit, that the
20 committee had completely lost sight of its duty to
21 scrutinise the trust's services as well as take an
22 overview of them in the example of the letter to
23 Julie Bailey from the council's head of law
24 administration in February 2008 essentially dismissing
25 her concerns about the trust as relevant only to an



1 individual case, which manifestly they were not.
2 Despite knowledge of the broad range of Cure's
3 concerns and of the fact of the HCC investigation, the
4 committee chose to focus solely on HCAI at the trust for
5 the remainder of 2008 and arguably did not behave as
6 a local representative body should have done on receipt
7 of Julie Bailey's list.
8 A letter to the trust expressing the committee's
9 concerns about aspects of the trust after a visit in
10 August of 2008 was weak and vague in its phrasing,
11 despite committee members finding problems with
12 understaffing and poor staff morale.
13 In the case of the county council, the committee's
14 regular relationship meetings with the trust were
15 indicative of too close a relationship at the expense of
16 the committee informing itself about the patient
17 experience. There were no corresponding meetings with
18 patients of the trust.
19 The committee's chairs during 2005/2009 either could
20 not see the point of seeking the views of the
21 constituents on healthcare issues, or could not remember
22 any public involvement in committee meetings at all.
23 That was a surprising omission, given that their core
24 purpose was to represent the public voice.
25 The county committee also placed undue emphasise on



1 overview at the expense of scrutiny. The chair said
2 that the committee would not have scrutinised a proposal
3 such as the trust clinical floors project, unless it
4 constituted or would lead to a significant variation in
5 service provision.
6 In 2006, when Toni Brisby phoned the chairman to
7 tell him about the trust Workforce Reduction Programme,
8 he told her not to worry too much about keeping the
9 committee informed about it, unless it would affect
10 service provision, and doesn't recall taking any further
11 steps in relation to that.
12 Despite the fact that three acute trusts in
13 Staffordshire were among the top ten with the highest
14 HSMR in the country in April of 07, the county committee
15 had done very little work on this issue and appeared to
16 have accepted the trust's assurance about coding.
17 Again, this may be thought to be a clear demonstration
18 of the limits upon public involvement, even at
19 councillor level.
20 I am going to turn briefly to the role of the press.
21 A number of witnesses have commented on the lack of
22 press attention to Mid Staffs prior to the HCC's report
23 being published. Ministers seem to be quite unaware of
24 the amount of interest the local press had in fact paid
25 to the problems at this hospital. Ben Bradshaw told us

1 that the media only started reporting the issue in any
2 depth and volume after the Healthcare Commission report
3 was published.
4 Later in his statement he said:
5 "My recollection about issues at the trust is that
6 there was virtually nothing in the press cuttings until
7 the HCC investigation commenced."
8 The secretariat have undertaken a brief review of
9 the local press reporting in relation to this trust, and
10 we're grateful for the assistance provided by
11 Mr Lintern, who is a journalist specialising in health
12 issues at the Express & Star, a publication which we're
13 told has a readership I think of about 340,000 and for
14 the exhibits which he has produced. However, what that
15 review has revealed is that there were a series of
16 articles from 2005 onwards relating to individual
17 incidents. Certainly weekly and often several times
18 each week there were stories about mishaps at the
19 hospital, examples of poor care, poor surgery, bad
20 diagnosis. There were also a number of articles which
21 can properly be described as "good news" stories. But
22 at no stage was there an article which we have been able
23 to identify which brought all of the strands together.
24 There was no seminal moment when the local newspapers
25 pulled the strand together and identified this as

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1 a failing trust.
2 It's fair to say that once the Cure campaign started
3 in late December of 07 the Express & Star did become
4 supporters of the issues that they were raising. We
5 certainly lay no blame whatever upon the press. It's
6 not their role to act in a regulatory or indeed
7 supervisory manner. But it is a demonstration of how
8 difficult it is to identify corporate failure from even
9 a large number of individual cases of bad care.
10 Sir, we've now examined the supervisors, the
11 regulators and those accountable for providing public
12 scrutiny of this trust. But what about those within it?
13 In speaking about the trust, I am very conscious not
14 to trespass upon the evidence which you heard in your
15 first inquiry, nor to repeat the points you made in your
16 first report, but it is relevant to see what the trust
17 looked like from within.
18 What was it that stopped the news of what was going
19 on in some of the wards and departments of this hospital
20 from leaking out to the outside world?
21 We've heard repeatedly in evidence that the buck
22 stops with the trust board. That is a given.
23 Sir Stephen Moss in his closing submissions to the
24 inquiry accepted that, and he gave us his summary of
25 important and significant issues. He came to speak to

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1 you with considerable weight of experience, both
2 clinical and managerial, and so it is our submission
3 that his words do carry a degree of weight, and
4 I apologise to him and to you for turning into bullet
5 points what he much more eloquently expressed, but they
6 were these.
7 The buck stops with the board.
8 The board's focus must be on faults and not focus on
9 what the trust got right.
10 Particular attention should be paid to the frail and
11 the vulnerable. If care is made right for them, he
12 said, it will be right for others.
13 Pausing for a moment, we do not entirely accept that
14 submission, because care of the elderly and frail is
15 particular and unique. We do submit that they are
16 a group who need very particular attention and, in our
17 submission, that may point to having a geriatrician
18 senior on every elderly care ward.
19 He went on. The problems associated with sacking
20 doctors needs to be addressed.
21 Well, again in our submission, we cannot offer
22 a solution to what seems to be an intractable problem.
23 But we do submit that it is worth in this context
24 reminding ourselves of the evidence given by
25 Sir Bruce Keogh, who related his experience of the value

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1 of transparency of results and audits so that each
2 clinician's results are recorded and made openly
3 available. That led not to gross sackings but to
4 improvement through the identification of doctors with
5 problems in their practice and consequent retraining.
6 Not all doctors can be treated and improved in that way.
7 Those whose performance cannot be improved, there should
8 be a f greater willingness, we submit, to take firm
9 disciplinary action.
10 He went on. Clinicians must speak out when they see
11 poor care and an effective whistle-blowing policy is
12 essential.
13 Compassion matters. And he raised the issue of
14 using psychometric assessment when employing nurses and
15 carers.
16 Ward sisters are needed and experience should be
17 awarded.
18 And best practice models should be produced in the
19 NHS.
20 Clinical governance and human resource policy and
21 procedure.
22 He said clinical governance is often staffed by
23 nurses who know little about it.
24 He said the trust often got the paperwork right but
25 failed on the implementation.

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1 And he told us what I suppose we knew from the early
2 days of this inquiry from the experts. Changing
3 structures can lead to disorganisation and does not
4 inevitably lead to improvements in service.
5 He also said this. There's a strong argument for
6 a single regulator split into two arms, financial and
7 care. Not to do so, he said, leads to gaps in knowledge
8 and practice. When involving on finance it is crucial
9 that the regulator is able to feed that information
10 directly to the quality controllers.
11 Sir, there's not time here to explore all of the
12 issues which arose from the evidence of trust witnesses,
13 and there is an extensive chapter, I'm afraid, devoted
14 to this evidence in the written submissions.
15 There are some particularly pertinent issues raised
16 by the trust evidence which deserve mention here. We
17 heard from some 42 witnesses who'd worked or were still
18 working for this trust. Those witnesses included the
19 chair and chief executive, although the inquiry was not
20 as well assisted as it might have been, given that
21 Mr Yeates was too ill to give oral evidence.
22 There was clearly a long-standing organisational
23 failing. Eric Morton, the interim chief executive at
24 the trust, said this:
25 "Organisations like Mid Staffs do not fall



1 overnight. It seemed that the organisation had not been
2 focused on clinical governance for a considerable period
3 of time. This had not been its driving principle."
4 He added later:
5 "Quality of care is at the centre of what any
6 hospital does. I think there had been a real lack of
7 focus on the quality of care at Mid Staffs. It simply
8 was not prioritised, particularly at board level.
9 Mid Staffs had been chasing a financial problem to
10 obtain FT status."
11 Of course, that is just one aspect although
12 a crucial one of the problems at the trust. However,
13 one might think that such organisational failure should
14 have been readily detected by those with responsibility
15 for oversight in the trust. But the evidence of the
16 trust witnesses suggests that one fundamental reason why
17 certain of those regulatory or monitoring bodies did not
18 detect such failings was that they themselves did not
19 have safety and quality at the core of what they did.
20 For example, the evidence as to the PCT's activities up
21 to the start of the HCC's investigation, as seen from
22 the perspective of those within the trust, suggests an
23 organisation that was concerned only with financial and
24 activity targets.
25 Dr Philip Coates told us this:



1 "My view from attending meetings with the PCT was
2 that the PCT and the trust were essentially
3 commissioning care/providing care from a spreadsheet.
4 They were interested inactivity levels, throughput and
5 monitoring contracts to make sure that we were not
6 overspending but they were not focusing on detailed
7 commissioning of healthcare for local people and
8 ensuring the provision of good quality care."
9 Insofar as there were mechanisms that were designed
10 to detect poor quality care, for example the HCC's
11 annual health check, they appear to have been
12 fundamentally flawed due to an over reliance on
13 self-assessment and a process of independent assessment
14 that could be satisfied by the trust producing
15 unrepresentative documentary evidence of good practice,
16 while ignoring the reality of patient care on the wards.
17 On that point, Trudi Williams pertinently said this:
18 "If you go out to prove a hypothesis, if you have
19 a hypothesis, you go out to prove it. So, you know, if
20 you thought we were compliant, we would be looking for
21 the evidence that said we were compliant."
22 You asked her:
23 "Would this be fair, that having found some evidence
24 suggesting compliance with the standards, you weren't
25 exactly energetic for looking for evidence that were you



1 not compliant?"
2 And she answered:
3 "I suppose you could say that. Did we look for all
4 the negatives? I can't say that we did."
5 Ultimately, of course, the HCC's surveillance of
6 mortality led to its investigation. However, the
7 trust's ability to self-certify compliance with core
8 standards and satisfy the HCC of that compliance until
9 that point suggests the need for far more effective
10 measures of quality and safety which would enable
11 a quality regulator to detect poor care and take action
12 far more promptly.
13 With the HCC's investigation and then its report in
14 early 2009, the level of monitoring of standards at the
15 trust by external organisations underwent
16 a transformation. For example, the SSPCT began to issue
17 performance notices for failure to meet A&E targets, and
18 sought to assure itself of quality by means of a near
19 constant presence at the trust. The CQC performed
20 a number of planned and responsive reviews.
21 So from the trust's perspective a new risk emerged,
22 that the trust progress would then be stifled by the
23 burden of regulatory action, and the need to keep a raft
24 of external organisations supplied with information.
25 In short, the evidence signals the continuing need

1 to identify and implement a system of regulation that
2 uses the right information efficiently and effectively
3 to detect failings in patient safety and quality of care
4 while avoiding such a burden upon providers as to be
5 counterproductive.
6 There were, of course, fundamental issues within the
7 trust which have been fully explored in your first
8 inquiry and commented upon, and it will help no one for
9 me to repeat any of that. What I can do relatively
10 briefly is to try to glean from the evidence we heard
11 from the trust a few seminal points. So if I go on for
12 another quarter of an hour, if you can bear it, and the
13 shorthand writer can bear it.
14 The first heading is the closed culture of the
15 trust.
16 Martin Yeates stated that the recruitment of the
17 trust was a problem. He said:
18 "It's always a challenge to recruit high quality
19 ambitious staff in a provincial town. A lot of staff
20 just wanted do their day job, with career progression
21 and development very much off their radar."
22 While the national average age of the staff nurse
23 was much younger, at Mid Staffordshire the average age
24 was 45 to 50. Nurses remained in post for much longer.
25 In his view, this resulted in stagnation in terms of



1 career development and refreshment of skills.
2 Toni Brisby agreed with Mr Yeates. Many staff at
3 the trust had been in place for a very long time. They
4 were wary of new appointments and new working methods.
5 To affect change required a change with vision, energy,
6 determination and a good deal of courage because there
7 was a great deal of resistance to change.
8 Helen Moss stated when she arrived at the trust in
9 December 2006 it was clear that the perception from the
10 nursing workforce was that the trust was a small
11 medium-sized DGH with nothing in particular that would
12 attract experienced nurses could because it didn't offer
13 specialist services and the opportunities for learning
14 and career development were not well developed. There
15 was likewise nothing in particular to attract fresh
16 blood from outside the immediate geographical area of
17 the trust.
18 Dr Moss stated that she walked the wards regularly,
19 but the nurses still didn't readily disclose the extent
20 of the problems they faced she said:
21 "It was -- the nursing workforce, it was a very
22 unusual culture and closed -- a closed workforce ...
23 they didn't readily discuss any issues and it took
24 a significant amount of time to gain the trust of the
25 workforce."



1 There was it seems a total lack of peer review at
2 this trust. Many of the staff had not only been there
3 a long time, but the Helene Donnelly example
4 demonstrates that many of the poor staff must have felt
5 and looked to others as being unassailable.
6 The same issue of lack of peer review seems to have
7 assailed the trust board. Sir Stephen Moss described
8 the trust board in this period as an immature board,
9 with an inexperienced chief executive. He added that an
10 immature board relies on external intelligence to tell
11 it when things are wrong. As it does not ask for help,
12 the regulator doesn't know what support is required.
13 A more mature board would be confident in asking for
14 help if it was required. As to where that help would
15 come from, Sir Stephen said that there may be reluctance
16 on the part of a trust board to approach the PCT as it
17 would not want to expose its weaknesses to the
18 commissioner.
19 The SHA could be a good source for advice.
20 Sir Stephen understood that Helen Moss received such
21 advice from Peter Blythin. But with the achievement of
22 foundation trust status the relationship could become
23 distanced. Many hospitals rely on peer networks rather
24 than approaching a regulator for help. Unfortunately,
25 he said, the board at the time didn't seem to have



1 healthy peer relationships, choosing instead to isolate
2 themselves from other local organisations.
3 When Antony Sumara attended an executive team
4 meeting the day after he started work at the trust in
5 August 2009, after about five minutes he interrupted.
6 He told the team that they didn't have a clue what they
7 were doing. They didn't have a single agenda point
8 which dealt with the main issue of poor performance
9 facing the trust, when this was all, according to him,
10 they should have been talking about. The agenda for the
11 meeting contained an item on the state of the football
12 pitch. Those present, he said, didn't have the right
13 focus.
14 He said the members of the team were doing their
15 best but they were almost all inexperienced and they had
16 been led by a chief executive who was himself in his
17 first role at that level. There had been failure of
18 leadership and no one had given the team clear
19 direction.
20 The next heading is that the clinicians were
21 divorced from the management and from management
22 objectives.
23 One group that was not leading the drive for
24 foundation trust status was the clinicians.
25 David Durrans gave fairly representative evidence on

that issue.
He said:
"I am not sure that there were many clinicians who understood what foundation trust status really meant, and a number of colleagues had difficulty in seeing what difference achievement of FT status would make to the care of patients. I believed these concerns were raised at the time by the clinicians. The reassurance given was that FT status would allow the trust to independently manage its own affairs from which we would derive benefit to clinical care. To A certain extent the clinicians believed that the management team knew what they were doing in seeking foundation trust status ... Even now [he said] I have difficulty in identifying any advantage in clinical care that has derived from the state status."
Ms Adams added that some of the trust consultants were vocal in raising poor staffing levels as a concern, but she said it was clear the senior management wasn't listening.
Kath Fox of UNISON presented a similar picture. She stated that concerns about staffing levels was probably voiced in nearly every JNCC meeting in this period, although that concern would not then be recorded in the minutes. Patient safety was not discussed per se. It



was taken for granted that a fully staffed ward would result in proper care.
During this period UNISON members would approach their representatives in the corridors and express their concerns about staffing levels.
Ms Fox said:
"The attitude of the union representatives in the JNCC meetings was concern at how the trust could reduce the numbers of staff when people were expressing concerns that they were already under pressure due to staff shortages. The attitude of the trust was 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 meetings; what we were saying in the meetings wouldn't have made the slightest bit of difference to them. They were going to make the staff cuts regardless."
Surprisingly the evidence revealed that even with something as basic and relevant as clinical governance, many of the trust's clinicians don't appear to have wanted to engage.
In a variety of ways the trust's governance structures in 06 to 08 did not make use of and learn from valuable sources of information that were available



to it, such as complaints and adverse incident reports. When Helen Moss came into post at the end of 2006, Dr Coates said there had been a backlog of about eight months of incidents reports many of which had lot been logged on the Safeguard system. Many incident reports highlighted inadequate nursing staff as an issue. However, little was done to change things.
Dr Coates said:
"Any suggestions for improvement discussed at any clinical governance meeting would refer the need to do something back to the relevant division, but no one checked whether the division did anything."
A key problem with the implementation of clinical governance in achieving action in response to identified problems was the failure to get engagement from consultant clinicians in the process. Dr Coates thought that the procedures and bureaucracy put many clinicians off. Those who attended governance meetings didn't feel that they achieved anything useful.
Allied to this, the culture amongst the consultants at the trust was one of suspicion towards clinical governance. There was a definite feeling among some consultants that they didn't want to be told what to do by someone else.
Helen Moss told us:



"You can put processes in place and they're there designed to work, but you have to change the hearts and minds and culture as well to go along with it."
This is reflective once again, we submit, of this issue of a lack of clinical engagement. Without clinical engagement in the basics of clinical governance, then the chances of improvement of practices is next to nil. Whatever then gets turned out by the Department of Health, whatever initiatives are started at the top, unless the clinical soil is fertile, the seeds will inevitably fall to stony ground at trust level.
Of the disconnect between the trust declarations of compliance with core standards dealing with clinical governance and the reality on the ground, Dr Coates told us:
"Whilst the clinical governance and appraisal schemes were ineffective, they nevertheless existed, which enabled the trust to tick the necessary boxes."
The experience of those doctors who did complain and tried to change the course of events was not an encouraging one. According to Dr Daggett, there were four or five consultants who persistently raised complaints. However, they were seen as "naughty boys" for complaining. He did not feel until around 2007/2008

1 that anyone was reacting to the consultants' concerns.
2 The message was always the same:
3 "There's no money. There's going to be less and
4 it's just going to get worse."
5 As a result the consultants who did try to do
6 something lost heart.
7 SUIs, complaints and surveys.
8 You heard in your first inquiry, sir, a lot of
9 evidence about the under-reporting of serious incidents,
10 but there is a regulatory aspect of that which is, of
11 course, relevant to this inquiry.
12 Throughout the period of central interest to the
13 inquiry, the trust had in place policies on serious
14 untoward incident reporting and adverse incident
15 reporting, which set out the purpose of reporting, the
16 definitions of incidents falling to be reported, as well
17 as how and to whom reports should be made.
18 However, the practice was clearly different from the
19 theory. Trudi Williams was able to provide an overview
20 of reporting and learning from serious untoward
21 incidents and adverse incidents at the trust, as from
22 2005 she was the line manager of the clinical risk
23 manager at the trust, who was in turn responsible for
24 incident reporting within the organisation. In essence,
25 she painted a picture of a culture of reporting in the



1 context of little encouragement by external bodies. She
2 stated:
3 "There was not much pressure externally to increase
4 the number of reports and it did not seem very different
5 to what was happening in Burton Hospital before I left
6 there. Incidents that the executive deemed to be SUIs
7 were put on an external database called STEIS. The SHA
8 had access to it. When SUIs were put on STEIS they
9 would have to be closed off by the SHA but we got very
10 little interaction and feedback from them at this time."
11 She clarified that this remained the position from
12 the time she returned to the trust in 2005 until 2008,
13 the start of the HCC investigation.
14 She said:
15 "I recall there being some SUIs on the STEIS system
16 which were not closed off and they had been on there for
17 a number of years with no one appearing to be
18 questioning us about them."
19 An example of a perhaps very serious SUI case was
20 the sad case of Gillian Astbury, who died after a series
21 of failures of care, most importantly a failure to
22 administer insulin. The report on the incident drafted
23 by Stuart Knowles noted that the incident had in fact
24 not initially been reported as a SUI. When asked how
25 this could be, Trudi Williams stated that it was not



1 until the investigation had been undertaken into her
2 death that it was apparent that the incident should have
3 been reported as a SUI. It was pointed out to
4 Ms Williams that there was no indication that the SHA
5 had ever had any input into it, in particular in
6 relation to following up any action plan instigated as
7 a result.
8 She said:
9 "It doesn't surprise me, because we weren't chased
10 for action plans. We weren't chased for reports once it
11 was reported on to the STEIS system. It was only much
12 later than that started to happen, once the Healthcare
13 Commission came in and started to do their
14 investigation."
15 What about another key source of information both
16 for the board and outside regulators, complaints? Sir,
17 again, you heard a great deal of evidence about
18 complaints in your first inquiry, and for that reason
19 I only touch upon them here in this very specific
20 context.
21 After period of maternity leave, Ms Llewellyn
22 returned to the trust part-time in 2005. The trust
23 complaints review panels had been terminated by the then
24 chair of the trust on the basis that they took up too
25 much of the non-exec directors' time. Ms Llewellyn had



1 then to report on complaints to what she called
2 a quality monitoring group. The trust was at the time
3 seeking to apply for foundation trust status, and the
4 board had other things to focus on instead of
5 complaints. A huge backlog of complaints had built-up
6 since she had been away. Nonetheless the complaints
7 reports that Ms Llewellyn was responsible for preparing
8 for the quality monitoring group and the trust board
9 were less effective than the old complaints monitoring
10 panels, because they were merely statistical. There was
11 no detail.
12 An annual report on complaints went to the trust
13 board, the PCT and the HCC to comply with regulations.
14 However, only a very low-level of detail was required.
15 Statistics continued to go to the Department of Health.
16 However, the information concerned numbers of complaints
17 and general type, such as care and treatment, or staff
18 attitude.
19 None of the core information was getting to the
20 board and none of the core information was being asked
21 for by the regulators. Even when relevant information
22 was reaching the board, it seems the board didn't react
23 appropriately to it.
24 Whilst the trust was aware of the findings of staff
25 and patient surveys, there's little evidence that it

1 responded to those with any urgency. This might be
2 considered particularly significant in relation to nurse
3 staffing.
4 The inpatient surveys for 05 and 06 both indicated
5 that the trust fell in the bottom 20 per cent of trusts
6 in relation to the question:
7 "In your opinion were there enough nurses on duty to
8 care for you in hospital?"
9 However, Peter Bell stated that the fact that
10 inpatient survey results were produced a long time after
11 the surveys made them of very limited value:
12 "We were concerned [he said] that patients' surveys
13 were not rating the trust very highly. We thought we
14 had taken steps to improve the patients' perception of
15 hospital care. I think the last survey took place in
16 approximately September/October 07 and related to
17 patients who had been treated some four months earlier
18 than the survey took place, with the results being
19 issued to a six or nine months later. Accordingly, when
20 we saw the results we were looking at historic
21 information. How good we measure such feedback when the
22 data was so old?"
23 In relation to the staff survey, the trust board
24 minute of 3 May of 07 records the findings of the staff
25 survey indicated that:



1 "A percentage of staff stated that they would not
2 want to be cared for in the hospital."
3 Toni Brisby said in her witness statement that this
4 was worrying. However, she could not recall what was
5 done to explore the matter further.
6 The minutes indicate that it would be pursued at
7 a divisional corporate level, and Mrs Brisby couldn't
8 recall it being dealt with again by the board.
9 Sir, I am about to turn to the issue of
10 whistle-blowing. I should think I've got about another
11 30 or 40 minutes to ago and I wonder if that would be
12 a convenient moment.
13 THE CHAIRMAN: On which case you're on target, so we'll have
14 a ten-minute break.
15 (3.07 pm)
16 (A short break)
17 (3.17 pm)
18 (Proceedings delayed)
19 (3.20 pm)
20 MR KARK: Sir, I was going to turn to the issue of
21 whistle-blowing.
22 An essential safety valve to allow for issues to be
23 raised when all internal avenues have been exhausted is,
24 of course, whistle-blowing. Many have asked, why were
25 there not more whistle-blowers alerting the authorities



1 to what was going on? And the answer may lie in the
2 treatment of one nurse who did have the courage to do
3 just that.
4 Helene Donnelly was a nurse at the trust who was
5 exceptionally prepared to speak out against poor
6 practice within the accident and emergency department in
7 2007. Her story and the way that she was treated is an
8 appalling one and can give no encouragement to any other
9 aspiring whistle-blowers.
10 On her account she had good reason to do what she
11 did. She said this:
12 "I think you'd asked me the question of what really,
13 what spurred me to act, and I think it was because I'd
14 seen people die, needlessly I think in some cases, but
15 certainly with a lack of dignity and respect, and that
16 was so distressing to me ... it was wasn't just once or
17 twice that happened, it was relatively frequently, and
18 that was really for me what upset me then ... and that
19 was the reason I had to speak out."
20 She sought the support of Adrian Legan, the
21 full-time representative of the RCN. She found him
22 discouraging. He was dismissive, telling her that the
23 sisters would be becoming back with slapped wrists and
24 that she should keep her head down and not cause any
25 more trouble.



1 Subsequently she discovered that he'd actually been
2 representing at least one of her sisters in her dealings
3 with the dealings in the trust. Indeed the trust
4 confirmed to the inquiry that a deal was brokered
5 between Martin Yeates and Mr Legan whereby the
6 investigation was halted without producing a formal
7 report, and the sisters returned to the department and
8 were issued with a warning. It also resulted in the
9 sisters returning to their old practices upon their
10 return.
11 Ms Donnelly only remained at the trust for a few
12 more months. The impression she had was that senior
13 managers within the trust knew about the practice of
14 massaging the figures of which she'd accused the and
15 they tolerated. Ms Donnelly's account, however, was
16 that her concerns came to nothing. Those she criticised
17 were soon back in their own positions and back to their
18 old habits. The trust didn't learn from the experience.
19 Other nurses observing how hard Ms Donnelly's life
20 had been made for speaking out, for all the difference
21 it made, were bound to be put off raising their own
22 concerns.
23 This witness's evidence is perhaps emblematic of an
24 organisation that did not have the safety and quality of
25 patient care at the heart of everything it did. In

particular, it was not an organisation that used valuable information that could have been readily available to it. It is as depressing an example of the poor treatment meted out to whistle-blower as one hopes to come across.

In your first report you commented on the behaviour of the legal department of this trust, and in particular its behaviour in relation to the reports surrounding the unfortunate and tragic death of John Moore-Robinson. I do not intend to travail that material again here, although it is dealt with in the written closing submission which we hope you'll receive next week. It is sufficient here to make these comments.

Both Ms Levy and Mr Knowles accepted that there was a developing emphasis on openness in the NHS and at the trust over the years. However, they stated that when they dealt with cases in their capacity as solicitor to the trust, their professional duty to act in the best interests of their client superseded any general policy or guidance to be open.

In the case of the Mr Phair reports, neither individual could in fact recall referring them to any manager within the trust to consider making disclosure. Both individuals were, of course, maintaining they hadn't given the matter particular attention.



Mr Knowles emphasised in this regard that it was important to recognise that the degree of openness within the NHS in 2006 was very different from the position now.

One might conclude in the context of this answer that it was unlikely, even had the reports been escalated for consideration at a high level, that a decision would have been made to make voluntary disclosure to the family.

The inquiry may conclude that there was a conflict between the growing emphasis on openness and transparency within the NHS as a whole over the period of 2005 to 2009 and the professional obligations of those within the trust legal department to protect its legal and financial position. The inquiry will consider whether in the case of John Moore-Robinson, whilst Ms Levy and Mr Knowles may have been acting in accordance with their professional duties to their client and there was no strict legal obligation to disclose the report to the coroner or to the family, the resulting non-disclosure of information that could have assisted both to understand fully what had gone wrong was unacceptable or at least undesirable.

The inquiry will consider whether greater alignment between the priorities of legal departments and the



trust they act for is required to produce greater public confidence in the openness that the NHS professes. This may demand changes to the NHSLA's guidance, at the very least it would require clearer instructions to solicitors acting for trusts about what the best interests of those organisations really require.

I am going to turn to paragraph 235, if that helps you to follow the note. This is under the heading "Lack of appropriate challenge from without the trust".

John Newsham stated that the PCTs had no input into the design of the trust's cost saving plan and were not involved in any of the debates about how they would be achieved. SASSHA on the other hand signed off the cost reduction plan. They described the proposals at high level but would have included detail such as the plan to alter the skill mix in the medical division and manpower numbers. The SHA would have known, for example, the number of qualified nursing posts that the trust planned to reduce but would not know the intentions on a ward-by-ward level.

I am going to speak briefly about HSMRs under this general subheading of a lack of appropriate challenge from external organisations. There is fortunately or otherwise an entire chapter devoted to HSMRs in the written submissions, but I am I'm afraid I am going to



keep you on tenterhooks to await those words.

But if you will allow just a few comments only. You know, of course, in April of 07 of the published HSMR for the trust.

Martin Yeates stated following the publication that he immediately engaged both Dr Foster and the firm CHKS to look into whether the trust had a genuine problem with mortality rates or not. He stated that both organisations confirmed that the trust's crude mortality rate was average for its cluster of hospitals and the logical conclusion related to data capture, and the quality of coding at the trust.

CHKS had identified in January of 2007 that the trust had fewer coders than it needed, and the trust was poor at capturing co-morbidity data. Mr Yeates stated that when a new head of coding was employed she did an excellent job and the trust's HSMR reduced from 127 to 88 in a year. Well, we now know principally as a result of coding many more individuals were being admitted for palliative care.

Mr Yeates concluded:

"I therefore realised that the figures had been doing a clinical services team a huge disservice and this confirmed what we suspected that this was a data capture issue, not an issue of clinical quality."

1 Dr Phil Coates, the clinical governance lead, said
2 this of the trust's approach to HSMR:
3 "Instead of acknowledging that patients may have
4 been dying unnecessarily and trying to identify what we
5 should do about it, our reaction was that we needed to
6 find some way to get the figure lower, and we started
7 taking the view that it came down to a coding problem.
8 We were aware that our coding procedures were poor and
9 could paint an inaccurate picture and it therefore
10 seemed natural to assume that this problem of lax coding
11 was the rational explanation of the problem."
12 Well, many of the trust's witnesses stated in their
13 evidence that CHKS was actually commissioned by the
14 trust to look into the HSMR and found that the trust's
15 mortality rates were normal. Dr Suarez was amongst
16 those witnesses and stated that the report to the trust
17 board in June of 07 was based on the CHKS review. This
18 does not appear to be correct.
19 Paul Robinson, head of market intelligence at CHKS,
20 produced a statement making it clear that no such work
21 was commissioned. Furthermore, the report of the
22 7 June 07 referred to above makes no reference to any
23 such work being conducted. Instead, it was CHKS's
24 earlier report and the chief executive's letter of
25 April 2007 that were relied upon.



1 Dr Coates made a supplementary witness statement in
2 which he conceded that there appeared to be no
3 documentation from CHKS suggesting that it did any
4 specific work on the trust's mortality rate. He raised
5 the possibility that CHKS might have given the trust
6 information informally during conversation, but he
7 confirmed that the calculation of the trust's crude
8 mortality rate was conducted by the trust itself.
9 The trust put together a mortality rate action plan,
10 in response to the Dr Foster figures. However,
11 examination of the plan reveals that whilst it contained
12 mention of improving trust-wide clinical audit,
13 establishing a monthly mortality group and conducting
14 a skill-mix review, most items related to data quality
15 an coding. Dr Coates stated that no meaningful
16 investigation of quality took place.
17 Of his dealings with the SHA on this issue,
18 Martin Yeates said:
19 "Steve Allen discussed the issue with me and
20 Rashmi Shukla had a number of conversations with various
21 clinicians and they accepted and agreed that the problem
22 was probably with HSMR coding, but they commissioned the
23 University of Birmingham to confirm whether this was the
24 issue ... Like us, they just wanted to understand what
25 the problem was so that we could all deal with it."



1 Dr Coates stated that he attended a meeting with the
2 SHA that was called by the SHA's medical director,
3 Rashmi Shukla, and involved various trusts within the
4 SHA area. In his view, the meeting entirely "missed the
5 point". He said:
6 "The meeting was fixated with comparative
7 statistical findings of Dr Foster's and a rival
8 commercial statistics service called CHKS, rather than
9 being focused around clinical outcomes.
10 Dr Coates stated that the CHKS model produced
11 different conclusions from the Dr Foster model. He
12 said:
13 "In my mind this made the whole thing seem like
14 a dog's dinner. It wasn't clear to me who we were
15 supposed to believe. It seemed me that the SHA were not
16 taking the mortality situation, other than as
17 a reputational issue."
18 Dr Coates suggested that what he wanted was
19 guidance, including from the HCC, who were represented
20 at the meeting, about how he should go about responding
21 to the HSMR in investigating mortality. He did not get
22 it from the HCC, nor, in his view, from elsewhere.
23 One has to conclude that had others outside the
24 trust provided a greater challenge to the trust's
25 explanation, there is at least the possibility that the



1 trust would have taken the issue more seriously than
2 they did and may have been forced into a proper audit of
3 mortality rates for various conditions.
4 Had they done so, it is possible at least that they
5 would have discovered what the HCC and the DFU
6 discovered much later, which was that the trust had
7 a much higher mortality for certain specific conditions
8 than they should have done. The fact that that evidence
9 had to be brought to the trust's attention is a good
10 demonstration of the lack of proper internal governance
11 and audit and an unfortunate reliance upon the
12 explanation of clinical coding, which was in all
13 likelihood wrong.
14 Similar comment might be made about the lack of
15 action in relation to the report of the Royal College of
16 Surgeons in the same year as the Dr Foster figures. In
17 that same year that surgical department was being
18 described as dysfunctional and lacking leadership,
19 particularly the colorectal department, yet because that
20 report was kept secret from the regulators no one
21 outside the trust was able, even if inclined to do so,
22 to add two and two together. Equally, no one within the
23 trust did so either.
24 We do not say positively that the HSMRs and the
25 Royal College of Surgeons' reports should be directly





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1 related, but those reading them might at least have been
2 alert to the apparent coincidence.
3 Before entirely leaving the trust, it is worth
4 making the point that to blame the likes of
5 Martin Yeates for all of the ills which occurred at the
6 trust would not be fair or accurate. Although he was
7 chief executive and must therefore carry a degree of
8 responsibility, he was put into a role for which many
9 would think that he was perhaps unsuited and certainly
10 untrained, and that brings us on to a short discrete
11 topic which is that of training of managers through the
12 NHS.
13 Geraint Griffiths pointed to the dearth of training
14 opportunities for commissioners and, therefore, the
15 value of the experience amassed by the PCT. He said the
16 majority of commissioning staff have learnt their skills
17 from on the job training, generally working their way up
18 through commissioning teams. There had been few
19 opportunities for specialist commissioning training,
20 such as the postgraduate diploma developed by NHS South
21 Central. A number of staff have now started to work
22 their way through this and it would be extremely
23 beneficial for this to be extended.
24 It's obvious from the approach taken by Monitor and
25 other regulators that if the first line of defence is to



1 be the trust board, it's crucial that appropriately
2 qualified and trained people are appointed. According
3 to Dr Moyes, Monitor ran programmes aimed at developing
4 the technical and management capabilities of those
5 running foundation trusts. These courses included
6 a course for the finance directors run by the Cass
7 Business School and further programmes for non-executive
8 directors.
9 Monitor also ran, we were told, regional conferences
10 for the governors of foundation trusts, out of which
11 came the guide that Monitor published on how governors
12 should discharge their statutory responsibilities.
13 There has been no evidence as to the effectiveness
14 of these courses or as to how widespread and available
15 they are.
16 Your ninth recommendation in your first report was
17 this:
18 "In the light of the findings of this report, the
19 Secretary of State and Monitor should review the
20 arrangements for the training, appointment, support and
21 accountability of executive and non-exec directors of
22 NHS trusts and foundation trusts, with a view to
23 creating and enforcing uniform professional standards
24 for such posts by means of standards formulated and
25 overseen by an independent body given powers of



1 disciplinary sanction."
2 This inquiry heard further evidence on the need to
3 provide training and support to those in leadership
4 positions. According to Martin Yeates, nothing trains
5 you for the pressures of becoming a chief executive.
6 He stated:
7 "There should be a structured mentoring process
8 whereby seasoned chief executives support those who are
9 new to the role."
10 He said this:
11 "There need to be people around and available to
12 bounce ideas and decisions off before they are
13 implemented and to talk to about whether or not you are
14 prioritising things correctly. If things stay as they
15 are it will continue to be the case that good directors
16 from whatever background are promoted and then left to
17 see if they sink or swim and that can't be a good basis
18 on which to proceed.
19 The need for greater and training and preparation
20 may well also be apparent in relation to the governors
21 of foundation trusts, on the basis of the evidence of
22 Mid Staffs if they're really to function as an effective
23 layer of quality assurance.
24 Additionally, more support may be required for
25 non-exec directors. Peter Bell stated that when he took



1 up the position of non-exec director at the trust in
2 2005, he knew no more than the average man in the street
3 about the NHS. By the end of an induction session at
4 the trust and a two-day course arranged by the
5 Appointments Commission, he still didn't feel up to
6 speed on the issues in the NHS and it took him about
7 a year before he was reasonably comfortable.
8 He said:
9 "More could possibly be done to prepare prospective
10 non-exec directors from non-NHS backgrounds in order to
11 ensure that more effective contributions can be made at
12 an early stage."
13 Sir, that completes what I have to say in general
14 about the trust.
15 In summary, there was at this trust clearly a lack
16 of clinical engagement with management.
17 The board did not receive critical material.
18 There was no external, proper challenge.
19 There was no challenge either from within or without
20 the trust, and the buck was allowed to stop within the
21 board.
22 Sir David Nicholson in his concluding remarks to us
23 said this:
24 "The board of Mid Staffordshire failed in its
25 statutory duties to provide good quality care to its

patients and managing within the resources provided. That no other hospital failed so profoundly and persistently in this period serves to emphasise the singular rather than the systemic nature of this case."

With respect to him, this seems to us to be a very dangerous attitude to take. The assumption is that any other hospital providing such poor care would have been uncovered by the systems in place. That, frankly, is a naive assumption and one which places reliance on a regulatory system which has been demonstrated to have failed in a significant way.

The assumption should be, we submit, the very opposite, that there are other failing hospitals and the system needs to be designed to ensure that those hospitals are also identified.

Sir Hugh Taylor accepted that the Department bore a degree of responsibility for the failure to regulate this trust effectively. He told the inquiry:

"It's clear that specific things went wrong in the regulatory and supervisory system in the case of this trust:

"There should have been better information sharing and closer working between the regulatory and supervisory agencies;

"Loss of continuity at SHA and PCT level must have



been a factor;

"The voices of patients and their families were missed by the agencies as well as by the trust;

"Flaws emerged in the way quality was assessed and also in the way that those assessments were interpreted. More sophisticated systems are needed in terms of trusts monitor their own governance and how this is regulated.

"The Department of Health [he said] cannot be absolved from these failings and has to take some responsibility."

Worryingly, however, even Sir Hugh Taylor ascribed to the sentiment expressed by other Department of Health witnesses when he said:

"... this case was so unusual in this regard. A one-off in fact, [which] means that one should be wary of lessons being extrapolated, as this case is the exception to the rule."

In her closing address, Ms Smith Queen's Counsel on behalf of the SHA described the events at the trust as the culmination of the perfect storm. In other words, an almost unique concatenation of events never likely to be repeated again.

With respect, we do not agree with that sentiment, and it is, in our view, a dangerous and inappropriate approach for any regulator or indeed performance manager



to regard the events of Mid Staffs as such. It is simply not logical to assume that in a regulatory system which has failed so profoundly in respect of one trust, there cannot be others failing in a similar way albeit for different reasons.

As the Patients Association pointed out in their closing address to you, in surveys in the Health Service Journal and in the Nursing Times, published shortly after the HCC report into Mid Staffs, there was a high preponderance of informed opinion of those who work within the health service which recognised similar issues of poor management and governance and poor levels of care of patients within their own trusts.

In our submission, the proper approach must be that there are highly likely to be other examples within the health service of poor management, poor governance and poor care, and it is the regulators' duty to discover them. This approach is supported by the many letters which the inquiry has received from all over the UK about alleged failures of care in other trusts and examples such as the undiscovered failures of care in Winterbourne View Home.

Sir Hugh was asked for his reflections on what had gone wrong and how a similar problem might be avoided in the future.



The bullet point issues which he identified were as follows:

If the local trust is not taking its duty seriously, it's always going to be difficult for the system to pick that up.

There is therefore a duty to ensure that trusts are complying with their duties on issues such as complaints, patient surveys, et cetera.

There must be an unceasing quest to engage with patients and obtain their views.

There should have been a more systematic and disciplined approach to the stewardship of regulatory bodies themselves.

The implications of the failure of a foundation trust should have been thought through by the Department.

Civil servants should encourage ministers to develop their agendas through a process of serious engagement with the system and services for which they are responsible.

Standards and quality measures developed by NICE must be allowed to bed in and be developed progressively. Unannounced inspections are extremely salutary for the organisation concerned, and should be continued.

1 Royal colleges have a role in developing the
2 standards with NICE, and in encouraging doctors to seek
3 peer reviews and supporting organisations in the
4 carrying out of peer reviews and encouraging active
5 professionalism among doctors.
6 Before ending the consideration of the evidence, it
7 is worth alluding finally to the final reports provided
8 by Sir Bruce Keogh when he was invited to add anything.
9 He made a number of points which are worth
10 repeating. First, he said:
11 "In terms of delivery quality it wasn't the CQC or
12 the PCT, it wasn't the SHA who treated patients badly in
13 Mid Staffs, it was individual clinicians, largely."
14 And therefore he said:
15 "For me in terms of really developing quality in the
16 NHS, there needs to be a significant focus on
17 professionalism."
18 He said:
19 "... if we want to improve quality, the first area
20 fee need to focus on, I believe, is improving
21 professionalism and focus on quality among individual
22 clinicians.
23 "The second level for preventing failure is peer
24 surveillance within the clinical team, and that means
25 when he see one of your colleagues not functioning as



1 well as you would like or they would like, is helping
2 them through that and bringing them back on track.
3 A good theatre team works like that, where even senior
4 people are told by relatively junior people that they
5 could do something better."
6 He said:
7 "The teams need to be supported within a healthy
8 organisation. So organisational health is important,
9 because how the organisation in managerial terms, in
10 leadership terms, supports the clinicians to deliver the
11 service is important. The board must be seen to ..."
12 The transcription is he said:
13 "The board must be seen to walk the talk."
14 But I think he meant "walk the walk":
15 "The board must be seen to be talking about
16 effective care, safe care and patient experience."
17 And for the fourth element he said:
18 "... is a national and regional system which
19 encourages, incentivises and regulates organisations to
20 ensure that they function as healthy organisations."
21 Sir, he said there a number of different levels
22 which I would ask you to consider.
23 Sir, it's right that I should end these submissions
24 by speaking very briefly about the patients who are at
25 the blunt end of this process of policy, budgeting,



1 commissioning and supposedly regulation.
2 As has been noted before, the higher up the
3 organisation of the NHS one travels, the further away
4 one is from the patients who are affected by the
5 decisions, and that is essentially what is meant,
6 I suppose, by the suggestion that the NHS needs to be
7 turned the right way up. The patient needs to be put
8 first again.
9 It would be invidious for me to choose any
10 particular patient story as an example of what can go
11 wrong when the management of a hospital doesn't do its
12 job properly, and in any event examples of what went
13 wrong were very much a part of your first inquiry.
14 But what we have gleaned from the evidence of the
15 patient relatives to this inquiry is that although the
16 experiences of patients at the trust about which there
17 was cause for complaint were many and varied, there was
18 a remarkable degree of consistency in their evidence
19 about the manner in which the trust and the wider NHS
20 responded to their concerns and complaints.
21 A number of themes emerged which were common to the
22 majority of patients' relatives and witnesses from whom
23 the inquiry heard. Those themes were:
24 Frustrating interactions with the hospital;
25 A slow and poorly managed complaints process;



1 A defensive attitude to complaints and complainants;
2 A reluctance to apologise and then badly worded,
3 meaningless apologies demonstrating a fear of
4 litigation;
5 A confused system of regulation.
6 Well, having spent the better part of a year
7 examining the system about which they were complaining,
8 we can perhaps sympathise with their frustrations. As
9 you heard in the first inquiry, and we have heard in
10 this, most of the patient relatives told us what they
11 wanted when things went wrong was a proper heart-felt
12 apology, an understanding of what had gone wrong and
13 why, and a genuine assurance that the same event will
14 not occur to another poor patient. In other words, that
15 the doctor will learn his or her lesson, as will the
16 hospital itself.
17 In fact, the truth is what all patients really want
18 is for things not to go wrong in the first place. We're
19 all in this room current or future patients of the NHS.
20 When we go into hospital what we all want, I suspect, is
21 a good standard of care, a degree of compassion and we
22 want to be safe. Proper management of each hospital and
23 proper regulation of the system should be able to ensure
24 that. Your recommendations we hope will assist the
25 Department of Health in meeting those simple ideals.

1 Sir, can I end by thanking my juniors,
2 Ben FitzGerald, Tom Baker, and Joanna Hughes who
3 contributed a considerable amount to this note.
4 Thank you.
5 Closing remarks by THE CHAIRMAN
6 THE CHAIRMAN: Mr Kark, thank you very much indeed for the
7 tremendous work that went into that closing submission.
8 I am afraid I must disappoint those present by saying
9 I have a few remarks of my own, but they are, you'll
10 also be glad to know, not nearly as long as that which
11 you've just heard.
12 Firstly, I need to say something about what follows.
13 After 139 days of public hearings and seven public
14 seminars, we finally reach the end of the public phase
15 of this inquiry.
16 The inquiry will now be adjourned to enable me to
17 consider all the evidence and the submissions made and
18 to prepare my report. Inevitably this will take some
19 time. I am not going to offer any indication of when it
20 might be ready to deliver to the Secretary of State, as
21 any estimate is likely to be wrong. However, I am as
22 always conscious of the need to complete this inquiry as
23 soon as is practicable.
24 I should say that in order to assist further in my
25 consideration of the wider issues involved, I am



1 intending in the course of the next month or so to visit
2 a limited number of establishments in order to observe
3 and identify examples of good practice and to provide me
4 with some context in relation to NHS healthcare
5 provision. I will, of course, ensure that the report
6 will contain a list of the organisations I have visited
7 for that purpose.
8 Turning to another matter, under Rule 13 of the
9 Inquiry Rules I cannot include any explicit or
10 significant criticism of a person in the report unless
11 I have sent that person a warning letter and give them
12 a reasonable opportunity to respond to it.
13 If in the course of my consideration of the evidence
14 I am minded to make an explicit or significant criticism
15 of an organisation or an individual, I will send
16 a letter to them stating what the proposed criticism is,
17 a statement of the facts I consider to substantiate it,
18 and a reference to evidence supporting the facts.
19 As the substance of many if not most potential
20 criticisms have been voiced and put during the course of
21 the hearings, I expect that the time needed for
22 a response will be short and it is unlikely that I will
23 grant more than two weeks for that purpose. Therefore,
24 I suggest that to the extent that they've not done so
25 already, core participants and individuals who have been



1 following the inquiry proceedings should be considering
2 what their response to such criticisms made might be.
3 I must emphasise that warning letters sent under
4 Rule 13 must be treated as confidential. Under Rule 14
5 a duty of confidentiality is owed by the inquiry team to
6 the recipient of the letter and by the recipient to me
7 as chairman, and where the letter has been disclosed to
8 a recognised legal representative by that representative
9 to me. That means that apart from any disclosure
10 authorised by me as chairman or otherwise by the rules,
11 disclosure of the contents of a warning letter will be
12 a breach of the rule and will be dealt with accordingly.
13 Can I then turn to some of the issues that clearly
14 have to be considered by me. No one who has followed
15 the proceedings of this inquiry can be in any doubt
16 about the impact the events in Stafford have had in the
17 wider health service and on public confidence in the
18 system.
19 While we have sat here, serious concerns have
20 surfaced elsewhere in various reports to which I have
21 been referred. Many of them have disturbing echoes of
22 what happened here.
23 To the extent that it was ever thought to be the
24 case, I do not think anyone now maintains that at least
25 some of the appalling experiences of which I have heard



1 are unique to Stafford. As is clear from the
2 submissions I have heard, there is almost a consensus
3 that much needs to be done to restore public confidence,
4 protect patients and to maintain appropriate standards.
5 As I have remarked at some of the seminars, there
6 seems to me to be a tide of public anger about what has
7 happened. I think this can only be assuaged by
8 identification and implementation of measures which
9 patients and the public are satisfied have a good chance
10 of achieving this.
11 This inquiry has heard evidence concerning a wide
12 range of issues. The challenge I face is not only to
13 address them, but to draw out the lessons to be learnt
14 for the system as it now is and indeed as it may well
15 change into under the proposed reforms.
16 Core participants and some witnesses have been
17 anxious to assure me that the lessons to be learnt from
18 this inquiry and any recommendations I make will be
19 considered carefully with a view to their
20 implementation. Obviously, I've not formed any
21 conclusions at this stage; in other words, instantly the
22 closing submissions have finished and before I've even
23 started writing my report. However, it is clear to me
24 that various identifiable issues will have to be
25 addressed and that I will have to come to conclusions

and probably recommendations on them.

I consider it may be helpful to those charged with planning and managing the ever-shifting components of the current system if I highlighted certain areas where I am likely to come to conclusions and make recommendations which could affect their thinking. This is not intended to suggest that a halt should be called in any particular planning or reform process, far from it. But it might diminish the help this inquiry can offer in such areas if those responsible are left unaware of the possibility of relevant points emerging from this inquiry. Therefore, I would like to make it clear that it is likely that I will have something to say on the following, among other issues:

Recruitment, standards, training and regulation of healthcare support workers.

The recruitment, standards and training of registered nurses.

The training and qualification of those charged with caring for the elderly.

The recruitment, training, support and regulation of senior managers of NHS organisations.

The standards applicable to healthcare generally.

The exercise of the fitness to practise functions of professional regulatory bodies.

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The engagement of healthcare generally in the leadership and management of their organisations.

The nature of standards set for the safety and quality of care, and which organisation or organisations should have the responsibility for setting and enforcing them.

The relevance of staffing levels and skill mix to those standards.

The interface between the regulation of governance, finance, and quality and safety standards.

The use of commissioning to require and monitor safety and quality standards or provision.

Methods of monitoring and enforcing those standards.

The potential adverse consequence of structural reorganisations and the requirements for addressing these.

The role of foundation trust governors and members, and other local public, patient and staff representatives.

The nature, scope and definition of a duty of candour and methods of enforcing it.

The involvement of external agencies in the complaints process and the use of information from it.

The obligations of disclosure to and obtaining of evidence by coroners.

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The means of embedding the patient voice throughout the system.

The development, collection, use and sharing of information and data, including safety alerts, mortality data and performance indicators.

And the protection of whistle-blowers.

I should emphasise that long though that list might appear to be, it is not exhaustive and no significance should be attached to its ordering.

Finally, may I turn to some thanks.

I have already expressed my thanks to counsel to the inquiry and his team, but I must repeat it today. Mr Kark, Mr Fitzgerald, Mr Baker and Ms Hughes have undertaken outstanding work at this inquiry. Their tireless efforts on my behalf in analysing huge quantities of material, often at very short notice, and then presenting it at these hearings has been invaluable and they're owed a great debt of gratitude.

I must also thank the solicitors' team led ably by Peter Jones. Much of their labour has been out of sight but it has been hugely significant. Their work in obtaining evidence often in very sensitive circumstances has been outstanding.

The secretariat team led by Alan Robson has succeeded magnificently in creating the complex

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infrastructure of an inquiry from a blank sheet of paper and keeping the show on the road and communicating and recording it with calm efficiency. Without them, very little of this inquiry would have happened at all and I am very grateful to them for all their efforts.

I would like to thank once again the legal representatives of all the core participants for their diligent assistance to this inquiry. Without their responsible and constructive contributions my task would be even more difficult than it already is.

Thanks must also go to the Stafford Borough Council and their staff for allowing us the use of their facilities and in the process causing a great deal of disruption to their normal operations, I am sure they'll be glad to get their offices back, but the community should recognise that without the council's assistance it's unlikely this inquiry, so important to local people, could have taken place in Stafford at all.

I am, of course, enormously grateful to all the witnesses who have given evidence to this inquiry, particularly patients and their families, but also to all those from within and around the NHS system. Giving evidence to an inquiry can never be an easy thing to do but it has been absolutely essential and I am grateful to each and every one of them.

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1 Finally, I am grateful to the people of Stafford and
2 Staffordshire, not only members of the public attending
3 the inquiry who have continued to do so with great
4 dignity and patience but also the community whose
5 members have helped us all here in ways large and small
6 while we've lived amongst them. In spite of the sad
7 circumstances which have brought us here, there's much
8 here for them to be proud of. I will do my best in
9 preparing my report to ensure that they are paid due
10 respect by the identification of the steps that need to
11 be taken informed by the lessons learnt from their
12 experiences. Thank you.
13 That is the formal end of the inquiry proceedings.
14 (4.04 pm)
15 (The inquiry adjourned)
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