THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Witness Statement of Ken Lownds

I Ken Lownds will say as follows:-

Background – My interest in the NHS

1. I have always been interested in the National Health Service ("NHS"). NHS hospitals have been a big part of my life. My grandfather was on the hospital management committee for what is now University Hospital of North Staffordshire. Prior to that he was a coal miner which meant that he spent a lot of time in hospital due to injuries to himself or his colleagues. My grandfather’s role was in fact that of a modern non-executive director.

2. I also spent a significant period of time visiting my brother in hospital who was being treated for cancer and who sadly died in hospital. I got to know his consultant, Spencer Trafford, quite well as I had known him since primary school. I was also admitted myself a number of times into hospital and was just generally interested in how the NHS was run.

3. I then went off to University and had very few dealings with the NHS until in or around 1996 when I bought a house back home near Stoke. I actually moved back to live here in or around 2000.
4. In 1999, I helped set up a Construction Best Practice Programme (CBPP), which was a national initiative at the time and I received a Government award for my efforts. The most pleasing and rewarding aspect of it was setting up and running two Construction Site Safety days to highlight the dangers to construction workers and to take some part in changing the culture. I am pleased to say that the safety behaviour on construction sites today is very, very different from that which I experienced when running these campaigns.

Return to Stafford – Joining the PPI forum

5. As we were based “back home”, I again became interested in what was happening in the NHS locally. In 2003 I joined the PPI forum for University Hospital North Staffordshire (“UHNS”), which was/is my local hospital. In my experience, public/patient oversight of the NHS is an area which as a society we have not fully understood. Discussing this in 2009 with Malcolm Alexander of the National Association of LINk Members (NALM), he suggested we need a new “model” for patient and public involvement; I responded the only model was no model.

6. Prior to PPI forums there was a different type of forum in place with a number of Community Health Councils (“CHCs”). CHCs had a role of overseeing the NHS but these were shut down by Hazel Blears in or around 2003 and replaced by PPI forums. I understand that there is a 2002 Act which sets out what the role of the PPI forum is and what is has the power to do.

7. In relation to Patient forums, it is my experience that people from the community recruited to such formal bodies find it difficult to go beyond “pleasant” conversations with the hospital and its management and rarely wish to take on the establishment. At the time when I joined the UHNS PPI forum, whilst it is fair to say that I was a novice in hospital
issues (as I knew little outside of what I had learned from my grandfather whilst growing up), I trusted hospitals implicitly. I imagine many people do. I spent no time considering things such as mortality statistics and what these could indicate about hospital performance. However, I quickly came to realise that hospitals were missing something vital.

8. There were no key operating standards. It seemed to me that key principles such as “zero harm” and “right first time” had passed the NHS by. Concepts such as quality management and control, which were second nature within industry generally and essentially placed the emphasis on doing things right first time, had also passed the NHS by.

9. I was personally particularly interested in certain departments such as ophthalmology and I began asking questions at some of my early visits with the PPI forum of such departments as to what standard operating procedures were in place. It became clear that there was no well defined system in place to which everyone worked. Consultants in a particular department slotted into how the senior consultant wanted things to be done. One of the first examples I saw of what I now call “managerialism” – others might call it bureaucracy – was the amount of time a consultant ophthalmologist was forced to spend in meetings, simply to set up with partner hospitals in Staffordshire and Shropshire a clinic for a new treatment for sufferers of macular degeneration. In order to offset his frustration, I took on the responsibility of setting up a North Staffordshire branch of the Macular Degeneration Society.

10. I attended a whole day’s workshop mounted by the Director of Nursing during which half a dozen nursing “leads” presented outlines of a range of innovations which they themselves had planned and implemented.
11. I made a visit to the colonoscopy clinic with a PPI forum colleague, and while it was located in a Victorian building, the team that I met was very impressive and was actually an example of what Cure the NHS call an organisation that has been “turned the right way up”; that is, an organisation which is led by the front line. What this means is that the sister and nurses were given free reign to design how the clinics operated and the consultant in charge supported them because their leadership reduced the administrative burden on his own shoulders, leaving him to concentrate on purely clinical matters.

12. On another occasion when the hospital’s A&E department was in “respite”, which means that the hospital was full and couldn’t accept more patients, I visited with the Director of Nursing the department very early one morning to meet the staff and in particular the bed managers. I found that they were using old fashioned perspex planning boards and were trying to manage this very large hospital at full capacity with this outmoded equipment and without the kinds of simple locally designed software that would have made their lives and more importantly their patients’ lives very much better.

13. As I was looking at things from a systems perspective, I was quite shocked at what I saw. However, colleagues on the PPI forum seemed to have no particular interest in what I had to say about the need for systems and standard operating procedures. I think it is fair to say that I probably did see things during my time with the PPI forum for UHNS which I should have challenged more vigorously, but that is something that is easy to say with hindsight. Whilst I was shocked at what I saw I was also well aware that the forum was frequently being suborned by the hospital Board. The forum as a whole was probably over-respectful and was certainly easily managed by the hospital. This was perhaps because there were a number of people on the forum who had been “touched on the shoulder by the hospital”.

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14. Membership of the PPI forum was via application but the interview was almost meaningless. The Department of Health had set up an organisation called the Committee for Patient Involvement in Health ("CPIH") and it was this organisation which appointed people to sit on the PPI forum. However, this organisation simply appointed a paid set of supporters; in Stoke’s case this was Age Concern, which did all of the admin in relation to the local PPI forums. From my experience it was fair to say that Age Concern was confused about its role in relation to the forums, and neither Age Concern nor the Committee for Patient Involvement in Health took much of an interest in terms of appointments to the forum or the forum’s progress.

15. Those that sat on the forum were generally encouraged to join by the hospital. Forum members were not paid and could be involved as much or as little as they wanted. When I got involved it is fair to say that I wanted to find out what was going on at the hospital but most of the other forum members didn’t seem to be particularly concerned in terms of drilling down to find out what was really going on on the ground.

16. The intention was for a PPI forum to have one meeting per month, but it was possible to set up smaller sub-groups to engage with specific tasks or groups of people within the hospital. However, in my experience these groups rarely achieved much. I did not see either the main forum or any of the other sub-groups taking a particularly active stance in order to seek views either from the hospital or the public about how the hospital was being run, or any of the issues that it faced. It was my view that the role, or at least one of the roles, of the PPI forum was to act as a societal challenge on the hospital – to hold the hospital to account. However, I did not really see the sort of challenges of this nature taking place within the forum that I belonged to. The forum did set up a number of interface meetings with the hospital and the hospital seemed happy for the forum to do so. Very little was achieved at these meetings.
17. A major issue that was emerging at this time, that is 2004, was hospital acquired infections. I was disappointed and perhaps alarmed at the inability of the hospital’s executive team to work out how to tackle what was in essence a crisis. The difference between the approach I would have seen in my various jobs in civil aviation and the one I saw in the NHS was stark.

18. Each hospital appointed a deputy director of nursing to act as the lead PPI interface between the forum and the hospital. In the case of the PPI forum for UHNS, this seemed to work fine until an issue came up in relation to a particular physician. This particular physician came forward to say that he believed that the Medical Assessment Unit was in a mess and needed urgent attention. I put an examining group together (a sub-group from the main forum) to look into the matter and we developed a survey to try to understand the nature of the problem within this particular unit. I spoke to the physician directly and began to work out a proper sample for the survey. However, as soon as I began to engage with the hospital about it, the PPI lead at the hospital stopped communicating with us and sought to bury the issue. There appeared to be no appetite from the forum members to change what was going on and examine why the hospital was refusing to engage with us. It seemed to me that the success of the forum was heavily dependant on the forum’s contacts within the hospital and, in our case, when we came face to face with the hospital, the PPI lead decided not to engage with us on an important issue. The matter was allowed to be kicked into the long grass.

19. I don’t doubt that the PPI forum was considered to be a thorn in the hospital’s side. When issues were raised they simply did not want to deal with, the issues were simply pushed aside and the person responsible for being the interface with the forum simply chose not to engage the issue any further. I don’t doubt that such a decision would have had the support of the hospital’s Chief Executive.
20. In addition to the 2002 Act which set out the role of a PPI forum, there was a rule book which set out how a PPI forum should function. My recollection is that the forum answers directly to the County Council Oversight and Scrutiny Committee. However, I was unclear as to the involvement that this Committee actually had with each forum or the interaction between this Committee and Age Concern/the CPIH.

21. I began to become increasingly frustrated with the other members of the forum and with the way in which the hospital responded (or rather didn't) to requests for information from the forum. In my role as both a forum member and as a member of the public I was keen to understand how the NHS worked within North Staffordshire. I really wanted to get to the nut and bolts of what the problems and challenges were locally. I remember explaining this to an Associate Medical Director and I recall his response, which was "Ken, when you understand the NHS, come and explain it to me".

22. I was also aware that a number of PPI forum members were getting into fights with hospitals over the issue of inspections. Forums were frequently refused access to hospital departments and this caused considerable friction. However, I was of the view that you needed really to get inside an organisation by getting to know people and that simply carrying out short inspections was insufficient if you want to really understand what was going on. I think that those from a Community Health background believed in turning up and doing unannounced inspections. It was my view that it was impossible to see what was really going on in such a short space of time.

23. Even when members of a PPI forum did carry out inspections or produced reports, it was my experience that they were simply stonewalled by the hospital and the Board.
24. During my time on the UHNS PPI Forum I did meet an extraordinary campaigner, Ian Syme, who did a lot of advocacy on behalf of patients. Ian did lots of work with the local newspaper and he spent time getting to know the local politicians (who were all Labour MPs until recently). I would attend briefing meetings with these politicians along with Ian. Ian started the North Staffordshire Health Watch with some of the parents of the babies affected by the actions of Dr David Southall. This meant that Ian found out a lot of things the public would not want to know about how hospitals really worked. I learned an enormous amount from him.

25. Over the years I had got to know a few people who had been involved in the local CHCs. Whilst the CHCs had also struggled to achieve change, it did seem as though the members had worked out a modus operandi for the best way in which to move things forward and engage with the hospital. To my mind, this meant that when the PPI Forums came to be set up, the struggle of establishing a modus operandi of interfacing with hospitals started afresh. However, the PPI forums seemed to take a step backwards in terms of their ability not only to work with the hospitals to bring about change but even to get a foot in the door in the first place. I quickly became frustrated by both the lack of desire of my fellow forum members to “push back” against both the leading nurse interface, and the board itself failing to demand greater access to the hospital. I later became aware that the Chairman of the hospital’s board did not believe in the entire concept of patient and public involvement forums, and was prepared to let us founder rather than help us to find a meaningful role.

26. In February 2005 I became the Forum’s Chair and prepared a document to re-launch the Forum with the support of the hospital. This document included seeds of some of the ideas which Cure the NHS have been promoting for the last 18 months. The hospital’s PPI lead, the Deputy Chief Nurse, rejected each and every one of these ideas so absolutely that we were able to share a joke about it with her.
As Chairman I attended hospital board meetings, including the closed sessions from which the public were excluded. It was at one of these meetings during a discussion on the Foundation Trust concept, that one of the non-executive directors, hearing that there were to be Governors elected by the public, asked "but how do we get the right people?". This put me on my guard about Foundation Trusts and I immediately started to research the details.

27. At one of these closed board meetings, I first heard about the very large deficit that the hospital finance team had just uncovered.

28. Unfortunately I then had to leave the forum to concentrate on personal business.

**UHNS' financial problems**

29. In autumn 2005, very major deficits emerged across the NHS. The one at UHNS was among the worst. Patricia Hewitt was now Secretary of State for Health, and she vigorously pursued every hospital to put their finances back in the black. In December 2005, because little progress had been made on the deficit at UHNS, its entire board was asked to resign, which it did.

30. In early 2006, Patricia Hewitt herself visited UHNS to demonstrate how seriously she treated this situation. The deficit threatened to derail a PFI project to rebuild the entire hospital. Local MPs lobbied her vigorously and she provided from Department of Health funds £60 million to rescue the project.

31. This was a time of enormous transition in the NHS in the West Midlands. The Strategic Health Authorities ("SHAs") were merged into one to be called West Midlands SHA. In Mid and South Staffordshire all of the Primary Care Trusts ("PCTs") were reconfigured. The prime mover in all of this was David Nicholson, who had been Chief Executive of the Birmingham and Black Country
SHA and who from mid 2005 until mid 2006 was Chief Executive of all of the Midlands SHAs as they went through the merger process, and then became West Midlands SHA.

32. While UHNS was having its board removed and replaced, was receiving visits from the Secretary of State, and having an extra £60million injected into its funds, Stafford hospital with a much smaller but still significant deficit was being pushed hard by David Nicholson to go forward with a Foundation Trust application. This seems completely the wrong way around. I attach to my statement as Exhibit KL1 [ ] a letter from David Nicholson which followed a “board to board” challenge between the West Midlands SHA board and the Stafford hospital board, which David Nicholson and Anthony Sumara both attended to assess the state of readiness of Stafford hospital for Foundation Trust application.

33. With hindsight we know that Stafford hospital should have been receiving all the support it could get to put patient care and patient safety back on track, rather than concentrating on applying for Foundation Trust status. It is clear from that letter that there were significant gaps in Stafford hospital’s readiness and capability at that stage, and it was offered support by David Nicholson. Cure the NHS would like to know if that support was accepted and what actions followed.

34. In early 2006 I attended a board meeting at UHNS and for the first time met Anthony Sumara, for whom we later lobbied to take over at Stafford hospital.

35. In mid 2006 David Nicholson became Chief Executive of the NHS. Cynthia Bower succeeded David as Chief Executive of West Midlands SHA for a further 3 years until she became Chief Executive of the Care Quality Commission (“CQC”) on 1 April 2009. Two key executives with an intimate knowledge of Stafford hospital and its problems were therefore, by the publication of the Healthcare
Commission’s report on 18 March 2009, at the helm of the NHS and its regulator.

36. In March 2009 I attended rallies in both Stoke-on-Trent and Birmingham, which had been organised to highlight the threat posed by the deficits to the quality of care and to the number of jobs in the NHS. At the rally in Birmingham I joined a number of Royal College of Nursing (“RCN”) representatives from UHNS and the West Midlands. Peter Carter, Chief Executive of the RCN, and Dave Prentice, General Secretary of UNISON, both spoke at the Birmingham rally, threatening the Government with dire consequences if the NHS and jobs should be harmed. These were two people to whom Cure the NHS later appealed for help in righting the situation at Stafford hospital. We discovered that neither was able to offer the support we had hoped.

**UHNS application for Foundation Trust status**

37. I had kept in touch with a number of the local campaigners who made me aware that they were starting a campaign against UHNS’ application for Foundation Trust status, and so in 2008 I started to attend board meetings there again.

38. When UHNS issued a consultation paper for its decision to seek Foundation Trust status in summer 2008, I decided to get involved in the campaign to fight the award of this status to the hospital. By this time my researches had convinced me that Foundation Trust status was a pathway to privatisation and was very far from being a more democratic way of running NHS hospitals. I attach to my statement as Exhibit KL2 [ ] a slide from a power point presentation by Chairman of Heart of England NHS Foundation Trust, Clive Wilkinson, that clearly shows the view that Foundation Trusts perceive themselves as businesses.
39. A paper by Frank Dobson, former Health Secretary, for members of the House of Lords, showed very clearly some deep concerns about the governance model for Foundation Trusts:

(1) MPs could no longer get answers to oral or written questions about Foundation Trust hospitals in their own constituencies from the Secretary of State or the Department of Health, and would simply be referred back to the hospital Chairman.

(2) The mechanism for electing governors from a list of public members of the hospital was far from democratic. I attach as Exhibit KL3 [ ] a spreadsheet showing the tiny numbers involved in these elections for public governors at Stafford hospital.

(3) By far the most serious deficiency is that the boards of Foundation Trusts are freed from the duty imposed on other NHS hospitals by the Public Bodies Access to Meetings Act 1960, of holding board meetings with the public and press present. This means that FT boards can make any decisions they wish, virtually free from public scrutiny. The governors, who are supposed to hold the board to account on behalf of the local community, have proved totally inadequate across Foundation Trusts, and this was dramatically demonstrated in the case of Stafford hospital.

Becoming involved with Cure the NHS and raising matters with politicians

40. In September 2008 I was involved in drafting a press release in relation to my local LINk campaign against the application for FT status at UHNS. I sent this to Local Midlands BBC Health correspondent, Michele Paduano. In response Michele sent me an email stating that UHNS was a lost cause in terms of fighting Foundation Trust status. He also sent me a press release from the HCC which related to its investigations in respect of Mid Staffordshire
Hospital. This was the first time I became aware of the problems at Mid Staffordshire Hospital.

41. The purpose of the press release was that the HCC seemed to be aimed at getting the attention of the Chief Executives of hospitals making it clear that they must "shape up". At that time Mr Paduano also put me in touch with Julie Bailey and explained what Cure the NHS was about. I contacted Julie and following an initial two hour telephone conversation, I met with her and the rest of Cure at the Breaks café in October. When I heard about the problems that they had all faced in relation to the poor quality of care of their relatives at Mid Staffordshire Hospital, I couldn't believe what I was hearing. I was deeply shocked and moved by the stories of the brave group of people who had been affected and said that I would help them in any way I could. In spite of what they had all been through they remained hopeful and were cohesive as a group in trying to bring about change.

42. I told the members of Cure that I would be prepared to assist them by using some of the contacts that I had developed over the years. One of the first people I decided to make contact with was Ann Keene, who at that time was Parliamentary under-Secretary of State for Health. I had understood that part of her portfolio was to deal with issues of patient safety and so I drafted a letter to her setting out a summary of all the incidents that members of Cure reported to me and I also included a number of press cuttings. I attach this letter, dated 11 February 2009, as my Exhibit KL4 [ ].

43. At the same time I also contacted my local MP, Bill Cash. Bill told me that he had received some complaints from patients and relatives about their treatment at Mid Staffordshire Hospital and he gave his word to me that he would get stuck in, and he did. I gave him a copy of the letter that I had prepared for Ann Keene and asked him to pass it on for me, which he agreed to do. I assume he did pass the letter on but I don't recall ever receiving a response from Ann. It was not
until September 2009 that I managed to meet with her, at the same time I met with David Kidney.

44. From that moment on, Bill was a staunch supporter of what I was doing to help Cure the NHS and indeed a support to the group as a whole. I felt that Bill vigorously campaigned on our behalf inside the Conservative party, who were in opposition at the time, to push for a Public Inquiry. Bill has been a tower of strength in providing us with all sorts of guidance and assistance on how Westminster works.

45. At that time I also contacted Bill Moyes, Chief Executive of Monitor, which I attach as Exhibit KL5 [ ].

46. The next key event was in March 2009 when Monitor, completely out of the blue, suspended the Chair of Mid Staffordshire Foundation Trust, Toni Brisby, and the Chief Executive, Martin Yeates. This came as a surprise to the whole community and not least to Cure the NHS. We understood that they had been asked to stand down from their roles, but later discovered that Martin Yeates had received a payout, which we found incredibly distasteful in the circumstances. We are disheartened to see that he has still not given his side of the story and was not involved in Robert Francis’ first Inquiry.. Nevertheless, at that time, the suspension of Toni Brisby and Martin Yeates gave us some hope that things were changing. A press release, issued by Cure at the time, is attached as Exhibit KL6 [ ].

47. We were dismayed at the response of the staff when the announcement was made that the two individuals had stood down. Many seemed unable to understand what had happened and wanted to point the finger at Cure rather than show concern for the stories about appalling care at the hospital. The staff appeared to have enormous loyalty to Toni Brisby and Martin Yeates.
Monitor then appointed David Stone and Eric Morton as Interim Chair and Chief Executive of the Trust. We hoped that by having a new Chair and Chief Executive, albeit interim ones, this would result in a positive change at the hospital. David Stone later came to the Breaks café to meet the group, but the meeting was very uncomfortable and unproductive. He didn’t even bring paper and a pen, and he began the meeting by stating how lucky we were to have a Foundation Trust in our area. This was very badly received by the group, and we told him so. I think he realised his mistake as he later apologised to me. I think he had just been sent in to do a job without realising the enormity of it, and I don’t think he knew what he was facing at that meeting.

49. David Stone went on to set out a 107 point action plan but really nothing seemed to get any better.

50. We experienced the same with Eric Morton.

51. When the Health Care Commission (“HCC”) published its report on 18 March, Eric gave a number of television interviews from outside the hospital stating how things had changed and the issues were all in the past; at the same time there were Care members sitting in the café who had lost loved ones that very morning. There was a huge inconsistency between the reality of the situation as we were experiencing it, and what the hospital wanted the public to know. I remember calling Manjit Obhra, who was Associate Medical Director at UHNS at the time to discuss my concerns with him about leadership and management following Eric’s interview. I discovered at that time that he had already been appointed Medical Director at Stafford and was due to take over soon, so he engaged with me and listened to what I had to say.

52. As damning as the HCC’s report was, we were aware that it had been with the hospital’s board for several months and assumed that this
was because there was fighting between the Government, the NHS Monitor, and the hospital over what should be excised. Cure the NHS would like to see a full copy of the draft as it was when it was first completed by the HCC.

53. The Government responded very quickly to the release of the HCC report. Alan Johnson made a statement to say that Professor Sir George Alberti and David Colin-Thome would be commencing investigations. There was also to be a series of Independent Case Note Reviews, although we quickly realised that this was badly organised – it wasn’t independent and didn’t get off the ground for approximately 6 months after it was announced.

54. Both Professor Alberti and Dr Colin-Thome came to meet the group during their investigations. We found Professor Alberti did not engage with us properly and when we asked him about if he had looked into the care on the wards he seemed to say that he “might have run into a couple of nurses in the corridor and asked them”. David Colin-Thome on the other hand took the issues very seriously and listened to us carefully. We met him on a number of occasions and felt he was pushing hard for change, but he simply was not able to do his report properly in the time allocated to him.

55. Around this same time, between February and March, I contacted Bill Moys’ office at Monitor to see if I could go and see him to talk about the issues and the ideas of the group. I spent half an hour with him but we did not make much progress. Nevertheless I continued to engage in correspondence with him until about July 2009.

56. Soon after the publication of the HCC’s report, I recall that Alan Johnson visited the hospital with Chief Nursing Officer Christine Beasley. He also took the opportunity to visit the café with Christine. He was very personable and it was clear that he was shocked by the wall of photos and the force of the views of the group. We told
Christine Beasley that it was our view that what Stafford needed was a team of experienced nurses from the West/East Midlands to come into Stafford and supervise the current teams. Christine Beasley said nothing and this never happened. At the time I also told Alan Johnson about my contact with Ann Keen and my letter to her, and he said he would facilitate a meeting with her, but that did not happen either.

57. On 2 April I followed this up with a visit to Alan Johnson’s office to meet with his advisor Mario Dunn. Catherine Hawes, a civil servant from Alan’s private office, took minutes. I never saw the minutes but recall that it was at this meeting I first raised our “stop and make safe” policy. This policy recommends that the board of every NHS hospital should have a special meeting on a regular basis to set out mortality rates and other hard data for the public. We then set about incorporating this and other ideas for change into a document, which we started to call “Turning the NHS the right way up”. We gave this both to Alan Johnson and to Andrew Lansley, Shadow Health Secretary, in May 2009.

58. At the meeting we also talked through our recommendation that the NHS needed to have a regulatory system similar to that employed by the aviation industry, and also about leadership coming from frontline staff rather than executives. I also referred to my experiences with other organisations such as Toyota, as an example of how quality management could be done well.

59. I felt that Mario, as advisor to Alan Johnson, was dismissive of our ideas. Mario suggested that the group should stop criticising the staff at the hospital and should simply move on. I found this to be insensitive and contemptible given the findings in the HCC report. That meeting was the last occasion that Cure the NHS was welcomed at Richmond House and we had no further meetings with Alan Johnson.
60. Also at around that time – April/ May 2009 – David Cameron came to visit the café. He made a very public commitment to campaigning for a full public inquiry. Ironically, we started to get the feeling that the opposition party was more interested in assisting us than the current Government were.

61. In or around April Julie and I also met with Peter Carter, the Chief Executive of the RCN. We challenged him about the letter he had written to the Press a year earlier during the HCC’s investigation, where he praised the hospital management, including Helen Moss, the then-Director of Nursing. We later discovered he had also written to Helen Moss herself to express the same sentiments. Nevertheless he claimed at that meeting that he did not know what had been going on at the hospital, but it was clear that he had been ignoring cases of bullying and incident reports that had been put forward by staff. He was only interested in protecting Helen Moss as one of his members. We had also invited David Prentice of Unison to come and meet with us at the same time as Peter Carter, but he showed no interest until a campaign was launched on behalf of the staff.

62. Baroness Young, Chairman of the CQC, came to meet the group at the cafe in the same month. On that day Julie assembled a group of members who were recently bereaved and had witnessed the kind of appalling care that was so dammingly set out in the HCC’s report, thereby demonstrating that little had changed. Again, nothing came out of that meeting.

63. The next flurry of activity came in July 2009 when the House of Commons Health Select Committee published its report on Patient Safety. The Committee had been sitting since the previous October and had looked at a whole range of patient safety issues, but as far as I can recall it did not touch upon bedside care. I believe there is a tendency to view patient safety simply in terms of the direct medical
treatment such as operating theatres, provision of medication and such like.

64. Cure had made two submissions to the Select Committee, although we were not allowed to give oral evidence, which we saw as unfair given that the hospital, the RCN, and the Royal College of Physicians were all entitled to have their say. We found that the questioning wasn’t very robust and the RCN made a number of submissions that we disagreed with – including the suggestion that a large number of incident reports have been submitted by RCN members from Stafford but that these had somehow gone into a black hole and couldn’t be found. We question whether this did indeed happen, but if it did, it raises concerns as to why the RCN had not done anything to tackle the issues raised with hospital management. In my view, this merely suggested that the RCN wasn’t willing to get involved and take on the hospital management.

65. The Select Committee report was quite damning in its own way but unfortunately no action seemed to follow.

66. In July 2009 there was a public meeting in Stafford about the hospital crisis. Dr Colin Thomé and Professor George Alberti were both in attendance. Dr Colin Thomé left enraged that nothing seemed to have changed at Stafford.

67. Dr Colin Thomé went back to the Department of Health and said that it was clear that we were not being listened to and that nothing was changing at the hospital. Andy Burnham MP was Health Secretary by this time, and the group started pressing him for change. The combined pressure of Dr Thome and our own efforts resulted in Anthony Sumara being recruited as the new Chief Executive.

68. Anthony had a reputation for being a “turnaround guru” and I was aware that he had previously held roles in the Birmingham and Black
Country SHA, and West Midlands SHA. He had also previously been the Chief Executive for UHNS and for Hillingdon Hospital, and he had also had a role in the London Primary Care Trust as a turnaround guru before coming to Mid Staffs.

69. In May/June 2009 a paper was released by North Staffordshire PCT which said that lessons needed to be learned from what had happened at Mid Staffordshire. Publicity about the hospital was therefore continuing to gain ground. In discussions with North Staffs PCT I learned from their Deputy Chief Executive Celia Riley that in 2005 as a staff member of the Department of Health’s regional office, she had been sent to Stafford hospital to investigate concerns but had found “the doors closed to her”.

70. Julie and I met with Anthony Sumara and Manjit Obhrai, the new Medical Director, in August/early September 2009. We discussed all of the issues that we were concerned about, and told him how we thought he needed to tackle the problem by clearing out the core of nurses, junior managers and supervisors who had ultimately been responsible for the unacceptable care suffered by so many. Anthony was very good at taking the criticism, and listened to all of our concerns. We presented him with a new version of our “Turning the NHS the right way up” document, specifically tailored to the hospital and setting out all of the elements of the culture change programme and systems implementation, which we believed would transform the performance of the hospital.

71. We have since spent many hours as a group discussing matters with him, and I believe he has really wanted to effect change within the hospital, but sadly our view is that without those core people being removed entirely and changing the supervisory system, the care on the wards will not improve.
72. By this point we felt we at last had the ear of the new Chief Executive, and that at least some progress could be made. We continued to liaise with our MPs, and Bill Cash in particular wanted to be kept informed of what was happening.

73. The independent inquiry chaired by Robert Francis was announced in July, but we were still very frustrated and felt that this was a disastrous mistake because it was not a Public Inquiry as we had hoped.

74. We were also disappointed at the lack of action from Andy Burnham. Julie and a group of Cure the NHS members "ambushed" him at his constituency office in Wigan in September 2009. Interestingly, the Wigan and Leigh NHS Trust had a worse standardised mortality rate than Mid Staffs. Julie and the group harangued Andy Burnham for about half an hour in the street; he did not invite them inside and away from the cameras. It was all recorded on video and received quite a bit of publicity. For whatever reason Andy Burnham did not seem to be prepared to spend any time talking to her.

75. Shortly thereafter we began a series of letters to Andy Burnham which continued through into 2010. I attach these letters as Exhibit KL7 [ ].

76. Since the Conservative party come into power, Cure the NHS has felt that the new Government generally seems much more eager to engage with us and Cure the NHS was given the opportunity to address the Conservative party conference in October 2010, where I presented the latest version of our document "Turning the NHS the right way up", which I attach as Exhibit KL8 [ ].

77. These are of course conclusions and thoughts on looking back with hindsight on events in Mid Staffordshire and since my involvement with Cure the NHS the group and I have had a clear view of what
needs to change in the NHS. I set out what conclusions we came to and what should be done to return the NHS to what we want it to be in a separate document to be provided to the Inquiry.

78. I am content to give oral evidence to this Inquiry if required.

Statement of Truth

I believe the facts stated in this witness statement are true.

Signed .................................

Ken Lownds

Dated .................................

16 Nov 2010
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL1 [ ] to the Witness Statement of Ken Lownds
In Confidence

Mrs Toni Brisby
Chair
Mid Staffordshire General NHS Trust
6 January 2006

Dear Toni

Initial Feedback to Mid Staffordshire General Hospital on Foundation Trust Diagnostic

Thank you for your Board's cooperation in the Foundation Trust Diagnostic Programme over the past three months. We set out below our initial feedback so that you are clear of what we consider to be the Trust's actions.

In light of our discussions at the Board to Board Challenge meeting on 22 December you will now be considering your action plan in response to the key issues identified. The FT Diagnostic Team will meet with the Trust to support this process during January and we will meet with you again in February to sign off this action plan and to agree with you a likely timescale for your FT application, which we can then share with the Department of Health and Monitor.

We will forward to you a summary of the outcomes of the diagnostic review when the Department of Health and Monitor have approved release, which we expect to be by the end of January 2006. This report will be a working document, confidential for the Trust Board members. The action plan which we will agree in February will not be confidential.

Initial view of readiness for FT application and next steps.

The provisional view presented to us by the Diagnostic Team prior to the Board to Board process was that the Trust was at least two years away from being in a
realistic position to meet the criteria for application. The main factors affecting this are:

- One star status
- Lack of a robust strategy that includes a convincing plan for Cannock Chase Hospital
- Confidence in the ability of the Trust to deliver the large recurrent cost improvements (≥5% of turnover) year on year.

Key Assessment Issues

Many issues were discussed during the Board to Board meeting and I know that you will not be waiting for a summary from the SHA before getting on with addressing these. For the record, however, the following are specific areas for you to focus on in your action plan:

1 Strategic direction

   a) The Trust needs to determine and define its strategy and implementation plan. The strategy you presented was aspirational and not sufficiently robust. We were unclear whether the Trust's plan was service expansion or contraction. You did not adequately address the risks around under-utilisation and clarity is needed about the financial contribution that Cannock Chase Hospital is making to the Trust's business. These are fundamental issues about which you need to be clear if you are to convince Monitor that you are ready for FT status.

   b) Clinical engagement and leadership in respect of the strategy and implementation plan are areas for further development.

2 Modelling the down-side

   a) The Trust needs to be clearer of the down-side case, specifically issues regarding:

- orthopaedic capacity remaining under-utilised
- shift in tariff under PbR
- impacts of patient choice and successful demand management schemes in the downside case

A clear clinically and financially sustainable alternative service (i.e. a realistic "Plan B") should be considered and modelled, showing what the Trust would do should these risks materialise either individually or collectively.
3 The financial environment and viability

a) The Trust has a plan to repay the historic debt over the next two years. We were confused about the Cost Improvement Programme (CIP) contributions during the meeting, and whether the Trust had a plan to deliver £9.6M or £8.5M this year. This appears to be an issue of definition regarding internal and external contributions to CIP which should be clarified before the action plan in this area is confirmed. The key issue regarding the CIP amount is the saving required as a percentage of income and how realistic the plans are in light of the percentages being higher than achieved by other Trusts. The Trust needs to ensure that its plans to deliver the cost savings are identified by item, quantified and systems put in place to ensure delivery of these, as the Trust identified that performance management of CIPs is an area that requires improvement.

b) The Trust needs to formalise processes and reporting of clinical and productivity improvement indicators and to link these to service and recovery plans.

c) The Trust needs to develop the cost and contribution understanding of each of the individual service areas as well as individual sites.

d) The Trust is reliant on two commissioners (93% of income) and there is a need to consider mitigating actions regarding the potential for changes in commissioner plans and associated income risk next year and beyond. In 2005/06 the Trust has significant over-performance with both commissioners. In view of the poor financial position of the overall health economy, this is unlikely to be affordable.

e) Currently both the Trust and its two commissioners are planning that Choice will have little impact on service demands. This may be short-sighted. The Trust activity plan differs from South Western Staffordshire PCT plans for demand management schemes.

4 Governance and controls

a) The Trust identified many areas where there were gaps in control and accountability. Some of these should have been addressed by now. However, it is important to ensure that the following are addressed adequately in the action plan:

i. there needs to be clarity of Executive responsibility for operations in the absence of a Chief Operations Officer

ii. an Executive lead for governance and risks needs to be identified quickly

iii. an appropriate assurance framework needs to be put in place
iv. the risk management system and reporting needs to be significantly improved
v. a timescale and plan should be put in place to assure integrated governance
vi. performance management systems across all areas need to be improved
vii. the Board reporting of strategic risks and performance needs to be revised following the above improvements

b) Once the Trust’s strategy is finalised the Assurance Framework needs to be derived from this. Other aspects of performance and risk management should then be aligned to this.

c) The Trust needs to take action to address organisational capability gaps identified in the following areas:
   i. assessing Board performance
   ii. finance capacity and structure identified as having some weaknesses in dealing with an FT regime, particularly cash management.

d) The Trust needs to develop actions to give greater confidence in the Trust’s ability to achieve and improve service performance, national standards and targets. The current one star status means there is much to do here.

e) The Trust needs to develop its use of benchmarking for continual improvement in clinical, financial and service performance.

The next stages of the process

We are keen to integrate the next stages of this process with the Delivery Team’s work with the Trust as much of the action required is essential to core business. As such, we are asking Richard Upton, our FT Diagnostic Project Director and Richard Upton, our FT Finance Lead, to attend the next scheduled meeting with your Delivery Team Manager. At this meeting the team will give feedback on the findings and discuss the action plan requirements, how this will inform the development plan that the SHA can support, as well as cover how monitoring delivery of the action plan will be managed.

We enclose the NHSFT Action Planning Framework that will be used to monitor the plans. This has been derived from the competencies which Monitor will assess. May we ask you to confirm to Andrea Green (andrea.green@cas.ma.nhs.uk) by 13 January 2008, the name of the Executive Lead responsible for developing the action plan.
Yours sincerely

David Nicholson CBE
Chief Executive

enc:  Action Planning Framework

cc:  Martin Yeates – Chief Executive (Acting)
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL2 [ ]
to the Witness Statement of Ken Lownds
Governance of Foundation Trusts
A New Era

Clive Wilkinson
Chairman
- 98% brand recognition
- £15 billion non pay expenditure
- Massive health spend 10% GDP by 2008
- Spend on equipment alone approximately 28%
"It's not a national health service

it's a national health system"
Structure of the NHS

Secretary of State ← ----- → Monitor

Department of Health

Strategic Health Authority 10

Primary Care Trusts 152

Acute Trusts 175

Foundation Trusts 92

Private Sector
• Reinventing itself through system reform and major policy initiatives:
  – Funds flow
  – Choice
  – Foundation Trusts
  – World-class commissioning

• With the aim of:
  – Setting and improving standards
  – Diversity of provision
  – Patient-centred care
  – Employer of choice
Challenges

Strong FTs
Financial legacy
Diversity of Providers
PbR
End of 10% growth
Choice
Public expectation
18 weeks
Standards

Responses

Professional Commissioning
Prioritising Change
Evidence on models of care
Changing Pathways
Investment Planning
Contracts
Quality standards
Measuring impacts

URGENT CARE
Alternatives to admission
Out of Hours Services
Crisis Resolution
Urgent Care Centres

LONG-TERM CARE
Case Management
Disease Management
Integrated Social Care
Self Care

IMPROVING HEATH
Minor Surgery
Diagnostics
"Tier 2" Services
Ambulatory Care
PwSI Services

Obesity/Smoking
Regeneration
Diet & Exercise
Sexual Health
Mental Wellbeing

CURE00330014225

WS0000000397
"It’s not about illness. It’s about wellness"
• Deliver patient care connected to the needs of local communities and individual patients
• Recognise and deliver its obligations to the continued wellbeing of the community
• Welcome working in partnership operating under legally binding agreements
• Give a greater voice to our local community
• Address the diversity and inequalities in health
• Deliver and set new standards of excellence
• Attract and retain the best staff
• Employer of choice
• Provider of choice
• The partner of choice
• Influential voice
• Legally binding contracts
• Financial flexibility and opportunities
• Income generation for the whole health economy
• New vehicles for partnership
• Commitment to local people
"A foundation trust is not a hospital; it's a healthcare business."

CURE00330014229
Section 1 = membership
- constituency
- open to all within catchment

Section 2 = the Governors’ Consultative Council
- representative of the Member
- partner organisations are represented
- appointment process for the Chair
- arrangement and responsibilities of the Governors

Section 3 = Information on the Trust Board
- Chair and CE appointment process
- Roles and responsibilities EDs and NEDs
• Membership is free

• Public Members must live within one of the electoral constituencies

• Eligible to become a member if you live outside of this area and have received treatment within the last 3 years

• Opt in versus opt out
  • Patients automatically become members (opt out)
  • Staff automatically become members
• Members must be over 16 years of age
• Members can vote in elections for the Governors' Consultative Council
• Members can stand for election as a Governor
• Members invited to attend special functions such as open days, tours and seminars
• Everyone is still entitled to take part in Trust activities
• NHS treatment is still free and based on clinical need
• Members will not have access to preferential clinical treatment or car parking
Help to shape the Trust's future
Governors' Consultative Council
   Elected (first past the post system) by the patients and public membership (majority)
   Patient Governors
   Staff Governors
   Stakeholder Governors appointed by our partner organisations
• Not responsible for the day-to-day running of the Trust
• Governors are unpaid and serve for a term of up to 3 years
• Governors meet at least four times per year
• Responsible for appointing the Chair and NEDs
• Set the remuneration of the Chair and NEDs
• Approve the appointment of the Chief Executive
• Appoint the Trust Auditor
• Consulted on the development plans and any significant changes to healthcare services
• 26 Public Governors
• 2 Patient Governors
• 5 Staff Governors
• 11 Stakeholder Governors

TOTAL = 44

- Birmingham Chamber of Commerce
- Solihull Care Trust
- Birmingham East and North (BEN) PCT
- Solihull Metropolitan Borough Council
- Joint Lichfield & Tamworth Borough Council
- University of Birmingham

- Birmingham City Council
- Solihull Chamber of Commerce
- Stepping Stones
- South Staffs PCT
- Birmingham City Council
Catchment Overview

**Birmingham**
Population: 977,087
29.6% of population from an ethnic minority background
A diverse, multi-ethnic inner-city community

**Borough of Solihull**
Population: 199,517
5.41% of population from an ethnic minority background
70% green belt land

**East Birmingham**
Hodge Hill, Shard End, Stechford, Sheldon
Population: 68,108
32,257 patients
Average deprivation ranking: 1,189

**Central Birmingham**
Nechells, Washwood Heath, Sparkbrook, Bordesley Green, Yardley, Acock's Green, Springfield
Population: 221,966
48,442 patients
Average deprivation ranking: 405

**Birmingham at Large**
Population: 687,013
15,140 patients
Average deprivation ranking: 1,884

**Solihull Central**
Shirley West, Shirley South, Shirley East, Olton, Lyndon, Elmdon, Selly, Bickenhill
Population: 97,793
31,806 patients
Average deprivation ranking: 5,955

**Solihull South**
Blythe, Dorridge and Hockley Heath, St Alphege, Knowle, Meriden
Population: 51,123
10,521 patients
Average deprivation ranking: 8,027
BHFOEB

1. To receive Apologies

2. Presentation of 10 Year Investment Plan by Mark Goldman and Adrian Stokes  
   
   Paper to follow

3. Any Other Business

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CURE00330014240

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WS0000000412
• Governance & Risk
• Audit Committee
• Donated Funds Committee
• Finance Committee
• Trust Board
• Governors’ Consultative Council (GCC)
• Governors’ Working Party
HSJ AWARDS 2006

Winner
Acute Healthcare Organisation of the Year Award
Heart of England Foundation Trust
Sponsored by CHKS
Witness Name: Ken Lownds
Statement No: First
Exhibits: KL1 – KL8
Dated: 16 Nov 2010

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL3 [ ] to the Witness Statement of Ken Lownds
| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V |
| 1 | UHNS PUBLIC CONSTITUENCY | | | | | | | | | | | | | | | | | | | | |
| 2 | THEREFORE | | | | | | | | | | | | | | | | | | | | |
| 3 | VOTED IN TURNOUT % VOTERS 000 | | | | | | | | | | | | | | | | | | | | |
| 4 | WEBSITE DRAFT CC/20 | | | | | | | | | | | | | | | | | | | | |
| 5 | Stoke N | 30 | 52 | 58 | 240636 | | | | | | | | | | | | | | | | | |
| 6 | Stoke C | 27 | 48 | 56 | | | | | | | | | | | | | | | | | |
| 7 | Stoke S | 36 | 53 | 66 | | | | | | | | | | | | | | | | | |
| 8 | Moorlands | 45 | 64 | 70 | 94489 | | | | | | | | | | | | | | | | | |
| 9 | NUL | 37 | 58 | 64 | 122030 | | | | | | | | | | | | | | | | | |
| 10 | Stone | 46 | 67 | 69 | | | | | | | | | | | | | | | | | |
| 11 | Stafford | 45 | 64 | 70 | | | | | | | | | | | | | | | | | |
| 12 | 173 | 273 | 1 | | | | | | | | | | | | | | | | | |
| 13 | 12 | 12 | 2 | | | | | | | | | | | | | | | | | |
| 14 | 266 | 455 | 457155 | 600 | | | | | | | | | | | | | | | | | |
| 15 | 3 | 14 | 4 | | | | | | | | | | | | | | | | | |
| 16 | 0.001312 | | | | | | | | | | | | | | | | | | | | |
| 17 | 0.131247 | | | | | | | | | | | | | | | | | | | | |
| 18 | 36 | 36 | 10 | | | | | | | | | | | | | | | | | |
| 19 | 0.13% | | | | | | | | | | | | | | | | | | | | |
| 20 | 17 | 17 | 5 | | | | | | | | | | | | | | | | | |
| 21 | 12 | 12 | 2 | | | | | | | | | | | | | | | | | |
| 22 | 25 | 25 | 2 | | | | | | | | | | | | | | | | | |
| 23 | 19 | 19 | 2 | | | | | | | | | | | | | | | | | |
| 24 | 26 | 26 | 3 | | | | | | | | | | | | | | | | | |
| 25 | 18 | 18 | 1 | 61 | | | | | | | | | | | | | | | | | |
| 26 | 56 | 56 | 1 | | | | | | | | | | | | | | | | | |
| 27 | 36 | 36 | 1 | | | | | | | | | | | | | | | | | |
| 28 | 25 | 25 | 1 | | | | | | | | | | | | | | | | | |
| 29 | 12 | 12 | 2 | | | | | | | | | | | | | | | | | |
| 30 | 25 | 25 | 1 | | | | | | | | | | | | | | | | | |
| 31 | 25 | 25 | 3 | 66 | 500 | 0.40% | | | | | | | | | | | | | | | | |
| 32 | WOULD VOTE FOR | | | | | | | | | | | | | | | | | | | | |
| 33 | % ELECTORATE CASTING A VOTE | | | | | | | | | | | | | | | | | | | | |
| 34 | 1575 | 9 | GOVERNORS | 1 | | | | | | | | | | | | | | | | | |
| 35 | 10 | 10 | 1 | | | | | | | | | | | | | | | | | |
| 36 | 928 | 100.00% | 129 | | | | | | | | | | | | | | | | | |
| 37 | 700 | 4 | GOVERNORS | 1 | | | | | | | | | | | | | | | | | |
| 38 | 675 | 5 | GOVERNORS | 1 | | | | | | | | | | | | | | | | | |
| 39 | 175 | 1 | GOVERNORS | 0 | | | | | | | | | | | | | | | | | |
| 40 | 175 | 1 | GOVERNORS | 0 | | | | | | | | | | | | | | | | | |
| 41 | DT PUBLIC MEMBERSHIP NUMBERS AT MARCH 2007 | | | | | | | | | | | | | | | | | | | | |
| 42 | PUBLIC | FT NUMBER AVE | | | | | | | | | | | | | | | | | | | |
| 43 | 477,180 | 59 | 8,088 | | | | | | | | | | | | | | | | | |
| 44 | 60,078 | 58 | 7,071 | | | | | | | | | | | | | | | | | |
| 45 | 55,920 | 57 | 6,214 | | | | | | | | | | | | | | | | | |
| 46 | 122,998 | | | | | | | | | | | | | | | | | | | |
| 47 | 50% | | | | | | | | | | | | | | | | | | | |
| 48 | Of all public members | | | | | | | | | | | | | | | | | | | |
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL4 [ ]
to the Witness Statement of Ken Lownds
Hon. Ann Keen MP
Parliamentary Under Secretary of State for Health
Services
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

11 February 2009

Dear Ann

STAFFORD HOSPITAL

I was very sad that I have to write this letter to you; after working so hard to get you and Labour into power. A decade has passed since then so how is it possible that the NHS under the care of your government could deliver such poor services? This wasn’t why I worked so hard to get you elected!

I enclose a set of the press clippings which tell the sorry story of care at Stafford Hospital. You will of course be aware that within the next few weeks the Healthcare Commission will be reporting on its investigation into the services there and this raises fundamental questions for you and for all your ministerial colleagues and predecessors at the Department of Health, “how could this happen?”

I have met the members of Cure the NHS and heard the heartbreaking stories about the care of their loved ones at Stafford, I’m sure you would be horrified by what they and their relatives have suffered.

Monitor should use its powers under the Failure clauses of the Act and clear out the non-executives, senior executives should also be sacked. It should be noted that the non-execs awarded themselves substantial pay increases as one of their first acts as a foundation trust and not long after that the Healthcare Commission began their investigation.

Ann, please do not use the normal stock answer for dealing with foundation trusts issues, this needs urgent action by all of the ministerial team.

I have asked Bill Moyes to come to Stafford to help make a fresh start, I do hope you will be able to come too, I believe the local community needs that demonstration of commitment to change.

Many thanks and my best wishes to you and to Alan. I look forward to hearing from you.

Ken Lownds

CURE0034000198
Witness Name: Ken Lownds
Statement No: First
Exhibits: KL1 - KL8
Dated: 16 Nov 2010

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL5 [ ] to the Witness Statement of Ken Lownds
Dr William Moyes  
Executive Chairman  
Monitor  
4 Matthew Parker Street  
London  
SW1H 9NP

2 February 2009

You will of course be aware that within the next few weeks the Healthcare Commission will be reporting on its investigation into the services at Stafford Hospital and this raises fundamental questions for you and Monitor;

How was it that the application process did not highlight the failings in services?

and

How was it that in spite of these failings you could award Stafford and Cannock foundation trust status?

You must have carried out an internal investigation within Monitor to find the answers to these questions; I would be grateful if you could share your findings with the public.

It is important that while the Healthcare Commission's report identifies clearly what the problems were and who created them that the hospital and the community use the day of publication to make a fresh start. Could I ask you on that day to come to Stafford to set out for patients and public the role you and your team will play in ensuring that only the highest standards of clinical and personal care be delivered?

I believe that Stafford Hospital should be put into 'special measures' until the board and staff have demonstrated over a substantial period of time that they can meet and maintain the highest standards. These 'special measures' should include the appointment of a local 'buddy' hospital against which they can benchmark and from whom they can receive support, monthly board meetings open to the members and the public, frequent briefing sessions for members, and a drive to increase dramatically the number of members in the public constituency.

My fellow - members, other campaign groups as well as myself will, of course, be only too happy to assist in any way we can as long as we know that a refreshed leadership team at the hospital have committed themselves to a new era.

Ken Lownds

CURE0007000152

WS0000000420
11 February 2009

Dear Dr Moyes

I enclose a set of the press clippings which tell the sorry story of care at Stafford Hospital. You will of course be aware that within the next few weeks the Healthcare Commission will be reporting on its investigation into the services there and this raises fundamental questions for you and Monitor;

How was it that the application process did not highlight the failings in services?

and

How was it that in spite of these failings you could award Stafford and Cannock foundation trust status?

You must have carried out an internal investigation within Monitor to find the answers to these questions; I would be grateful if you could share your findings with the public.

It is important that while the Healthcare Commission’s report identifies clearly what the problems were and who created them that the hospital and the community use the day of publication to make a fresh start. Could I ask you on that day to come to Stafford to set out for patients and public the role you and your team will play in ensuring that only the highest standards of clinical and personal care will be delivered?

I believe that Stafford Hospital should be put into 'special measures' until the board and staff have demonstrated over a substantial period of time that they can meet and maintain the highest standards. These 'special measures' should include the appointment of a local 'buddy' hospital against which they can benchmark and from whom they can receive support, monthly board meetings open to the members and the public, frequent briefing sessions for members, and a drive to increase dramatically the number of members in the public constituency.
27 February 2009

Ken Lownds

By email

Dear Mr Lownds,

Thank you for your letter of 11 February.

Monitor has been in close contact with the HealthCare Commission throughout its investigation at Mid Staffordshire NHS Foundation Trust (the Trust). The Healthcare Commission has briefed us regularly on the work they have undertaken and on the interim conclusions they have drawn.

Monitor has also held regular meetings with the Trust’s Board during the period of the investigation. We have ensured that the Board has acted on the findings of the Healthcare Commission as they have emerged and has considered very carefully the wider implications for the governance of the Trust. We fully supported the Trust in appointing PricewaterhouseCoopers (PwC) to help them decide how governance of the Trust can be improved.

Neither the Healthcare Commission nor PwC have yet published their final conclusions and recommendations. We expect both reports to be completed during March. Once these are available, and Monitor has had an opportunity to review them and any response made by the Trust, we will have to consider whether the Trust is in significant breach of its Authorisation.

If we conclude that the Trust is in significant breach, or has been and risks being in significant breach again, we will then have to decide whether or not to use our formal powers of intervention. This is not something we can decide at the moment as the key evidence (that is, the reports referred to above and the
Trust's response) is not yet available. Whatever decision we reach, it will be made public, as will the reasons for it. If we decide that the Trust is in significant breach of its Authorisation, Monitor will publish a clear statement of what has to be done by whom and within what timescale.

In your letter you questioned whether or not the "failings in services" were highlighted during our assessment of the Trust's application to become a foundation trust and, if they were, why the Trust was authorised as a foundation trust.

Monitor requires applicant trusts to demonstrate that they are financially viable, legally constituted and well governed prior to authorising them as an NHS foundation trust. Monitor carries out a rigorous assessment of each applicant before determining whether or not these three tests are met. If a trust meets these tests then Monitor will authorise the trust as an NHS Foundation Trust.

When Monitor was assessing the application from the Trust in January 2008, we ascertained that the standardised mortality rate for certain procedures appeared to be outside the expected range. We assessed this data carefully, and took advice from the SHA and the PCT, neither of which raised any concerns in relation to the quality of care at the Trust. With the benefit of an independent review carried out by Birmingham University, the consensus was that the underlying reason for the high mortality rates was primarily inadequate clinical coding. In all other respects, the Trust met our authorisation and therefore Monitor's Board made the decision to authorise the Trust from 1 April 2008.

Our assessment process, however, is not static. Although the tests we apply and the processes we adopt have not changed materially, we now devote more of our time to examining evidence of poor clinical quality or inadequate services. We have also continued to develop our arrangements for ensuring that any concerns that the Healthcare Commission or other bodies relay to us during the course of assessing an application to be a foundation trust are understood and reviewed in detail.

Once we have received and considered the final reports from the Healthcare Commission and PwC and the Trust's response Monitor will determine what action is required.

I hope this helps answer the questions you raised in your letter.

Yours sincerely

William Moyes
Chairman
Dr William Moyes  
Executive Chairman  
Monitor  
4 Matthew Parker Street  
London  
SW1H 9NP

2 March 2009

BY EMAIL

Dear Dr Moyes

Mid Staffordshire NHS Foundation Trust

Thank you for taking the trouble personally to respond to my letter.

Your reply contains some interesting information and raises a large number of further questions about Monitor, its procedures and its decision-making but I will leave those until after the publication of the Healthcare Commission’s report.

I must, however, comment on PWC’s involvement at Stafford, this is something that had not previously been shared with the public.

Only a year ago before authorising foundation trust status Monitor would have scrutinised the Mid Staffordshire governance arrangements including the experience and capability of the executive and non-executive teams. If that process was robust why does governance need to be improved now? Does the Mid Staffordshire board itself not have the capability of improving the governance arrangements? If not then it should not be in place.

Why is money that should be devoted to frontline care being spent in this way?

Why was the hospital’s public membership not included in this exercise?

I restate my willingness to help at Stafford in any way I can as long as I know that a refreshed leadership team at the hospital have committed themselves to a new era. I am not prepared to support the non-executive directors who in the midst of the Healthcare Commission’s investigations voted to accept substantial increases in their remuneration. The logical, professional, and public-service-minded approach would have been to postpone any such discussions let alone votes until the Healthcare Commission’s report had been published.
Annex to NOTICE dated 3 March 2009 of exercise of intervention powers under section 52 of the Act to:

Mid Staffordshire NHS Foundation Trust

The formal intervention relates at this stage to matters of organisational and strategic leadership capacity.

The aim of this formal intervention is to provide stability to the board of directors of the Foundation Trust.

Overall, intervention is a secure mechanism of ensuring that appropriate regulatory control is in place to help stabilise the Foundation Trust, assist in its successful recovery and to protect the services it provides for patients.
Dear Bill

That's fine but meanwhile the care on the wards which is criticised so heavily by HC has not changed; we know that from the case reported to us last Friday, the death occurring Thursday.

The Health Secretary either does not or will not acknowledge this part of the problem and it is not in the Alberti brief.

Who is protecting the patients there now?

We will continue to push hard through all channels we know.

By coincidence I know and respect the prospective Medical Director and will meet him one-to-one soon. He will have my total support. I assume that is not yet public knowledge so I will obviously keep it strictly confidential.

The time is not yet right to meet Eric and David, last week's press release did serious damage in the community; I can assure you of that.

I hope we can continue our dialogue from time to time; hopefully you'll come soon.

Brgds

Ken

William Moyes wrote:

Dear Ken

Thank you for your recent email about Mid-Staffordshire.

As you know, I and my colleagues in Monitor have complete confidence in David Stone and Eric Morton. In the first instance it is up to them to decide whether they need to bring additional support into the hospital or whether there are changes they want to make in the Board or the senior team. This is not something where I would want to second guess their judgement. I would very strongly encourage you and your colleagues to give David and Eric time to reach considered judgements about what is the best course of action.

We will shortly be meeting the Trust to review their plan of action and to begin the process of satisfying ourselves that it will address rapidly and effectively all the criticisms in the Healthcare Commission's report. And as you know, the Secretary of State and I have also asked Sir George Alberti to look specifically at the emergency care pathway and to report on whether the standards of emergency care are now of an appropriate quality. Sir George will also be advising Monitor on whether the Trust's plan is appropriate and being implemented rapidly and effectively. This will mean that he will be scrutinising all the services criticised by the Healthcare Commission

I realise that you and your colleagues are anxious to see a rapid improvement in the quality of care in Mid-Staffordshire Hospital. So are we. If David Stone thinks that further changes are necessary to achieve that, he will have our full support. While I fully understand your desire to see changes made rapidly, I believe the best interests of the hospital will be served by allowing David and Eric a little time to reach their own conclusions based on their very extensive experience of leading and managing successful hospitals. But you can be sure that we will be keeping in very close touch with them throughout.
Bill Moyes,

-----Original Message-----
From: Ken Lownds
Sent: 20 March 2009 10:16
To: William Moyes
Subject: Re: Mid-Staffordshire NHS Foundation Trust

Dear Bill

Thanks for all that - but we remain concerned that Eric's team includes senior execs whose previous performance is severly criticised in the report.

Should they not, at least as a precautionary measure, be suspended until David and Eric are absolutely clear about their involvement?

will be using your powers to dismiss?

We also remain concerned about the minute-by-minute care of the elderly on the wards discussed in the report.

Bill, you're right that it won't change quickly but how can patients be given the care, dignity and respect by the same front line team who so signally failed in the past?

I inferred from Alan Johnson's statements that he had not grasped that this was also of major concern.

What about non-execs and governors?

The newspaper statements of the staff governors demonstrate very clearly that they don't understand the governor role, and these are the people delivering the care as we speak.

It seems to us that there was clearly and remains a group of people who turned their loyalty from patient care to the personalities of the 'leaders'. Loyalty in the correct place is admirable, but it must be in the right place.

As a member I really was very upset by Eric's letter. Untimely, and ill-judged it has upset bereaved relatives a great deal and undermined straight away their picture of him as a 'new broom'. This was all the stuff we got from Yeates and Brisby. I understand Eric's urge to rebuild the reputation, but he won't do it this way, just the opposite.

I do urge you to get Peter Blythin from West Midlands SHA for a while. Not only would he be Eric's 'outside' practical nursing care guru constantly on the wards but he knows Karen Morrey well having worked with her at UNHS.

Bill, I do appreciate these personal contacts. I haven't spoken with Julie yet today but I do feel it would help enormously if you could come to the cafe which is our base and talk with some of the members. We are hearing of new cases all of the time, one yesterday. David Kidney has also been called on to intervene.

What's making this phase very difficult is that the group feel that David Kidney failed us very badly by not challenging Yeates and Brisby a long time ago so it will take us time to come round to him.

Perhaps you would be kind enough to give Julie a call today, she really
would appreciate it.

Have a good weekend

Thanks again - your personal touch is very much appreciated

Brds

Ken

cure the NHS

William Moyes wrote:

Dear Ken

Thank you for your email.

I have spoken pretty much every day this week to either David Stone or Eric Morton or the two of them. I have a great deal of confidence that they are tackling the issues unearthed by the Healthcare Commission. They obviously cannot rectify all the problems immediately. They know that the emergency care pathway and nursing standards are key priorities.

I have also had conversations with the Secretary of State, who has read the Healthcare Commission’s report in full, as have I. I don’t think any of us are in doubt about what that report says.

You will be aware from the Secretary of State’s statement yesterday that he and I have asked Sir George Alberti to report urgently on the hospital’s emergency care pathway. I have also instructed the Board of the Trust to supply me with a detailed plan of action on how they propose to remedy each and all of the defects identified by the Healthcare Commission - and any others that may be identified by Sir George - together with the detailed timetable for implementation. I shall be meeting the Trust in the near future to discuss, that and I will meet them regularly until the plan has been fully implemented. I will also be seeking Sir George’s advice on whether the plan is proving effective in practice.

I do indeed intend to visit the hospital, but in the immediate future I
would rather allow David Stone and Eric Morton time to focus on planning and implementing the changes required to remedy the most important defects identified by the Healthcare Commission.

Bill Moyes

-----Original Message-----
From: Ken Lownds
Sent: 18 March 2009 21:33
To: Claire Lloyd
Cc: Bill Cash
Subject: STAFFORD HOSPITAL

Claire

I hope you're well.

Another message for Dr Moyes.

Thanks

Brgds

Ken

Cure the NHS

QTE

Dear Dr Moyes,

Thank you for your handwritten note, it was greatly appreciated.

Cure the NHS needs you to be aware that relatives of current Stafford patients are coming forward to say that their loved ones are still receiving the standards of care condemned in the Healthcare Commission's report.

I do urge you to add senior nursing resource from outside the area to Eric Morton's team as a matter of urgency.

I'm not sure from the exchanges I heard in the Commons today that the Secretary of State fully appreciates that the poor care extends across several medical and surgical wards where the elderly are treated.

Could I suggest a visit to Stafford today to meet Julie Bailey and her members and to pay the hospital a visit?
Thanks
Brigds
Ken
UNQTE
27 March 2009

Ken Lownds

By e mail

Dear Ken

Mid Staffordshire NHS Foundation Trust

I am writing to update you on what the actions Monitor is taking in relation to Mid Staffordshire NHS Foundation Trust and also to invite you and Julie Bailey to meet with me when I visit the Trust next Thursday 2 April.

Monitor will wish to ensure that the Trust has in place appropriate plans to address the issues highlighted in the Healthcare Commission’s report and is able to deliver these on a timely basis. To this end I have requested Professor Alberti to expand the remit of his review and, in addition, to advise Monitor on the following:

- the Trust’s action plan and—whether or not it addresses all of the recommendations in the Healthcare Commission’s report;
- the planned timing of its implementation; and
- whether any further senior management changes are required to ensure that the action plan can be delivered.

In carrying out his work, I have specifically requested that his review also includes the care provided on the medical wards 10, 11 and 12.

I enclose a copy of two letters I have recently written to the Acting Chairman. The first of these, dated 18 March 2009, sets out our expectations of the Trust in...
relation to developing plans to address all of the Healthcare Commission's recommendations. The second, dated 26 March 2009, sets out the process going forward and how Monitor will work with the Trust, Professor Alberti and the Care Quality Commission to ensure that all recommendations from the Healthcare Commission's report are addressed and that appropriate standards of care are delivered at the Trust in the future.

As noted above I will be spending the morning of 2 April visiting the Trust and would welcome the opportunity to meet with you and Julie Bailey at the Trust. This will give us the opportunity to discuss the actions we are taking and any concerns that you may have. Please contact my PA, , on and she will make the necessary arrangements.

I hope this letter will provide you with further assurance that action is being taken by both Monitor and the Trust to ensure that all recommendations in the Healthcare Commission’s report are addressed and that the delivery of high quality care at the Trust will be assured.

Yours sincerely

[Signature]

William Moyes
Chairman

CC: Julie Bailey
Email Exchange Ken Lownds, cure the NHS and Monitor Friday 10 July 2009

Copied to David Kidney, Tony Wright, Charlotte Atkins, Kevin Barron, S Staffs PCT, CQC, RCN

Bill

I hope you're well.

We have given David and Eric a lot of time - How do I put this? We find it very difficult to 'tune in' to each others' communication preferences I'm afraid - but the dreadful care is still happening.

We copy these cases to the local and regional CQC team and in the first instance ask Manjit Obhrai to help - we don't have the name of this case yet but will pass it on to him when we do. I know Manjit well and trust him implicitly. I was also delighted to hear yesterday that Karen Kelly has moved from UHNS A and E to Stafford; again I know and trust Karen.

But neither Manjit nor Karen nor any other senior manager can be everywhere at once and that's why we suggested right at the outset that there should be a special 'support and coaching' team of independent senior nurses under the leadership of Peter Blythin -ON SHIFT-_ until the Stafford nurses have relearned compassion and care and until the permanent workforce is up to strength in every sense of the word.

Bill, you really should have put Stafford in 'special measures' in March because nothing will really change until there is a radical change of senior management and nurses, doctors, and everyone else has been given time and space to sort themselves out, and the 'culture' refocused on safety, dignity, and care. RCN tell us that there is a big training job to do as well. This latest example illustrates that and of course there are more. On Wednesday Julie had a call from a gentleman who had been told by PALS at Stafford Hospital that his best course of action was to call Julie!! We know from conversations with CQC that Stafford Hospital's complaints handling is far from 'fit for purpose', still.

This to Julie last night -

QTE
> Hello I am so grateful to have this opportunity to get this off my chest re Ward 12 at Stafford Hospital. My father died in this ward last year and I witnessed appalling treatment by the staff. Unfortunately I did not have the ability or wherewithal to complain. Yesterday I visited my friend (aged only 58) in the ward and do not intend to let the neglect she is suffering go unrecorded. She is too weak to stand up for herself, In fact too weak to stand up! But she was bullied yesterday morning and told to wash herself at the sink. She was upset and tried, but collapsed onto the bed and so was 'allowed' to wash herself in a bowl. Her lips are dry, cracked and bleeding and I asked a nurse for something to help,
I suggested a 'lollipop' stick to wipe her lips. The nurse replied that I would have to bring something in myself. I realise that these are relatively slight problems but in my opinion her needs are not being met. I am sure there are other things that have happened that I do not yet know about. I have been on holiday and did not know how ill she was. She has been in hospital for 9 days and is rapidly deteriorating. Her husband emailed me first thing this morning and she has been transferred to Critical Care Unit at 2am this morning. I hope this marks a turn for her well being. I have emailed my MP Tony Wright and Stafford MP Mr Kidney.

> UNQTE

The reason that this is so alarming is that this is the typical pattern of the deaths at Stafford that you can read in the cases submitted to Andy Burnham by our lawyers. This lady should be saved from that.

Bill, you must act to rectify this appalling situation; four months have now passed, and you asked me to give you time, I did that, your solution has not worked. What are you going to do?

George Alberti said on 24 June that the nursing workforce was 20% short still - and if some of the rest is agency the real effective caring, compassionate, and competent workforce available to work on 10,11, and 12 - the problem wards for years now will be far less.

If it is 20% or more down you should be shifting elective cases to Burton ISTC or UHNS or anywhere - inconvenient but safer!

You also need to get a full time chief exec in place ASAP - one who understands nursing care and nurses.

I'm sure David Kidney, Tony Wright, and my MP, Bill Cash, will ensure that this is passed on to Andy Burnham and Mike O'Brien today.

I'm on if you would like to talk.

Thanks

Brgds

Ken

Dear Ken

Thank you for your email earlier today addressed to Bill.
As you are aware by now, Bill Moyes is currently on annual leave.
However, your email was passed to Edward Lavelle, our Regulatory Operations Director. Edward and the senior team are involved with Mid Staffordshire NHS Foundation Trust on a daily basis. We have also taken the opportunity to make the Trust aware of the specific concern you have
raised. Edward would be happy to discuss your email with you, but he has in the meantime asked that I respond to the matters you have raised as follows:

* We expect to be in a position to make some further announcements as to proposed changes to appoint a permanent leadership of the Trust in the next ten days;
* The Care Quality Commission (CQC) will also in a similar timescale, publish its three month 'stock-take' report which will identify the progress made in the period since the publication of the Healthcare Commission's report in March. This will include the areas where real progress has been evidenced as well as where further progress is required. At the same time, the CQC has specifically reviewed the Trust's complaints handling processes and has made some further recommendations as to how this can be improved. The Trust has taken these recommendations on board and is taking action to rectify shortfalls; 

We are encouraged by your comments as to the Medical Director, which we share, and also those in relation to Karen Kelly. Manjit has agreed to take on a more active role in understanding and reflecting on the concerns of patients and their relatives.

The Trust will continue to report progress against its Transformation Plan.
If you would like to discuss anything further with us please feel free to do so. Bill will be back from leave on Monday 20th. I shall make sure he sees your note on his return.
Best wishes
Claire.

----Original Message----
From: Ken Lownds
Sent: 10 July 2009 10:28
To: Claire Lloyd
Subject: STAFFORD HOSPITAL

Claire

Sorry this has come on a day when Bill's out but the email last night made Julie and myself realise that we couldn't leave it to others any longer.

Thanks
Brgds
Ken
Edward

Your reassurances are welcome but they fall very far short of the mark. Who will protect the patients in Stafford Hospital who have been getting the most
appalling care for years and continue to get it, tonight, over the weekend, until you folks get more boxes ticked?

Protect them from the harm caused by the kind of bullying, inept, and uncompassionate nursing related in the case I quoted?

That's not the only case reported to Julie last night - the other was a death in early April - so too late!

It is six months since I first raised this with Bill; please understand that nothing can or will change until you bring the nursing establishment up to the safe number and beyond with good quality nurses, not agency nurses, not healthcare assistants doing tasks they should never be asked to do, and not newly qualified nurses straight from uni.

And then you need to put the nursing back into the nurses, who's going to do that?

Who will accept the duty of care to protect these patients?

With respect Edward I suspect you are really rather out of touch with the awful truth of these wards at Stafford where and what the care is like for elderly patients, you have no idea, if you did you and Bill would have intervened long before now.

I repeat my call for action to protect patients, now.

It is not myself with whom you should be talking on Monday it is Andy Burnham, Mike O'Brien, and Ann Keen and together you need to devise a plan to protect patients from the abuse set out in my earlier email and you need to get it in place by midday Monday.

It is not CQC's role to intervene in individual cases or to run the hospital, but if they have the powers they should certainly insist on 'load-shedding' as I set out earlier.

You talk about the complaints process at Stafford and the CQC's work in that area, I'll tell you about our involvement in that another time.

Manjit will have intervened in that particular case today but why should people need to appeal to Julie and myself? How many don't know about that route?

Edward, the time for niceties has gone; let's have some action.

Thanks

Brgds

Ken
Dear Mr. Lowndes,

Claire showed me your e-mail to me yesterday. This is a very positive and constructive response to the action Monitor took yesterday. We will obviously keep very close to David Stannett. It is likely that Monitor will use its formal powers in relation to implementing the recommendations of the Healthcare Commission once these are published.

You raised in your e-mail what you can do to help rebuild the quality of care and the reputation of the trust. The previous report did make a start on
rectifying the deficiencies in the service the hospital offers, but there is clearly a lot more to do. The purpose of our intervention is to get this work done, effectively and as rapidly as possible.

The new Chair and interim Chief Executive will need some time to formulate a plan, and focus key staff on implementation. I hope you and your colleagues will give them the time they need. This is by far the biggest contribution you can make at the moment, and I would urge you to do that.

I do plan to visit Mid Staffs at some point and I will ensure there is an opportunity for us to meet.

Yours sincerely, William Hague
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL6 [ ]

[Removed for privacy] to the Witness Statement of Ken Lownds
GOVERNMENT REGULATOR’S INTERVENTION IN STAFFORD HOSPITAL IS
WELCOME BUT SHOULD HAVE HAPPENED A LONG TIME AGO

Our NHS Public North Staffordshire (KONP - N Staffs) is relieved that the
government's regulator, Monitor, has taken decisive action to intervene urgently in
the management of Stafford Hospital, part of Mid Staffordshire NHS Foundation
Trust. The language of the formal notice issued to the hospital on 3 March 2009
and the letter to the council of governors is devastating. Acting before the formal
publication of the year-long investigation of the hospital's services by NHS
watchdog, the Healthcare Commission, Monitor cites inadequacies in the quality of
clinical and nursing care and senior management failings as just part of the reason
for the intervention.

The remaining non-executive directors and the governors can now be in no doubt
that they should follow the hospital's chairman and chief executive in resigning.

It beggars belief that in 2008 in the midst of these problems the governors offered
the non-executives substantial pay rises and the non-executives accepted them.
They should repay every penny over and above the remuneration as it was before
foundation trust status was awarded.

In recent months KONP - N Staffs has joined the campaigning group "Cure the
NHS" in fighting for action at Stafford Hospital. All the members of "Cure the NHS"
and to watch their loved ones dying in Stafford Hospital in the last two years, not
with the dignity that the NHS owes to all its patients, but in an environment in which the culture of care had collapsed completely. We should all pay tribute to Julie Bailey, the founder of "Cure the NHS", and to all the members of her group, without their courage and determination in spite of the grief and anguish they were feeling, these failings at Stafford would not have come to light. Monitor must understand that similar cases are still coming to light.

No-one who knows the NHS is in any doubt that many parts of its services have been transformed over the last few years and waiting lists reduced significantly. However this spectacular failure in the quality NHS services for elderly and vulnerable people raises some fundamental questions about the NHS in 2009.

Why did the government in the person of the Secretary of State for Health, Alan Johnson, wash his hands of the complaints made by relatives of patients who had died at Stafford? In fact members of the public or Members of Parliament are brushed off if they raise any question about services at a 'foundation trust' and are referred back to the trust itself; a ridiculous system. They are still NHS hospitals, the Secretary of State is responsible for the NHS, he is part of the government.

Why, only a year ago, did Monitor authorise Stafford Hospital's application to become a foundation trust? How could they have missed the warning signs?

Why did Monitor not intervene many months ago when the Healthcare Commission began to point to significant failings at the hospital?

Why were the failings missed by South Staffordshire Primary Care Trust, by the West Midlands Strategic Health Authority, and by the Staffordshire County Council Health Scrutiny Committee?
Why was it that Stafford MP David Kidney, knowing full well of the many complaints about the poor care chose to side with the hospital management?

How could Peter Carter, the general secretary of the Royal College of Nursing, after a visit to Stafford Hospital last summer write to the Stafford press in glowing terms about the management at the hospital, was he not aware of the true state of affairs?

Within the hospital there will still be fundamental questions to answer for staff in positions, not least for the professional heads of nursing, are they not the guardians of the professional standards of care delivered to patients?

As chairman Toni Brisby and chief executive Martin Yeates depart, this grim period in the history of Stafford Hospital begins to draw to a close. We trust that Mr Yeates will receive not one penny more than the absolute minimum owed to him under the terms of his contract.

KONP - N Staffs welcomes the arrival of the interim chairman, David Stone, wishes him well and offers all the support it can give to him in ensuring patient safety, inabilising the services at the hospital, and in re-establishing its reputation. We rer convinced that front-line staff in Stafford Hospital, nurses, doctors, consultants, care assistants, professionals and support teams are all desperate to deliver only the very best care. During the era which has just closed there it is clear that the pursuit of financial goals to please the government was put ahead of the quality of care and prevented them from delivering high quality care; in future the safety and care of patients must come first, all day, every day.

KONP - N Staffs must make it clear that they share the real anger felt by the "Cure the NHS" members and many other local people about Stafford Hospital and the way it and the NHS leadership has let them down. They are angry with the
government and with the other bodies who are supposed to monitor and uphold patient safety. Why did these patients have to die at Stafford? Why did their relatives have to undergo such grief and anguish?

Will Secretary of State for Health, Alan Johnson, come to Stafford to apologise?

NOTES TO EDITORS


2. NHS Hospital Foundational Trusts operate under the National Health Service Act 2006 Sections 30 to 65.

3. Monitor is the regulator of foundation trusts. The secretary of state appoints the members of Monitor.

4. Keep Our NHS Public - North Staffs consists of the local members of the national organisation - Keep Our NHS Public.

4. Cure the NHS - contact Julie Bailey,
Witness Name: Ken Lownds
Statement No: First
Exhibits: KL1 – KL8
Dated: 16 Nov 2010

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL7 [ ]
to the Witness Statement of Ken Lownds
OPEN LETTER

Rt Hon Andy Burnham MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
Westminster
London
SW1A 2NS

27 November 2009

Dear Mr Burnham,

THE ESSEX HOSPITAL DISASTER aka – “STAFFORD NUMBER TWO”

You can’t avoid the reality any longer!

We know from The Patients Association report, from NCEPOD, from The Alzheimer’s Society report, and from the many contacts we have from all around the country that many aspects of care in the NHS are in crisis. Our NHS is in crisis.

Even in the hospital in your own constituency there are major questions over the standards of care and over the mortality rates. A ‘Cure the NHS’ group has been established there to try to get to the bottom of this.

Stafford Hospital are about to begin an “honesty and courage” programme with our support and involvement so that staff can begin to look at their own role in the disaster there and can begin to rebuild their own attitudes and behaviours towards patients and their loved ones.

Time for you to be honest and courageous, too!

The fundamental error in all NHS and government thinking and the reason why all these failures are happening (and are endemic now in the NHS) is that errors and appalling
standards of care are inevitable, and should be accepted as part of everyday life in the NHS, on the wards, in the A&E department, and in the operating theatre and, therefore, can be left to be discovered after patients have suffered and died.

This is wrong, very wrong, and wholly unacceptable.

The only approach is getting all treatment and care right first time with zero harm to patients – zero.

Antony Sumara and his team at Stafford Hospital has adopted zero harm and right first time as the core of everything they do and we are now working with them to develop and to deliver the changes in attitudes, beliefs, behaviours and approaches that are necessary to achieve this.

The 'Stafford Care Square' is another essential element of patient safety and quality of care management which we are helping them to develop. This will be another first in the NHS.

Our challenge to you, Mr Burnham, is to help us to do this and to make sure that these radical changes to the whole approach of the NHS are implemented very, very rapidly.

Why don't we have a video or telephone conference this afternoon and a workshop in Stafford with David Nicholson, Barbara Young and Antony Samara's team next week to get started?

We'd like Andrew Lansley to be included in that of course because this is such an important change in the NHS and because we are a non-political group.

Finally, you should be aware that, in early April 2009, we set out for Mario Dunn, Alan Johnson's advisor, a process for checking the safety of all acute hospitals. A detailed version was then sent and this has been included in the documents we have sent to you under the title "Turning the NHS the right way up again."

We urge you to order all hospital boards to conduct this process in public, in an emergency session next week. It's included below.

No more Staffords. No more Basildons.

No more harm to patients!
Stop this appalling care now. It’s for you to take the lead.

Thank you

Yours sincerely,

[Signature]

Julie Bailey
Cure the NHS

"STOP AND MAKE-SAFE" FOR THE WHOLE NHS, A TASK FOR THE HOSPITAL BOARD – STARTING AT STAFFORD

The plan to have mortality rates published as a matter of course is a welcome first step in this process. All hospital boards, including those of foundation trusts, should immediately hold special public sessions to set out for their local populations at the very least:

1. their mortality rates. They should explain:
   a. their non-standardised and standardised statistics
   b. the comparison against their 'peer groups' and national rates
   c. an explanation of what these mean
   d. the steps they have taken to reduce their figures to the lowest possible levels
   e. the steps they took to address any previous adverse gaps between their own levels and the lowest reported rates.
f. the steps they have taken to cross-check and revalidate their coding. This should be done both internally and by external verifiers.

It should be a fundamental principle of the NHS that the mortality rates of all hospitals should be the lowest in comparison with the rest of the world.

The Health Secretary should take personal lead in ensuring that the action plans to reduce all mortality rates to the lowest possible as soon as possible.

2. their 'untoward' incidents record. They should explain:

   a. the number, nature, and classification of all incidents at their hospital
   b. the speediness of reporting
   c. the comparison against their 'peer groups' and national rates
   d. an explanation of what these mean
   e. the steps they have taken to reduce their figures to zero.
   f. the steps they took to address any previous adverse gaps between their own levels and the lowest reported rates.

The Health Secretary should take personal lead in ensuring that the action plans to eliminate adverse incidents. It should be a fundamental principle of the NHS that 'untoward' incidents can be and will be eliminated.
OPEN LETTER

Rt Hon Andy Burnham MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
Westminster
London
SW1A 2NS

30 November 2009

Dear Mr Burnham,

“STAFFORD NUMBER TWO, THREE, FOUR, FIVE, SIX ……” HOW MANY?

Hardly had we dispatched Friday’s letter which started “You can’t avoid the reality any longer!” than we find Colchester added to the list and now this long list of other potential Staffords.

This is where the lack of any ‘safety management system’ or any “quality of care management system” that provides patient level safety and care data as the care is delivered really lets you down. As a matter of urgency today we ask you to consult other safety-critical sectors, aviation, nuclear, chemicals; in the public sector the Civil Aviation Authority would be an ideal starting point, Dupont Safety Resources in the private sector.

We’ve been most disappointed today by Baroness Young, she should resign, it’s as simple as that Her remarks are just unacceptable for a regulator of safety. If she has genuine concerns with Dr Foster’s data or their analysis of it she should discuss it with them behind closed doors before she makes pronouncements in public. They are after all the Government’s chosen and unique source for this data - what does she mean - “alarmist” how can data be alarmist? And “flaky”? The team at Dr Foster are her NHS ‘data partners’; by criticising them in public she’ll create even further confusion.
What a mess the CQC is! As Chief Executive of West Midlands Strategic Health Authority Cynthia Bower signally failed over a couple of years to do anything about Stafford Hospital, did she know about the appalling care there? How could she not? But if not, why not?

The other group of people who’ve disappointed us a great deal today are the hospital bosses of those performing poorly according to Dr Foster. Their reactions too are wholly unacceptable. Whatever it is that they think, they should say “we will be implementing the zero harm approach started by Stafford Hospital and redoubling our efforts not to harm our patients and to deliver only the highest levels of treatment and care first time”. Will you today please call each one of those leaders who have spoken so complacently in public and tell him or her that the response is wrong and they need to apologise as a first step?

Antony Sumara is quoted in the Dr Foster report promoting the zero harm message; why has that not been adopted across the NHS already? You’ll be interested to know that Antony and his team are working on an a ward level measure of mortality, SUIs, complaints and other data as part of their implementation of the zero harm policy.

We see in these protests from all of the hospitals involved an exact replay of what we had from Stafford Hospital’s management for years, complacency, self-denial, total failure to acknowledge and act on patient and relative concerns. Until all NHS acute trusts implement a zero harm approach and deliver it, the gravest concerns about the quality of care must remain.

The last seventy-two hours have also demonstrated vividly that the system of monitoring and measuring the NHS acute sector is disjointed and dysfunctional, especially the self-assessment basis of the CQC performance reports. The media have made an excellent job of explaining how it all fits together but there is more to do. It would be really helpful if you published, today, a simple explanation of the three, CQC, Dr Foster, and NPSA.

So even more urgency in the need for you to order all hospital boards to conduct the “stop and make safe” process in public, in an emergency session this coming week. It’s included again below. Complaints should be added as well because it is our belief that hospitals use the complaints system as a way to browbeat and ‘fob-off’ any dissatisfied patient or relative in the hope that they will not have the emotional stamina to follow the complaint through to its conclusion. Time for all hospital boards to be holding all their board meeting in public.
How much more evidence do you need to convince you that there are fundamental failings in the NHS? Stafford, Maidstone, Birmingham Children’s Hospital, Northwick Park, Basildon, Colchester, and now this long lost of others.

Since we first met Alan Johnson we’ve been offering solutions, but he, Ben Bradshaw, and Ann Keen all resolutely rejected them, and now you and Mike O’Brien are doing the same, why?

Please start to explain to the whole NHS that it has to be zero harm in future, zero! No more harm to patients! Getting that started will give patients and public the reassurance they need.

Stop this appalling care now. Be honest, be courageous. It’s for you to take the lead.

Thank you

Yours sincerely,

Julie Bailey
Cure the NHS

"STOP AND MAKE-SAFE" FOR THE WHOLE NHS, A TASK FOR THE HOSPITAL BOARD – STARTING AT STAFFORD

The plan to have mortality rates published as a matter of course is a welcome first step in this process. All hospital boards, including those of foundation trusts, should immediately hold special public sessions to set out for their local populations at the very least:

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c. an explanation of what these mean

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f. the steps they have taken to cross-check and revalidate their coding. This should be done both internally and by external verifiers.

It should be a fundamental principle of the NHS that the mortality rates of all hospitals should be the lowest in comparison with the rest of the world.

The Health Secretary should take personal lead in ensuring that the action plans to reduce all mortality rates to the lowest possible as soon as possible.

2. their 'untoward' incidents record. They should explain:

a. the number, nature, and classification of all incidents at their hospital

b. the speediness of reporting

c. the comparison against their 'peer groups' and national rates

d. an explanation of what these mean

e. the steps they have taken to reduce their figures to zero.

f. the steps they took to address any previous adverse gaps between their own levels and the lowest reported rates.

The Health Secretary should take personal lead in ensuring that the action plans to eliminate adverse incidents. It should be a fundamental principle of the NHS that 'untoward' incidents can be and will be eliminated.
OPEN LETTER

Cure the NHS

Rt Hon Andy Burnham MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
Westminster
London SW1A 2NS

27 January 2010

Dear Mr Burnham,

YOUR SECRETIVE INQUIRY INTO THE DISASTER AT STAFFORD HOSPITAL

So your Inquiry into the disaster at Stafford Hospital has finished taking evidence; if it was not totally secret it was definitely secretive.

We don’t know who many of the witnesses were, we don’t know who has submitted written evidence, we certainly will never know what evidence they submitted. Most ridiculous of all is that we are not allowed to see our own written evidence. Why? Because it draws on other evidence to your Inquiry and the rules say that it has to be confidential, and this in turn is the bizarre conclusion of your own and your government’s resistance to a proper public inquiry under the Inquiries Act 2005.

This state of affairs makes your own position and that of your government look foolish and we want you to release our own evidence into the public domain forthwith, this is what openness and natural justice dictate.

In fact Robert Francis had to admit by the end that the rules were pretty useless because it is so easy to identify many staff witnesses from the summaries of their testimony; witness C111, former chair of the hospital 2004 – 2009, now who could that be?
We also bring your attention to the premature and ill-judged analysis made by your Inquiry of its own evidence and set out in its closing statement, viz.

*In conclusion, the evidence suggests in our submission serious shortcomings in the leadership and management of the hospital. Overall, with limited exceptions, the Inquiry may be left with the impression that staff on the wards sought to do their best in difficult circumstances, often short of adequate numbers or of suitably qualified staff, demoralised and under pressure. Those at the top of the organisation did not heed warnings and appreciate the reality of the ward environment or the effect of their decisions on that environment.*

Which hospital is this?

It is certainly not the Stafford Hospital everyone knows has delivered appalling, incompetent, disastrous care for so many years. It is certainly not the Stafford Hospital so roundly condemned by the Healthcare Commission in March 2009. It is certainly not the Stafford Hospital so roundly condemned in the House of Commons by your predecessor in March 2009.

This is a ludicrous, ill-judged, and frankly naïve conclusion. In fact it directly contradicts the evidence given to the Inquiry by relatives of patients who suffered and died in Stafford Hospital as set out elsewhere in the closing statement by your Inquiry team; so it can’t even analyse its own evidence! It was also made before the Cure the NHS had submitted its own written evidence so it is also premature!

We note that it will soon be a year since the full horror of the tragedy at Stafford Hospital began to emerge and that in that time neither you nor your predecessor have done anything, anything, to protect NHS patients either from a repetition of the kind of inhuman and inept treatment that our loved had to suffer in their dying days or from the numerous, very numerous avoidable errors that do so much damage to NHS patients every day.

Within weeks of the publication of the Healthcare Commission’s report we set out for Alan Johnson among other ideas for fundamental improvements to NHS patient safety a ‘stop and make safe’ process for all NHS hospitals; we believe that had this been instituted very many patients would have been protected from potential harm and you would have had far earlier notice of the poor performance in the Essex hospitals.

This would, of course, have also benefited patients and relatives in your own constituency where we now know that problems, apparently every bit as bad as Stafford, are emerging. You must now investigate all of those same
failures at all levels of your department and the whole NHS that we pointed out before the Healthcare Commission reported a year ago.

Indeed even now the NHS has no safety management system of the kind so common for very many years in safety-critical sectors (civil aviation with its three major groups of highly-qualified and highly-professional workers, pilots, engineers, and air traffic controllers is the most appropriate comparator to the NHS) so you don’t have any really reliable evidence that tells you where each and every hospital stands in its safety performance. The new CQC registration process really is too weak; will Stafford Hospital pass?

We also have to say to you that the hospital in the Secretary of State’s own constituency meeting ‘in private’ sends a very, very bad signal. Didn’t David Nicholson last year urge all hospital boards to meet in public? You and your predecessors have constantly talked about public and patient involvement yet this, the most obvious way of meeting that aspiration, is denied to your own constituents.

So has your Inquiry revealed anything useful to the people of Stafford and Mid Staffordshire, the communities that have been so badly damaged? Frankly no. All it did was to confirm that the staff and management at the hospital were for many years heartless and incompetent. If this had been phase one of a full public inquiry it could have served a useful purpose but as a whole inquiry in itself designed by you for your own ends definitely not. We trust you will make the Robert Francis’s report public as soon as you receive it.

It was clear from the start that you wanted your Inquiry to pretend that the Government, its ministers and the Department of Health have no role in the NHS, that the SHA, PCT, Monitor, and the very many regulatory bodies have no role in patient safety. So the vast array of questions facing those bodies and their ‘controlling minds’ during this whole sorry affair, with David Nicholson at the top of the list of those who should be questioned, but you too fairly high up for your role in authorising Stafford Hospital to proceed in its foundation trust application, still remain.

Mr Burnham the solution is obvious, order a public inquiry under the 2005 Act now; get it started as soon as possible, then the time and effort spent on your Inquiry won’t be entirely wasted.
Finally a point of information that we'd like you to answer. Both ourselves and other campaigners have been trying hard to discover precisely the boundaries of the remit if the Health and Safety Executive in relation to NHS hospital patients and their care, there seems to be no clear answer; in fact as far as we can discover there is no formal agreement on this issue. Please set out for us the acts, orders, agreements, memoranda, and other documents which set out the HSE’s remit.

Our invitation to you to visit our group at the Breaks Café remains but the group will be in Westminster on Tuesday 2nd February, why don't you find us some time? The members would certainly appreciate it and it would be really useful to discuss these key questions of patient safety with you.

Thank you

Yours sincerely,

[Signature]

Julie Bailey
Cure the NHS
APPENDIX

From our letter to you of 27 November 2009:-

The fundamental error in all NHS and government thinking and the reason why all these failures are happening (and are endemic now in the NHS) is that errors and appalling standards of care are inevitable, and should be accepted as part of everyday life in the NHS, on the wards, in the A&E department, and in the operating theatre and, therefore, can be left to be discovered after patients have suffered and died.

This is wrong, very wrong, and wholly unacceptable.
The only approach is getting all treatment and care right first time with zero harm to patients – zero.

Antony Sumara and his team at Stafford Hospital has adopted zero harm and right first time as the core of everything they do and we are now working with them to develop and to deliver the changes in attitudes, beliefs, behaviours and approaches that are necessary to achieve this.

The ‘Stafford Care Square’ is another essential element of patient safety and quality of care management which we are helping them to develop. This will be another first in the NHS.

Our challenge to you, Mr Burnham, is to help us to do this and to make sure that these radical changes to the whole approach of the NHS are implemented very, very rapidly.

We urge you to order all hospital boards to conduct this process in public, in an emergency session next week.

"STOP AND MAKE-SAFE" FOR THE WHOLE NHS, A TASK FOR THE HOSPITAL BOARD – STARTING AT STAFFORD

The plan to have mortality rates published as a matter of course is a welcome first step in this process. All hospital boards, including those of foundation trusts, should immediately hold special public sessions to set out for their local populations at the very least:

1. their mortality rates. They should explain:
   a. their non-standardised and standardised statistics
   b. the comparison against their ‘peer groups’ and national rates
   c. an explanation of what these mean
   d. the steps they have taken to reduce their figures to the lowest possible levels
   e. the steps they took to address any previous adverse gaps between their own levels and the lowest reported rates.
f. the steps they have taken to cross-check and revalidate their coding. This should be done both internally and by external verifiers.

It should be a fundamental principle of the NHS that the mortality rates of all hospitals should be the lowest in comparison with the rest of the world.

The Health Secretary should take personal lead in ensuring that the action plans to reduce all mortality rates to the lowest possible as soon as possible.

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_The Health Secretary should take personal lead in ensuring that the action plans to eliminate adverse incidents. It should be a fundamental principle of the NHS that 'untoward' incidents can be and will be eliminated._
OPEN LETTER

Cure the NHS

Rt Hon Andy Burnham MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
Westminster
London
SW1A 2NS

23 February 2010

Dear Mr Burnham,

STAFFORD HOSPITAL

Thank you for letter of 10th February.

Quotes from your letter are in italics.

During your political slot broadcast on Channel 4 last night you claimed that the NHS was in the best shape ever. That is an insult to all of those from this community who died in Stafford Hospital over the last decade while your ‘best ever’ NHS delivered care that we the loved ones they left behind can only describe as appalling, disgusting, inhuman, incompetent, inhuman, unprofessional. How dare you claim the NHS is in the best shape ever after the Stafford Hospital disaster and similar failures of care at most recently in Essex? And after the report by the Patients’ Association and the Alzheimers Society? Did the degrading treatment offered by your ‘best ever’ NHS cross your mind as you signed off that broadcast?

Why don’t we ask Channel 4 or one of the other broadcasters to set up a TV debate between you and me? Then I can hopefully help you to understand just how bad your ‘best ever’ NHS can be. Of course some patients get ‘best ever’ care but what about those like my Mum and the loved ones of all our members who got ‘worst ever’ care?
You and your 'best ever' need to own up to 'worst ever' care as well. It's widespread in the NHS. 'Worst ever' care delivered to thousands who like my Mum were degraded and humiliated in their last days by NHS staff, worst ever care delivered to those misdiagnosed and discharged to die, 'worst ever' care for the thousands killed by avoidable errors made by NHS staff.

When you do make your statement to the House tomorrow will you refrain, please, from telling us how bad Stafford Hospital was, how bad the nursing was, how chaotic the A and E was, how poor the management and the board, how much bullying went on? We already know. In the last weeks of her life my mum had to endure the hell that those wards were, all our members' loved ones had to endure that hell. Our loved ones died because of the awful place it was and the awful and incompetent care they received.

What we want to know is why it was allowed to get in that state in the first place and why no-one did anything to restore decent standards and so had to endure top the unnecessary suffering and death.

That's why we will not cease demanding a full public inquiry set up under the terms of the Inquiries Act 2005.

Do not now try to make out that it wasn't as bad as the Healthcare Commission reported; I can assure you it was far, far worse than you, than Mike O'Brien, Ann Keen, and the rest of your Government colleagues could ever imagine.

We also urge you not to use that awful phrase 'it's time to move on'. When you've lost a loved one because of the failure of an organisation which the Government controls, supposedly on your behalf, it is not possible to 'move on', let alone when that government is in deep denial about its part in your loved one's death.

That 'move on' thinking is the same as that which leads you and your Government and only a week ago Department of Health officials to say when anyone challenges you about the scale of NHS failures or the number of avoidable deaths 'the vast majority receive good care'. That's absolutely unacceptable. When an avoidable error kills an NHS patient it's a personal tragedy that should not be rendered down into 'just one of a small percentage of failures'. It's a culture of excuses and denial and it must be changed; you are the person to start that change.
And this is not confined to Stafford Hospital, there is now a substantial list of NHS failures across the country, who knows what the real scale of failures is? Stafford has shown that the whole NHS regulatory system is not and has not been fit for purpose for a long time, perhaps it never has been.

One matter of extreme importance did emerge during your inquiry is the allegation against a senior member of staff in relation to communications with the coroner. Now we find that is being investigated by an NHS insider. That must be wrong. Staffordshire Police should be leading this investigation.

"The events at Mid-Staffordshire were appalling and I am acutely aware of the devastating effect that has had on families such as yours and on the wider community."

Devastating is the right word so it mystifies us why you neither you nor any of your ministers have yet taken the trouble to come and listen to our groups devastating experiences or the many ideas we have been promoting for radical change at Stafford Hospital across the NHS.

Having experienced what we have, heard of so many similar experiences from bereaved relatives, including those in your own constituency, read so many other accounts such as the Patient Association's, and after last week's revelations about the major failings in the NPSA's alerts system and the slowness with which hospitals respond, can we conclude anything other than that your Government's stewardship of the NHS has been an utter failure? We cannot.

We set out for Alan Johnson on 2nd April last year a range of ways of ensuring that the whole NHS was safe; we suggested organisations who would be able to assist in implementing well-tried and well-tested ways across the NHS; neither he nor you have done anything to pursue those suggestions or to implement any new thinking to eliminate the kind of appalling care that prevailed at Stafford Hospital from the whole NHS and to eliminate all avoidable deaths. We conclude that the whole of the Department of Health is not fit for purpose. Not fit for purpose because if the objective of the Department is to heal sick people it seems not to be able to organise that without killing very many patients, thousands of patients, as well. Call them 'excess deaths', 'avoidable deaths' whatever you like, the duty of the Department and the NHS should start and end with 'zero harm to patients'.

Since the publication of the Healthcare Commission’s report nearly a year ago we have seen no evidence from your Department that its ministers or its officials understand the basic
concepts of safety and quality that have driven many other sectors for decades. That is a major failure on your part and of your ministerial predecessors in Richmond House.

That is precisely why I felt a further independent Inquiry was necessary, to allow more patients and families like you to be able to tell their own stories. I know that many people — including staff at the hospital — have provided evidence to the Inquiry and I look forward to hearing the conclusions of the Chairman Robert Francis QC in due course.

So it was ‘your’ inquiry, it was not independent, it was designed by you for your ends. Thank you for making that clear.

Our members and many other families had already told our stories to the NHS through the complaints system, the deeply flawed complaints system. We had told our stories to the Healthcare Commission; we had already told them many times to the local and national press; we had told them to your ‘Independent Review of Casenotes’ (that has so many failings we shall have to cover it in separate correspondence); how do you think it could help to tell them again in private to lawyers appointed by you?

Really it was a very small number of current and former staff who appeared but a great deal of what they said was at best feeble and generally contradictory. Many still couldn’t see what they had done wrong. Judging by the public summaries of staff evidence it looks as though the word had gone round to avoid mentioning Martin Yeates’s role and, of course, he did not appear in person. Too sick to appear? Who decided?

*The precise procedures that you refer to in your letter were of course entirely a matter for the Independent Chairman to decide, including who could and could not attend the hearings.*

Mr Burnham, no-one believes that. The inquiry was conducted to your specification. Both Peter Carter of the RCN and Tony Wright MP were advocates of private hearings. Apart from the moral aspects of such an approach, in practice it did not help to encourage current staff to appear, so from that point of view it was a failure. Robert Francis himself had to admit that the privacy rule was rather farcical since many people could anyway be identified by their role or former role at the hospital.

*We remain determined to learn all the lessons from what happened at Mid-Staffordshire and, in building on the earlier reports, the Inquiry will mark a further important step in that journey.*
The main lesson to learn from the disaster at Stafford Hospital is that from 1997 till now the succession of health secretaries and ministers, Department of Health officials, NHS officials in the SHA, the PCT, in the many NHS regulatory bodies, in Monitor, local councilors, and many others failed to act to stop the disaster in spite of the copious and very public information that was available from 1999 onwards.

With all due respect to Robert Francis we doubt very much that he will have unearthed any 'lessons' about running Stafford Hospital specifically that Antony Sumara will not have already discovered and addressed. We have been desperately trying to persuade you as we did Alan Johnson before, that the major lessons for the NHS nationally have been very clear for many years; they have been set out for you by ourselves for a year and so the only conclusion we can take is that you do not want to listen.

However, I have always stressed there can never be any room for complacency.

We say you and your predecessors have been very complacent; how else could we still have thousands of deaths by avoidable error in the NHS every year? Thirteen years after Tony Blair said “Twenty four hours to save the NHS!” It is now ten since the excellent report “An Organisation With a Memory” was published; but what happened to the implementation? The recent ‘File on Four’ showed how poor it has been.

Patient safety must be the subject of a continuous process of improvement.

Continuous improvement is fine in itself but when thousands of lives are being lost because of avoidable errors and lives ruined by atrocious hospital care it immediate and rapid change that is the only option. You don’t even seem to grasp that radical change is needed. ‘Zero harm’ must be the top priority; it’s been adopted at Stafford Hospital.

This has been the fundamental gap in your whole approach to the NHS. This is what former Health Secretary John Reid said in 2004:-

The singular value that I want to use as the measure of what we are going to do over the next few years is that of equity of access to health services free at the point of delivery. That value cannot be met when some people were waiting 2 years or 18 months or 15 months or 12 months for their operations. Fortunately there is now nearly no-one waiting that long in this country.

"Singular value", "equity of access". Completely flawed thinking. Apart from a complete failure to understand that 'capability' is the prerequisite to success in pursuing targets, the approach was admirable but targets and the avoidance of financial deficits became the
obSESSION of your Government and the command and control style driven so hard by you and your predecessors in pursuit of them led to a collapse of the culture of care at Stafford hospital, we have no doubt of that.

And it is this ‘command and control’ style from the top of the NHS, what we’ve heard described as ‘kiss up, kick down’, which we believe lies at the heart of the widespread culture of bullying across the service. Last year Sir Ian Kennedy warned about the “corrosive” nature of bullying among NHS staff and managers saying that it was something which permeated the delivery of care in the NHS, was caused by the NHS’s “hierarchical” culture and occurred across all staff groups.

As for a culture of zero harm we see that it was one of the themes of ’NHS Live’ in July 2004; this is how Nigel Crisp introduced one of the sessions:-

Don Berwick, who I am delighted is with us this afternoon, challenges us to contemplate an NHS where there is no unnecessary death, no unnecessary pain, no feelings of helplessness among patients and staff, no delays, and no waste. Knowing Don, he does not want us merely to contemplate it, but to do it. Thinking about this from an equality perspective, when you set local targets this autumn for the next planning round, remember Don’s challenges for all our patients and all our staff.

Did no one listen to Don Berwick? Did none of the assembled NHS staff think ‘an NHS where there is no unnecessary death, no unnecessary pain, no feelings of helplessness among patients and staff’ was worth delivering? It certainly wasn’t heeded by John Reid or his successors. That is the indictment against all of you, the zero harm idea has been around for years, some say millennia, you did nothing to deliver it.

That is why we established an Independent Regulator - whose powers we are strengthening through the introduction of registration of NHS providers.

It is the ‘regulators’ who have failed so badly; how many inspections of Stafford Hospital’s activities have there been by regulatory bodies since 1999 when the hospital received national prominence?

As you know, we do not agree on the need for an Inquiry under the Inquiries Act 2005.

Of course we don’t agree. You want to pretend that responsibility and accountability starts and ends inside the hospital itself. We know full well that it extends all the way the a succession of Health Secretaries, you included.
Such an inquiry would have been lengthy.

What is more important than the truth! Your Junior Minister's assertions that we wanted a short inquiry is patently nonsense. We have been pursuing you and Alan Johnson to set up a full public inquiry under the 2005 Inquiries Act since soon after the Healthcare Commission's report was published, we will continue to do so until you do set one up or the High Court sets one up.

..... and would have distracted staff and managers for months

Your recent inquiry certainly didn't because very few staff attended.

The hospital needs to recover quickly for the sake of patients.

A completely separate issue. Recover quickly! If the ministers, the Department of Health, and thousands of NHS officials over the years had been doing their jobs properly there would be nothing from which to recover. 'Zero harm, right first time' should have been the very first goal after Tony Blair's pronouncement. What a pity you didn't start that process though in 2007 when you were Health Minister and approved Stafford Hospital's proceeding to the final stage of the foundation trust application process. Incidentally when you did your front line visits to hospitals with a West Midlands paramedic in 2006 did you visit Stafford hospital? You record that he told you each hospital was different; what did they say about Stafford?

But it was interesting to hear an insider's view of the differences between various hospitals and their A&E departments.

In the future, when basic waiting guarantees have been standardised, it will not be necessary to perform manage every stage of the patient journey. Instead, what should be measured is the quality and safety of what every NHS organisation is providing. Overall, from 2009, there should be fewer national targets and the inspection regime should focus on placing clear and authoritative information before the public that will be relevant to the choices they make, including patient satisfaction results for each NHS organisation.

Given the thoroughness of the reports already produced by the Healthcare Commission,

It took the Healthcare Commission long enough to notice that there was a serious problem at Stafford Hospital. Didn't they notice when they were first set up in 2004 that Stafford Hospital had dropped from three to zero stars? It was only my own persistence after the
death of my mother, Bella, that their attention was engaged. They had already failed to act
on a number of Dr Foster alerts.

Professor Sir George Alberti

George Alberti came to visit the group. He acknowledged openly that he spent very little
time in the hospital. When at our insistence his remit was included to include nursing
standards he met that remit by in his own words stopping a few people in the corridor.
Independent, of course not, a Department of Health 'czar'.

and Dr. David Colin-Thome,

We've got to know David well but he was not given the time to conduct anything remotely
approaching a 'thorough' investigation. We have told him we simply do not accept his
conclusion that the SHA nad PCT suffered 'organisational loss of memory'. Independent, of
course not, a Department of Health 'czar'.

as well as the availability of an Independent Clinical review to those who have had concerns
about the care they or a loved one received at the hospital,

Another farce. Not independent and extremely badly organized, seriously overrunning its
original target. We have told you before that one of the doctors who was supposed to do the
reviews has been very rude and offhand with our members. We shall write to you separately
about this issue.

the Francis Inquiry was the best option.

No it was the worst option because you've now wasted time and resource on what will prove
to add very little to the knowledge of why there was a disaster. The 'why' is so important. A
full 'root cause analysis' getting to the bottom of why the Government and whole NHS
structure failed the community over such a long period.

I am very keen to visit the hospital again and would hope to meet with you at that time to
hear about the work you have been doing with Antony Sumara. However, in light of the legal
proceedings you have instigated and with the Francis Inquiry due to report soon, I feel it
would be more appropriate to do so after I have had the opportunity to consider the
conclusions of the Inquiry.
We look forward to welcoming you but we are disappointed to see that our first invitation to you was sent in June last year, why so long in accepting it? You did come to Stafford but were not prepared to see out group separately; you should be more sensitive to what our members have been through.

Can you explain why your Junior Minister Mike O’Brien treats myself and my fellow members with such disdain and cruelty? O’Brien kept our group in the freezing cold for four hours last Friday, a group comprising a number in their eighties, refusing to invite them into his office. When he finally deigned to speak to us it was on the pavement.

We know you’re both afraid of the truth we are telling; well you have to hear it, neither you nor anyone else can make the truth of all of those ‘excess’ and unnecessary deaths go away, whether it was one hundred, one thousand, four hundred or four thousand, one was too many!

All of that misery and suffering inflicted by NHS staff, by supposedly caring professionals. All of that happened during your stewardship of the NHS. You and your Government colleagues failed, failed disastrously. This will be an enduring stain on the time you spent in power.

Our recommendations. For a year now we have prided ourselves in offering a wide range of practical and radical changes to the NHS., please have another look at them. Please order the immediate implementation of the ‘stop and make safe’ process, outlined in the appendix.

Please hold a full House of Commons debate into mortality statistics and deaths from avoidable errors. The scale of avoidable deaths in the NHS is frightening, we know that some hospitals still do not report serious untoward incidents in a timely manner nor do they respond to alerts as they should. Precisely how many NHS patients are killed by NHS staff errors every year? How many die unnecessarily every year because of substandard care who would have survived had they been treated elsewhere? We saw only in the last few days that hospitals in your own constituency have reassessed the number of patients coded as palliative care in the most dramatic way so as to reduce the gross mortality ratio. We challenge you to have all of these recodings audited by a third party. See the appendix for the details.

Closely allied to this has been the removal of the Dr Foster Unit as the mortality statistics analyst. You reportedly told one of your constituents that some hospitals were unhappy with the scores they were awarded; is awarded the correct word? Would you set out for the public a full explanation of mortality statistics, why and how you changed the analyst, and
whether the new supplier will use the exact same methodology as Dr Foster? Mortality statistics are used far too little to inform the public about the safety of their local hospital; that needs to change.

We cannot close without mentioned the issue of rewards for failure in the NHS; would you set out for us how it was that former chief executive Martin Yeates could simply be paid off by the board and former director of nursing and governance Helen Moss simply transferred without a blemish on her record? To us this seems totally unacceptable. How is this possible?

But first order a full public inquiry under the terms of the Inquiries Act 2005 into the disaster at Stafford Hospital, a proper inquiry under the Inquiries Act 2005, not like the sham you’ve just conducted.

Thank you

Yours sincerely,

Julie Bailey
Cure the NHS
"STOP AND MAKE-SAFE" FOR THE WHOLE NHS, A TASK FOR THE HOSPITAL BOARD – STARTING AT STAFFORD

The plan to have mortality rates published as a matter of course is a welcome first step in this process. All hospital boards, including those of foundation trusts, should immediately hold special public sessions to set out for their local populations at the very least:

1. their mortality rates. They should explain:
   a. their non-standardised and standardised statistics
   b. the comparison against their 'peer groups' and national rates
   c. an explanation of what these mean
   d. the steps they have taken to reduce their figures to the lowest possible levels
   e. the steps they took to address any previous adverse gaps between their own levels and the lowest reported rates.
   f. the steps they have taken to cross-check and revalidate their coding. This should be done both internally and by external verifiers.

It should be a fundamental principle of the NHS that the mortality rates of all hospitals should be the lowest in comparison with the rest of the world.

The Health Secretary should take personal lead in ensuring that the action plans to reduce all mortality rates to the lowest possible as soon as possible.

2. their 'untoward' incidents record. They should explain:

   a. the number, nature, and classification of all incidents at their hospital
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e. the steps they have taken to reduce their figures to zero.

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The Health Secretary should take personal lead in ensuring that the action plans to eliminate adverse incidents. It should be a fundamental principle of the NHS that 'untoward' incidents can be and will be eliminated.
Wrightington, Wigan and Leigh NHS Foundation Trust

Mr Andrew Foster, Chief Executive
Email: /n
Ref: FOI2010/0593
Date Received: 25/01/2010
Response Due: 19/01/2010

19/02/2010

Dear Mr Cubells

INFORMATION REQUEST UNDER THE FREEDOM OF INFORMATION ACT 2000

We are now pleased to respond to your request for information under the Freedom of Information Act regarding the use of the ICD 10 code Z51.5.

1. In reference to code Z51.5 and using the International Classification of Diseases 10th Revision - ICD-10, can you please provide the total number of patients that were attributed this particular code in regards to your trust - please provide total numbers of patients on a yearly basis, from and including 2003/04 to 2008/09 inclusive in regards to the above mentioned code.

Specialist Palliative Care is a package of care for patients identified as having advanced illness that cannot be cured who have specific symptoms warranting involvement of the specialist Palliative Care Team.

The criteria used by the Trust for referral to the palliative care / care of the dying pathway are:

- Patient has advanced progressive life threatening illness
- Patient is suffering from difficult pain and symptom control problems
- Patient and or family have complex psychosocial problems
- Patient is nearing the end of life and requires care and support for themselves or their family, which may include bereavement support
- Patient requires symptom control or support during curative treatment
- Own team unable to meet the patient/carer needs
- The patient, if competent, agrees to referral

Some of these patients are dying and die in Hospital as part of the same episode of care whilst many who are seen during their inpatient stay are discharged into the community. The Trust's Palliative Care Team then

Chairman: Mr Les Higgins  Chief Executive: Mr Andrew Foster CBE
Ilness with the community-based specialist palliative care services to provide appropriate ongoing support whether this takes place in the patient's own home, care home or hospice.

The care for dying pathway can be delivered to patients in a care setting that could include one or more of:

- Hospital
- Hospice
- Care / nursing home
- Patient's own home

The decision as to the most appropriate care setting to deliver palliative care is based on discussions and agreement between the Palliative Care Team, the patient and their carer or family.

The trust only assigns the ICD10 code for palliative care when there is written clear documentation in the notes that the patient has been seen by a member of the Palliative Care Team. This complies with NHB Connecting for Health Guidance on the Coding of Palliative Care.

In relation to your specific request, the data extracted from our systems indicates the number of patients coded for palliative care as requested in financial years where data is available were:

- 2005 / 2006 - 11
- 2006 / 2007 - 4
- 2007 / 2008 - 8
- 2008 / 2009 - 304

On reviewing these figures the Trust realised that data capture for ICD10 code prior to 2008/09 did not appear to be complete and therefore the palliative care service was not being properly funded. Further investigation identified that the Trust enhanced its ICD10 coding in 2008/09 and improved the recording of patients seen by the palliative care team from September 2008 onwards.

The Trust felt it best to review paper records of episodes of palliative care to provide greater accuracy for the number of patients referred for palliative care in earlier years. According to paper records maintained by the Trust's Palliative Care Team, the numbers of patient referrals for palliative care per calendar year were:

- 2006 - 298
- 2007 - 289
- 2008 - 282
- 2009 - 360

The Trust believes these figures from the paper records present a more accurate record of the true numbers of patients who were referred for palliative care.
I trust that this information answers your original request, however if you are not entirely satisfied with this response please do not hesitate to contact my colleague Lisa Back, Information Governance Co-ordinator on... If we do not hear from you within 28 days we will assume that we have been able to accommodate your request under the Freedom of Information Act 2000.

Yours sincerely

Andrew Foster
Chief Executive

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If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision. Generally the ICO cannot make a decision unless you have exhausted the complaints procedure at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

Chairman: Mr Les Higgins  Chief Executive: Mr Andrew Foster CBE

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OPEN LETTER
Cure the NHS

Rt Hon Andy Burnham MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
Westminster
London SW1A 2NS

29 March 2010

Dear Mr Burnham

YOU’VE LET THE PUBLIC DOWN – AND VERY BADLY

As you leave office we can only conclude that you have missed a major opportunity to lead the NHS into a new era of “zero harm, right first time” care. Frankly since you took over last Summer you’ve done nothing give us any reassurance that you even understand what patient safety is.

We were disappointed that your junior minister, Mike O’Brien, refused even to get out of his car last week to meet us when he visited Stafford. Wouldn’t it have been an excellent opportunity for him to hear our views of the Inquiry at first hand? There have been so many flaws to it and as we tried to tell you from the start you will find out little more than the Healthcare Commission found out.

The secretive nature of the proceedings was extremely unfair and means that the public will never know who appeared let alone the full version of what they said. The number of current staff who gave evidence was extremely small thus disproving the government’s theory that secrecy would encourage them to come forward. Without those elements which a public inquiry would impose, compulsion on witnesses to attend and cross examination under oath, the evidence of staff and former staff does not really add up to much.

Could we ask you to feed back some corrections to statements made to the Express and Star by the junior minister? Thank you.

Mr O’Brien said the impact of another inquiry would distract the hospital at a time when it needed to concentrate on improving standards.
Cure the NHS say that since very few current staff from the hospital gave evidence at this Inquiry the whole hospital could hardly have been distracted. In none of our extensive discussions over the period of the Inquiry with the chairman, the chief executive, the medical director, and the chief nurse, have we heard them refer to this possibility.

Further that the junior minister should not deny either members of Cure the NHS or the wider public a full and proper investigation into the disaster at Stafford Stafford, why it happened, who was accountable. Those accountable will of course be found not only in the hospital but in all of the regulatory bodies, i.e. ****************. It is these people that a proper inquiry, that is a public inquiry under the Inquiries Act will need to interrogate.

said: "I think Cure the NHS have got all they are likely to get.

Cure the NHS say that this is wholly inappropriate way for a junior minister to talk about a group of people whose loved ones died in such miserable circumstances of the NHS which he plays a role in overseeing.

I think we need to give the hospital the opportunity to look after patients rather than being distracted by yet another inquiry which could take 18 months or more.

Cure the NHS refer you to the answer above. A proper inquiry into the disaster at Stafford Hospital will focus entirely on the regulatory and government system for running the NHS. It will be calling you and your predecessors in the Department of Health, NHS chief executive David Nicholson, and many NHS officials, Bill Moyes, and Cynthia Bower, as former chief executive of the West Midlands SHA. The objective being to find out why none of these ministers, officials, regulators, inspectors, managers, executives and non-executives, failed to act to prevent the disaster, so much suffering, so much grief.

"The price of what they want, for the hospital, is too high. That hospital needs another inquiry like a hole in the head. We need to get this hospital up to standard and focus on that."

Cure the NHS say that this is even more insensitive than any of the previous remarks. Wholly wrong, wholly inappropriate, and this from a man with strong links to the area, a former student at North Staffs Polytechnic.

He added: "The lawyers for Cure the NHS asked for an inquiry of between four and six weeks. It was clear a public inquiry like they requested would last 18 months to two years."
Are you sure? Cure the NHS briefed Leigh Day on 18 March 2009. Since that date Leigh Day have vigorously supported Cure the NHS in their call for public inquiry under the Inquiries Act 2005 and started the appropriate steps for legal action to secure such an inquiry on 27 March 2009. The objective of the inquiry will be to get to the truth of the Stafford Hospital disaster, the length of time it takes should be of secondary importance. Had your recent secretive inquiry been given a proper remit and one not dictated by the desire to deflect criticism, responsibility, and accountability from ministers, Department of Health officials, and many other NHS managers, executives and non-executives, then the time and effort of the past six months would not have been so badly wasted.

This hospital needs to get a move on.

The NHS believe the hospital certainly does get a move on, but we can say confidently that your recent inquiry will not have provided any learning for the new chief executive in how to run the place. We meet the chief executive frequently and we believed he is ‘getting a move’ on with many ideas provided to him by Cure the NHS. Not least of these ideas is ‘zero harm, right first time’ which is the only moral approach for the NHS. We note that the hospital has adopted this concept, you have not.

The belief that we could do it in six weeks was in my view, as a lawyer myself, complete nonsense."

Who set the timetable for the inquiry? You did. Would you mind reviewing with Mr O’Brien the papers from your office and from Robert Francis QC before and at the beginning of the inquiry?

As I said to the Express and Star "The groundwork for a public inquiry has already been done. We believe until we have a public inquiry the hospital will never move on. As soon as Antony Sumara leaves the problems will re-surface again. "We are hearing new complaints and problems every day. We want the Government to know we are not going anywhere and we will be a thorn in their side throughout the election campaign."

Thank you

Yours sincerely,

Julie Bailey
Cure the NHS
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KL8 [ ]
to the Witness Statement of Ken Lownds
TURNING THE NHS
THE RIGHT WAY UP AGAIN

AN ACTION PLAN

FOR

RADICAL CHANGE TO THE NHS

Presented to

RT HON. ANDREW LANSLEY MP
Secretary of State for Health

By

CURE THE NHS

OCTOBER 2010

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INTRODUCTION

THIS IS AN ACTION PLAN!

CURE THE NHS IS A NON PARTY - POLITICAL CAMPAIGNING GROUP
SINCE MAY 2009 A NUMBER OF DOCUMENTS HAVE BEEN PRODUCED BY
CURE THE NHS UNDER THIS TITLE.

THE FOCUS IS MAINLY ON ACUTE HOSPITALS BUT ALL OF THE ISSUES APPLY
TO ALL SITUATIONS WHEN CARE IS DELIVERED

CURE THE NHS LOOK FORWARD TO ADDING DETAIL FOR THE PARTY ON
EACH OF THESE TOPICS

WHILE THIS DOCUMENT ADDRESS PRINCIPALLY PATIENT SAFETY IN NHS
ACUTE HOSPITALS THE IDEAS ARE APPLICABLE ACROSS THE NHS AS IT IS
NOW AND WILL BE AFTER THE FULL RESTRUCTURING SET OUT IN
“LIBERATING THE NHS”
INTENTIONALLY BLANK
KEY MESSAGE

The disaster at Stafford Hospital showed that acute care in NHS hospitals is in crisis.

This paper sets out an action plan to “turn the NHS the right way up again”.

It's essential to rebuild the culture of care which has collapsed.

There are three key steps needed to do that rebuilding:-

1. a transformation of culture which sees frontline staff across the medical professions shoulder the burden of leadership of acute hospitals. This is the culture of 'professional commitment' without which nothing succeeds.

2. the development of a Patient Safety Management System to set out the patient safety philosophy of the NHS, the way that risks to patient safety will be managed, and accountability for patient safety in every hospital, in the regulator body, and in Government

3. the development of Patient Quality Management System to form the detailed source of all care quality standards, measures, processes, and procedures.

4. the establishment of a unified regulatory body

First and foremost there must be an immediate “Stop and Make Safe” challenge at every NHS hospital to demonstrate to the public and to the Government that it is safe; this process will use hard evidence of mortality rates, avoidable harm, complaints, and diagnosis success.

“Stop” doesn't mean “Don't treat patients until you've done this”; it means “produce the hard evidence and reflect!”.

The essence of the patient safety philosophy:-

Highest quality care! Right first time! Zero harm!
First "Stop and make safe!"

Then:

Develop and implement:

ALL NHS ACTIVITY - HIGH QUALITY CARE, RIGHT FIRST TIME, ZERO HARM
1. THE NHS NOW – “THE WRONG WAY UP”

There is a major gap between the public’s expectations of the NHS acute sector and what it can currently deliver.

The failures at Stafford Hospital covered all its activities and all of its professional staff.

- Chaotic A and E
- Appalling, incompetent, and inhuman nursing
- Uncaring, incompetent, and unprofessional care by consultants across the spectrum of royal college membership
- Uncaring, incompetent, and ignorant management, governance, and leadership

The national complaints system failed everyone who tried to use it.

All regulators failed either to identify the failings, which had persisted for at least a decade, or to act when they did.

The Department of Health failed, the local politicians failed, the Government failed.

By the most recent indications from current patients and their relatives little has really changed.

All of our discussions with the hospital management, with Royal College of Surgeons members, with Department of Health officials and with doctors, patients, and relatives around the country lead us to believe that acute care in the NHS is in crisis.

There are no quality standards for key elements of care, there is no recognisable risk management, there are no systems to support patient safety and delivery of care right first time with zero harm.

Record keeping is unprofessional, uncontrolled, and open to abuse by staff.

Key measures of care that would give hard evidence of the true quality of care and the number of avoidable deaths and scale of avoidable harm are completely absent.
Worst of all though is that the culture across the NHS seems to be disorganised and operating always on the edge of chaos.

It is clear that our society is no longer able to provide a sufficient cohort of dedicated and capable young people who can nurse people in a caring manner.

Project 2000 has been a disaster and this needs to be acknowledged. Trainee nurses should start on the wards with their tutors. The basics of “hands on” personal care nursing are the principle requirement and as our population ages these capabilities should extend to the emotional demands of nursing the elderly with dementia.

We believe that the “culture of care” has collapsed as a result of two factors:-

Domination by “managerialists”, managers and executives more interested in the hospital as a business institution than as a place of safe care and treatment for the sick

The retreat of the professionals from all royal colleges from any responsibility for the overall quality and safety standards of the acute hospitals in which they work.

The result is that hospitals regularly persecute professional staff who attempt to raise issues about hospital standards, so-called “whistleblowers”, and torture, it is the only suitable word, patients or their relatives who complain about their treatment.

The culture of denial enforced by the last government has made it almost impossible to bring these issues into the political or public domain.

Unless these failures are tackled robustly and immediately another five years of appalling treatment will ensue across the NHS.

Cure the NHS believes the NHS does not know what highest quality care is, nor does it understand the concepts “right first time” and “zero harm”.

This is an issue for our society and we the public and patients need to ask the professionals who deliver care in the NHS “How do you view us when we turn to you in our hour of need as patients and loved ones of patients? The evidence is that on very many occasions you treat us and our loved ones with contempt, you organise
yourselves in the most chaotic way and try to deliver care in the most disorganised way; you change notes, you change death certificates, rather than the truth you tell us any old story. That is our truth about today's NHS and you as its professionals, please tell us your truth!"

Until the public and the Government have had that conversation with the NHS front line we will not be able to “turn the NHS the right way up” because we are looking to them to do it. First let us understand each other.

This paper sets out how to tackle these failings and to transform the NHS into a service where every single one of us can go to any hospital and know that NHS also stands for “No Higher Safety Standards” anywhere in the world.

As a society we have little idea about what our NHS really does. We have little understanding about end of life care and how we should deal emotionally with our loved ones from when they enter a hospital to when they die there. We do not challenge the NHS, respectfully of course. This was the failing that led directly to the Stafford Hospital disaster. As patients and relatives we don’t ask or challenge; as non-executives we don’t, as councillors we don’t, as hospital governors we don’t, as PPI forum and LiNK members we don’t, as Members of Parliament we don’t, as coroners we don’t. We must start a nationwide discussion on this issue.

We must start to ask, to comment, and to challenge. This can always be done respectfully but we must start. We must be prepared to learn about the fundamental measures of performance that will keep us safe during our stay in hospital.

To date we have as a society paid only lip-service to a “patient- centred NHS”. Too many lives have been lost too many lives will be lost if we don’t grow up as a society and make a start on this new way of running our NHS, with the public, the owners of the service, as the principal regulators.

Please note that the group’s views on elements of "Liberating the NHS" are implicit in what follows. We apologise for not being able to cover the other elements, particularly GP commissioning. We welcome the disappearance of Primary Care Trusts and strategic Health Authorities.
The NHS seems to be characterised in 2010 as a service which has the most extraordinary technologies which can heal and treat the sick and injured, administered by professionals with the most extraordinary psychomotor skills, but working in acute hospital environments that can only be described as chaotic, uncaring, and lacking almost all the systems which have for many years been common in most safety-critical sectors.

Today's NHS does not seem to know what "highest quality care" is.

Turning the NHS the Right Way Up again – Led by Medics Not Managers
2. "STOP AND MAKE SAFE FOR THE WHOLE NHS"

This process was originally devised and presented to the previous Government in April 2009. Conducted at a special and widely advertised public board meeting it would ensure that the Government knows what every hospital's performance is on avoidable deaths, avoidable harm, and quality of care is. There is no other way of finding out and at the moment no-one knows.

It should include at least:-

i. 'excess' deaths (HSMRs), how many of our patients would probably have survived if they had been treated at a different hospital? Explain. Thousands are dying unnecessarily every year. This would include a review of all deaths in the hospital, those for which a post-mortem had been ordered, those for which an inquest had been ordered. Many relatives report complete dissatisfaction with hospitals’ handling of production of death certificates, post-mortems and inquests. There is a need to examine the recommendations of the 2004 position paper "Reforming the Coroner and Death Certification Service" have been carried satisfactorily into the Coroners and Justice Act 2009.

ii. serious untoward incidents (SUls), avoidable, and often repeated, errors. Explain. Thousands are dying unnecessarily every year.

iii. complaints – Review and explain the anonymised serious complaints. Explain. Tens of thousands are receiving appalling treatment every year without the public or government knowing.

iv initial diagnosis rate and ultimate correct diagnosis rate – the ability correctly and quickly to diagnose is clearly a critical measure of the hospital’s capability and a major factor in getting it right first time and doing no harm. Explain

This will form the start of a radical new way of running the NHS which for the first time makes patients and public part of the primary system of regulation, that is, the hospital needs to explain to the local population and to the Government exactly how it is performing in regard to the life and death of its patients.

The results show be circulated widely in local and regional media.
Explaining hospital performance to the local population is the best stimulus for highest quality and zero harm.

After the initial special session they should be held monthly.
3. TURNING THE NHS THE RIGHT WAY UP AGAIN

This will be an NHS led by medics not managers.

This is a major challenge that *Cure the NHS* believe the Secretary of State should pose now to the royal colleges, colleges, unions, and all frontline staff. Laws, regulations, standards, speeches, and exhortations will change nothing. It is only a change of heart and a change of behaviour in all of these frontline carers who can change it.

Professional commitment is the key, from everyone involved.

We hope that the Department of Health including the Government team will pursue a similar culture so that they can demonstrate to the NHS that they believe in this way of working. The Commissioning Board and the Regulator should do the same.

An enormous amount of time and effort involving every single staff member in the NHS will be required to make this a reality. We caution against named initiatives with high-profile launches. We suggest all low-key, all led by NHS frontline staff. We must have faith in them to deliver.

The conference speeches could make a major impact by signalling that the change has started.

The steps must include all of the steps set out below:—
We see it this way now:-

COMMAND AND CONTROL CRUSHES CARE

Prime Minister

Chancellor

Health Secretary

Chief Executive NHS

Strategic Health Authority / Monitor

Hospital Board

Hospital 'Exec'

Management

Supervision

Carers - nurses, consultants, doctors, healthcare assistants, therapists, porters, cleaners, clerks

Patients and their relatives, loved ones and carers
Patients and their relatives, loved ones and carers

Carers - nurses, consultants, doctors, healthcare assistants, therapists, porters, cleaners, clerks, etc.
THE FRONTLINE LEADS - ON WARDS, IN THEATRES, IN CLINICS

THE FRONTLINE SAYS TO THE SUPPORT (= EVERYONE WHO IS NOT ON THE FRONTLINE, SUPERVISORS TO THE PRIME MINISTER):

"THIS IS THE HIGHEST QUALITY CARE WE WILL DELIVER
THIS IS WHAT WE NEED YOU TO DO TO SUPPORT US,
THIS IS WHAT WE NEED YOU TO STOP DOING!"

THE SUPPORT ASKS THE FRONTLINE:

WHAT DO WE NEED TO DO TO SUPPORT YOU IN DELIVERING HIGHEST QUALITY CARE?

WHAT DO WE NEED TO STOP DOING TO SUPPORT YOU IN DELIVERING HIGHEST QUALITY CARE?
4. CULTURE TRANSFORMATION

The “culture of care” has collapsed across the NHS. To rebuild it will require an enormous effort and activities involving every single staff member. This transformation activity must be led by NHS frontline staff equipped with the necessary skills.

The change will need to be “jump started” by the Secretary of State and his ministers taking the initial robust steps.

Culture change or culture transformation are always extremely challenging and achieving this in the NHS will definitely be no different but we all need to hope and believe that it can be and will be.

The challenge of taking over leadership and moving to a culture that puts delivering highest quality of care for every patient, right first time, with zero harm as the prime objective of every minute of the day, will need to be started by the Secretary of State and the actions outlined above should provide the “jump start” but the main thrust will need to be led by a team of trained frontliners.

The challenge to the front line medical professionals should be delivered in a series of roadshows covering, in the next six months, every single staff member in the NHS. The challenge to them will be to take the leadership of the NHS from the executives who currently dominate hospital activities and to commit to the new NHS “Patient Safety Commitment”

The objective is that every single NHS staff members, whether permanent, interim, temporary, locum, or agency, focuses only on patient safety, on right first time, and on zero harm, until that it what is delivered to every patient.

This will start to “turn the NHS the right way up”; it will be front line care staff that deliver this culture change, every professional, every non-professional.
5 THE CHALLENGE TO THE ROYAL COLLEGES AND THE UNIONS, TO ALL FRONTLINE STAFF

NHS staff drawn from across the medical professions do extraordinary work to save lives and cure illnesses and bring comfort to the dying. However hands-on work in the operating theatre the clinic or ward is just a small part of NHS hospital work and sadly the professions have universally failed to rise to the challenge set for them by Norman Fowler through Roy Griffiths a quarter of a century ago and the have ceded hospital leadership to the managerialists who now pervade the NHS.

Managerialists because the culture in all hospitals puts the importance of the hospital as an institution and its political goals above those of delivering highest quality care with zero harm, right first time on all occasions to all patients. The command and control culture fostered by the last Government has added to this managerialism and has crushed the culture of care to which the NHS once aspired.

The typical NHS hospital is today manned by non-executives who well understand that their role is not to challenge but rather unerringly to supporting the executives. Sadly these executives and their manager colleagues have brought few of the skills that Roy Griffiths would have imagined, many of the executives will be interims being paid a daily rate well over the odds. NHS managers are impossible to fire for incompetence and simply transfer elsewhere in the NHS. Permanence of the management team is not typical.

Nursing is carried out by agency or bank nurses with little commitment to the patients or the profession.

The chief executive of the RCN made serious misjudgments over his relationship with the board at Stafford and the whole of this union's activities appears to have been devoted to keeping the previous government happy rather than tackling performance standards.

It is now time for the royal colleges to rise to the challenge of taking the leadership of NHS hospitals from the cadre of managerialists. It is time for the cadre of managerialists to return to the role they should have occupied all along, that of general management.
Alj NHS hospitals should have a medical leader, supported by a team of clinicians and care deliverers.

Rather than chief executive the most senior non-clinician in a hospital should be a general manger leading a team of specialists to facilitate and support the work of the clinicians and the other whose job is directly to serve the patients on the frontline. The team should include expertise in operations research, IT, quality and safety management, finance, and HR, logistics, estate management, commissioning and all those functions and activities that enable the clinicians to have an effective and problem-free working day or night.
THE NEW NHS “PATIENT SAFETY COMMITMENT”

The NHS has its constitution and all sorts of promises and commitments, clearly at the moment, they carry no weight. One short operating philosophy is required and we believe that something along these lines should be at the heart of everything that the NHS does; it would appear at the start of the Patient Safety Management Manual, would appear prominently throughout all NHS premises, and would form the core element for discussion in the “roadshows” that we suggest should be conducted throughout the NHS over the next few months.

"The whole objective of the NHS is to heal people, therefore your first thought at every instant should be how can I do this right first time, how can I do it without harming my patient?"

Humans do make errors and in complex NHS care they will from time to time but proper preparation and focus of attention will eliminate most of them. The risks of every treatment action must be thought through in advance and error avoidance routines put in place together with action plans in the case that errors do occur.

Lack of attention and focus, sloppy and unprofessional working, treating patients without dignity or respecting, harming them in any way, being rude to them or their relatives is no part of the NHS.

Any NHS staff member who acts in such a manner will be removed from the service.”

.. send a letter signed by all non-execs and execs confirming that henceforth the entire focus of the hospital’s activity will be zero harm, and getting everything right first time. This is not only the only moral approach but it also delivers what patients need and want, it is far more efficient than tens of thousands of complaints costing millions to administer and further millions to settle in legal costs.
7. A RAPID CHANGE TO COMPLAINT HANDLING

One of the most iniquitous characteristics of the NHS today is the way that hospitals 'torture' (it is the only suitable word) patients and relatives through the complaints system. It should be noted that staff on wards do this while patients are still sick and in their hospital beds. It must be stopped at once.

There is no process for complaint handling that will work if they are investigated by staff whose primary duty is to the hospital, protecting clinical staff from investigation. That is why a change of culture from top to bottom is the sine qua non for improving the NHS.

Right First Time and Zero Harm are the keys to complaints. If hospitals concentrated on getting it right they would not have to worry about complaints.

As a matter of urgency the NHS Chief Executive & Monitor to write to all hospital chairs and chief execs to instruct them:-

* to reverse the current behaviour of being as obstructive as possible with complaining patients and relatives

* to pass on to all complainants within one month all of the information they require including copies of all of their own records and appropriate hospital records (cases not already being handled by the Litigation Authority).

   to assist all current complainants in resolving their complaints at once with Parliamentary and Health Service Ombudsman or Litigation Authority regardless of what stage they are at

* to notify to the NHS Chief Executive and chief Executive of Monitor of all complaints outstanding for greater than 6 months and reasons for failure to close

* to notify to the NHS Chief Executive and chief Executive of Monitor of all resolved complaints that took greater than 6 months to resolve and the reasons for failure to close them.
*  to send a letter signed by all non-executives and executives to said chief executive as appropriate confirming that henceforth all complaints will be investigated and resolved within days if not hours and on the occurrence of any medical error an immediate and full explanation will be given to the patient and/or relatives and that they are taking steps to embed this in the culture. This letter will of course be circulated to all staff.

Tragically the drive by the last two Governments to protect Prime Ministers, Blair and Brown, and a succession of Health Secretaries and Ministers from bad news has led to the "torture" of complaining patients and relatives and the harassment of any "whistleblowers". The contemptuous treatment by Tony Blair himself of Rose Addis and her family set the tone for the way the NHS has subsequently treated anyone who had the audacity to complain about the quality of services.

Prime Care Trusts, Strategic Health Authorities, ICAS, and all the bodies involved should be given the same instruction.

The Litigation Authority should be required to do the same and explain for any case overriding reasons why it cannot be resolved and settled at once.

The regular Litigation Authority settlement data should be published very widely in national, local. And regional media. There is no greater spur to better performance than this.

It remains a fact that settlements for claims against the NHS are circular flows of taxpayers' money. Paid in taxes paid back to a specific taxpayer who would without a doubt prefer the care to have been of highest quality, right first time, with zero harm.

Thirty years have passed since Philip Crosby set out the concept that "quality is free"!
8. THE COMPLAINTS “SYSTEM”

As we suggest above no system for handling complaints will be effective if there is no professional commitment to highest quality care, delivered right first time, with zero harm.

There is ample evidence that NHS hospitals have forfeited the right to investigate their own complaints but the system suggested in the White Paper for involving Local Involvement Networks will not prove satisfactory. The national experience with PPI forums and Local Involvement Networks suggests that they will never get round to doing anything and they simply will not have the skills and experience to be able to do what is complex and emotionally demanding work.

"Stoke-on-Trent the LINk has achieved meaningful yet."

Staffordshire LINk has had to be closed down once because it had been hijacked by a particular group of people who had no intention of letting any others participate. Having started again we wait to hear that is has achieved anything significant.

The Stafford Hospital experience demonstrates that there is a serious problem in this kind of formal public monitoring.

Local HealthWatch bodies will not meet the Government’s aspirations.

National HealthWatch embedded in the Regulator’s organisation is certainly a workable idea but it the transformation of culture throughout the NHS that will make the change. Professional commitment to right first time and zero harm.

For many years if not since the inception of the NHS itself when doctors largely shaped the culture the principal cultural driver has been the recourse following serious errors to medical defence unions to protect the interest of the medical profession.

So caring, committed, skilled, experienced doctors in all the branches of the medical profession have turned from the needs of their patient and his or her relatives to their own protection. Openness, candour and honesty have been and still are, hard to find after something has gone wrong.
The medical defence unions operate only as instructed by the clinicians and the colleges who make up their client base.

The only way change can come is therefore by those clinicians' determining that new instructions will be given to their defence unions. This instruction needs to be that first we apologise to patients and relatives and set out a full record of everything that happened. Then we will turn to the implications for our professional standing.

Hospitals have fallen into a similar position in which the needs of the Litigation Agency, CNST, dictates that minimal information is given to patients and their relatives after errors or poor care resulting in complaints.

In a service such as the NHS there should be very few complaints.

Clinicians can and should lead on this; it would made a dramatic change to the NHS culture.

Nurses are protected by their unions; a similar initiative is needed.
9. A RAPID END TO BULLYING, MOBBING, AND HARASSING
WHISTLEBLOWERS AND ANY OTHER STAFF AT WHATEVER LEVEL

The other face of the culture of secrecy and denial in today’s NHS. Strictly speaking bullying is of one person by another. “Mobbing” is the activity when it is carried out by a larger group of people.

These bad behaviours can occur in many circumstances and can affect the most junior or the most senior staff in any hospital.

Recently it has become associated with suppressing “whistleblowers”.

Any organisation in which there is a need for “whistleblowing” activity is already dysfunctional.

Members of Parliament had a debate on “whistleblowing” in Westminster Hall in 2009.

With respect Cure the NHS suggest that there is a major gap between the understandings of this issue by Parliament and the brutal reality of the average NHS hospital as it operates today.

As with the culture of “torturing” patients and relatives who make complaints the real answer lies only in an entirely different and truly professional culture; the kind of culture which will be established only by a major change of heart and behaviour by all NHS staff but a similar process should be undertaken to signal very powerfully and unmistakably to all bullies operating in the NHS that their behaviour will not be tolerated. These bullies can be individual nurses or doctors or whole boards acting in a misguided belief that suppressing a “whistleblower” and driving him or her out of office will improve the institution.

There have been high profile cases and and doctor has recently launched an action against Great Ormond Street Hospital. The doctor should be returned to work, competence and professional behaviour are not issues. The NHS cannot afford this kind of exclusion.

In this case and to preclude and stop all others the NHS Chief Executive and the Chief Executive of Monitor should write to all hospital chairs and chief execs to instruct them:
* to return to work each and every suspended staff member unless they can cite overriding competence or other issues. Behaviours that might remotely be interpreted as “whistleblowing” are not considered “overriding”.

* to set out how many staff have been dismissed over the last decade, why, and whether any settlement included a “gagging” order

* to send a letter signed by all non-executives and executives to said chief executive as appropriate confirming that henceforth “speaking out” is encouraged and that they are taking steps to embed this in the culture. This letter will of course be circulated to all staff.
10. NON-EXECUTIVES AND BOARDS

_Cure the NHS_ believes that hospital "boards", are not required. Hospitals are not businesses and should not be run as if they are. Patient safety and quality of care come first, followed by dignity and respect, all these have to be delivered within the financial constraints but the level of activity should never exceed the hospital's capability safely to deliver it.

The previous generations of boards have focused almost exclusively on inflated views of strategy, financial, and "operational" performance and neglected patient safety.

A brief glance at any hospital's board minutes, with the possible exception of Stafford Hospital, will show that patient safety is rarely at the top of the agenda, in fact it is normally well down the list.

The previous government politicised these boards by populating them with chairmen and other non-executives who well understood that their main purpose was to ensure surpluses and to deliver waiting time targets, but also to suppress any bad news, or at least not to challenge and ask questions that might reveal uncomfortable truths. The Stafford Hospital disaster could not have happened if this had not been the case. The sheer scale of avoidable deaths, serious untoward incidents, and complaints are a result of this culture. This era must end. Truth about patient safety and quality of care must predominate.

The leadership of the hospital must pass back to frontline carers, or rather they now need to take it from the current executives. The job descriptions of managers and executives can be changed to reflect this change. The job descriptions of most frontline carers will not change because their leadership will be largely through changes of behaviour.

The accountability in the hospital which has been "turned the right way up" must be shouldered by every staff member ensuring that in their own work they will deliver highest quality care and will deliver it right first time and with zero harm.

Medical professionals from across the royal colleges and unions will have to decide the precise structure for this accountability. It does not need to be the same in each
hospital but their must be on frontline member of staff who can be held accountable by the Regulator for patient safety and the quality of care.

From conversations with such professionals Cure the NHS conclude that this will not necessarily be something that most of them will welcome, to say the least. The NHS cannot properly run in any other way, but, of course, the level of support provided by the support team can vary as necessary.

There should be no attempt simply to recruit clinical professionals as old-style chief executives. It is the whole culture which needs to change not just the background of the people in the leadership positions.

It would be anticipated and hoped that the style and shape of the hospital's organisation and culture would also be "the right way up".

The public should take over the oversight function from the non-executives; this can be done through regular "Stop and Make Safe" reports to them. This should be the public as individuals and not recruited to formal bodies such as HealthWatch. The formality attracts people who like formality but not challenging the hospital's performance.
11. SYSTEMS

Since virtually everything done in the NHS is safety-critical it is essential that as much as possible of its activities are “systemised” so that everyone can work to clear and accessible procedures and standards.

The last Government commissioned reports from three renowned medical organisations based in the United States. The headline conclusion was that the NHS had no system for improvement. What is described below would be that system.

It is symptomatic of that governments attitude to the suppression of bad news and its reckless attitude to patient safety and zero harm that it suppressed those three reports.

What a testament to that Government’s failure and their attitude to the people of this country.

This is the legacy the current Government must shoulder; it must very rapidly "Turn the NHS the Right Way Up".

"Governance" as it has been practised for the last decade has failed patients and public and the term should be abandoned; patient safety should be the main strand of NHS activity and the main focus of all audit and review work.

While the new culture will be the key differentiator from the past two key "systems" ...ust be put in place.
12. THE PATIENT SAFETY MANAGEMENT SYSTEM

This will underpin everything that is done in the NHS, it will set out the patient safety philosophy of the NHS as set out above.

Backward – looking "quality control", measuring failures after they have happened is not appropriate for healthcare and the NHS; the only acceptable patient safety philosophy for the NHS is right first time, therefore zero harm as the constant objective.

The key elements must be introduced quickly and then detailed filled in over the next few months.

The Patient Safety Management System can be fully inspected and audited to give evidence of compliance or non-compliance. At the moment there is nothing equivalent that can be inspected or audited.

Explaining the Patient Safety Management System will be a key element of the culture change programme.

It will also set out how the NHS as a whole and in each NHS location will manage patient safety, will identify and manage risks to patient safety, and who will be accountable for patient safety from the Secretary of State, through the NHS to frontline staff members.

. . . its system and its partner system the Patient Quality Management System will enable complete consistency of delivery standards across the NHS.

Cure the NHS believe that work on this system can begin immediately under the aegis of the Medical Director.

While many safety critical sectors have mature safety management systems Cure the NHS believes that the system currently being adopted by civil aviation worldwide is very easily accessible and could be adapted to the NHS very easily.
An action team should be formed around the Medical Director including people from outside the Department and the NHS, people with a reputation for task completion. *Cure the NHS* will suggest some members for the group.

Advice should be sought from *CAA Group Director Safety Regulation, Ms Gretchen Burrett* and from *Dupont Safety Resources* who are acknowledged world leaders in safety systems application.
13. PATIENT QUALITY MANAGEMENT SYSTEM

Fitting within the Patient Safety System should sit a new Patient Quality Management System. This system contains all of the detailed procedures, standards, and processes without which a safety-critical organisation cannot operate. Such a system is totally absent from the NHS meaning that no-one in the service can give a definitive view on quality standards.

Hospitals produce action plans after failures that result in patient complaints, but without a quality system to adjust it is very difficult or impossible to embed changes of practice.

As NICE produces its standards they should all find their place within the Patient Quality Management System. A great deal of the material for this system will exist already.

The Patient Quality System can be fully audited to give evidence of compliance or non-compliance. At the moment there is nothing equivalent that can be inspected or audited.

A further task group under the Medical Director should begin work on this at once. It needs major front line involvement to have any chance of success.

Quality systems have many detractors but safety-critical sectors cannot be without them. A key criterion of the PQS should be that it enables highest quality care, enables right first time, enables zero harm but does not impede the ability of the care giver to make key decisions.

Everything in this system will be based on the Patient Safety Commitment set out above.

Backward-looking quality control measuring failures after they have happened is not appropriate for healthcare and the NHS; the only acceptable patient safety philosophy for the NHS is right first time, therefore zero harm as the constant objective.

The systems fit within the culture of professional commitment as follows:-
ALL NHS ACTIVITY - HIGH QUALITY CARE, RIGHT FIRST TIME, ZERO HARM
14. THE OUTCOMES FRAMEWORK

It will be seen that this approach of a culture of professional commitment supporting the Patient Safety Management System and the Patient Quality Management System with a set of measures, regularly reported to the public and the Government, replaces and simplifies the "Outcomes Framework" of the White Paper.

The domains are unnecessary because these two systems and the supporting culture apply across all NHS activity. The detail of the the Patient Quality Management System will differ for each separate area of activity but the basic elements of the Patient code will apply together with a specific set of reportable and auditable measures.
15. THE CONTRIBUTION FROM CIVIL AVIATION, AND OTHER SECTORS

There has been quite a lot of interest in the contribution that civil aviation safety concepts can make to the NHS, sadly this too, like many patient safety initiatives has not been set in a safety system context. This is no criticism of those delivering this or any other patient safety initiatives, the NHS just cannot provide the right environment.

This must now change, and part of the Medical Director's patient safety systems development work should be a rapid but in-depth review of the entirety of what civil aviation, and other sectors can provide. While the focus to date has been on the use of flight-deck checklists in the operating theatre context and human factors application more widely, these concepts should now become part of the Patient Safety Management System and Patient Quality Management System and therefore be applied across the NHS.

_Cure the NHS_ believe that an aviation sector model applicable to the wider range of hospital activities is that of the aircraft engineer in the normally very pressured "line maintenance" activities on a busy airport.
16. STANDARDS, TARGETS, MEASURES

"If you don't measure it you can't improve it" is a common phrase in quality systems.

Whatever is measured, the capability of the "system" of staff and resources to deliver must be a prime consideration. This lack of consideration of this element was a major factor in the 'games' played to cheat the previous Government's targets.

Appropriate quality measures should be set for every minute step of treatment within the NHS system, from the first call to a GP to discharge from hospital. These should be devised and defined by the frontline carers in close cooperation with patients and public, "nothing about me without me" is critical here. Currently patients and public really do not know what to expect, this of course leads to confusion and distress.

The patient-centred quality standards set out in the Patient Code at the end of this document should form a key part of the measures.

Performance against the key measures will be set out by the frontline team each month as part of the "Stop and Make Safe" report to the local population.
17. THE PATIENT SAFETY INITIATIVES

Clearly many people in many organisations have been doing excellent work on a range of patient safety initiatives. Their work should all be drawn together within the new Patient Safety Management System.

The National Quality board work can be drawn into work done on the Patient Safety Management System.
18. MEDICAL RECORDS

There is no NHS – wide system for compiling, collating, and managing patient notes and records.

With immediate effect the NHS Chief Executive and the Chief Executive of Monitor should write to all hospitals telling them that forthwith and until a full standard operating procedure is developed:-

Every ring-binder, or other enclosure used to compile notes will have attached inside its front a cover a dated list of page numbers which will be added to as each new page, image copy, printout or other item is inserted. A simple serial number should be used for each new page or other item entered. One set of notes only will be used for each patient and they should be cross-checked every shift.

Without proper records there can be no high quality care and harm to patients is unavoidable. The current systems can be described only as shambolic and of course they are open to major abuse.

If it is not already, it should become a serious criminal offence to remove, make additions to, alter or in any way change patient records post facto in order to cover up errors.
19. SERIOUS UNTOWARD INCIDENTS

All NHS staff have a duty to declare errors and near misses as soon as they happen through the approved channels. As healthcare professionals all NHS staff are aware that negligence in treating their patients will lead to dismissal, loss of professional status, and possibly legal action.

Never events should never happen, and serious untoward incidents should stop. It is 2010 and they simply should not happen.

For the occasions, hopefully rapidly disappearing, when errors are made with or without harm or death to the patient we should put in place a “mandatory reporting system”; civil aviation has had such a system for years. Its rules are clear and concise, and make it clear in what cases action may be taken to limit the professional activities of those individuals involved.

There is also a voluntary system for reporting less serious incidents.

Some voluntary systems already exist.

There has been a fundamental flaw in thinking on “learning from errors” that has led to a decade of poor performance in the National Learning and Reporting System, the alerts system, and the whole of the National Patient Safety Agency’s activities.

The system must be made robust, to date hospitals have treated it with scant regard and even contempt without fear of any sanction.

The report “An Organisation with a Memory” presented in the year 2000 could have and should have transformed the NHS and eliminated avoidable harm and deaths.

It said “reports go up in the short term”. It is a decade since that report and patients are still dying from gross negligence.
20. SIMPLIFYING REGULATION, UNDERSTANDING ITS LIMITATIONS

Patients and public will become the principal regulators of the NHS. It is their NHS and they must be given the key evidence about the quality of care, success in preserving life and avoiding death to patients in NHS hospitals.

Cure the NHS suggest that the "regulator" in person should be one accountable person, the Director General, of the Regulator, perhaps the Care Quality Commission, with direct reports in one organisation covering every aspect of NHS activity. The accountable person should be recruited by an ad-hoc panel acting for the Secretary of State. The Director General would report directly and only to the Secretary of State. There would be no non-executives or boards involved in any part of this structure. We believe that separate regulatory bodies, non-executives, and boards simply diffuse the "mission and the objectives.

No system of regulation will be successful in protecting patients without the professional commitment of all of the clinical and support staff who treat and nurse patients.

It is this professional commitment which has collapsed in the NHS, across the professions represented by a series of royal colleges, colleges, and unions, principally UNISON. They failed utterly at Stafford Hospital to protect patients they continue to fail to this day. They have been and continue to fail patients at acute hospitals across the country.

It is this professional commitment which must be renewed or else under the pressure of increasing demand from an ageing population and of a much tighter financial regime quality will deteriorate even further.

Regulators, regulations, laws, systems and procedures, exhortations from the government and professional bodies are of no use without a fundamental change of heart and behaviours in all NHS front line professionals that puts patients first.

It is the regulator which would devise and own the Patient Safety Management System" to form the foundation on which everything in the NHS will be done and the NHS "Patient Quality Management System which would encompass all NHS quality standards, procedures and processes.
Some parts of the PQMS probably exist already but are not "systemised". It would be for front line staff to work with the regulator to define the detail and set it out in a way that supports and does not obstruct them in their day-to-day work on the wards, in the clinics, and operating theatres.

The minute-by-minute delivery of right first time, zero harm care requires each individual NHS staff member to audit his or her own work and that of his or her colleagues to ensure that goal is achieved.

For many years it has been widely recognised that post-facto inspections, audits, or surveys are not an appropriate way of assuring quality.

While surveying patients for "outcomes" as envisaged in the consultation paper is valid for evaluating effectiveness of treatment weeks or months after a hospital episode, it has no place in assuring during the episode that the treatment is delivered right first time with zero harm.

The investigatory branch would comprise a small group of permanent specialist who would draw together specialist teams to investigate and report on hospital failures.

The NHS regulatory structure would look like the diagrams below.
21. FOUNDATION TRUSTS, DEMOCRACY, AND PRIVATE BOARD MEETINGS

It was claimed by the previous Government that the system they had devised for running foundation trust hospitals was more democratic than the full public ownership model.

This is simply not the case; in fact it could be deduced from the experience of the Mid Staffordshire NHS Foundation Trust and from the public consultation campaign of the University Hospital of North Staffordshire that the system is far less democratic.

This is particularly the case for those foundation trusts that hold their board meetings in private.

The NHS suggests that the membership and governors’ system is simply abandoned; it will save money and it will be more open and honest.

The terms of the Public Bodies Access to meeting Act 1960 should be reimposed on foundation trusts until boards finally disappear and proper accountability to the local population is established using other mechanisms.
22. A DRAFT PATIENTS’ CARE CODE

What's written here applies in whole or in part to any situation where NHS staff are delivering care.

This is based on the 66 points of care failure which Julie Bailey identified in the incompetent and uncaring nursing of her mother, Bella.

It is a set of quality standards for the Patient Quality Management System and is written for the era of "not about me without me" in an NHS that has been "turned the right way up"

"Just like all my fellow patients I know the difference between on the one-hand very -\ilful, dedicated and experienced staff working at the limits of human ingenuity to cure me but finding that I reacted differently from their expectations or that they mind a tiny but perfectly understandable mistake and on the other sloppy, careless, ill-prepared teams who put no thought into what they will do and consequently making stupid errors and not knowing what to do.

Everything you do to me you must get right first time, there's absolutely no reason why you shouldn't.

You first duty to me as I enter the NHS system is not to kill me or harm me, this rather defeats the point of my coming to you in the first place!

If you think I am too ill to save and I will die please do everything you can, my relatives and loved ones can't ask for any more.

Each and every one of these pleas is for a purpose, if you don't heed them you will contribute to my deterioration and death, don't doubt it.

Please don't :-

Kill me or harm me

By

Confusing me with another patient and then performing – obviously the wrong – surgery on me
When you have identified me correctly performing wrong site surgery on me
Using me as a guinea-pig
Making fundamental blunders during surgery on me
Please prepare for blunders by having a number of “error correction” procedures ready in case you do blunder
Not being prepared if I react in a different way from the one you predicted before you started the procedure – in fact please do a risk analysis so that you are ready for me to react in a number of ways and have prepared procedures and all the team briefed for each of them
(Be honest with my loved ones and your colleagues if you do make an error and I don’t survive, we know you are only human but try to get it right in the first place; human frailty, openness, and honesty, can be forgiven, Incompetence, dishonesty, ignorance, and stupidity cannot.)
Treating patients in the NHS is not for you if you are not able to perform right first time and cause zero harm.
* zig before reading my notes
Leaving my notes in a mess, altering them, removing pages, failing to make it clear who you are and what you did
Getting my initial diagnosis incorrect
Putting me in the wrong ward
Leaving me in pain
Giving me the wrong drug or drugs or the prescribed drugs but at the wrong times and/or the wrong amounts
Leaving me unattended
Leaving me without food
Leaving me without a drink
Leaving me without a bedpan when I need it
Telling me to go in the bed, it’s inhuman
Leaving me unwashed
Leaving me unshaven
Leaving my hair unwashed or uncombed
Leaving me in soiled sheets
Letting me develop bedsores
Being rude to me or my relatives and friends and refusing to answer our questions
Manhandling me without help and the proper equipment
Keeping quiet when you see your colleagues doing any of these harmful things. An organisation which needs “whistleblowers” was in crisis a long time before
Bringing your "daily life" into my care. Treating the sick is very special needs your complete attention and the level of focus needs to be much higher than in your normal daily life. If you cannot manage this you should not be working with patients.
And very much more .................

Please

keep me alive and unharmed
by

Making absolutely sure you check and double check I am who you think I am
Making absolutely sure you check and double check what was planned for me and in
the part of my body
Carrying out only what is the correct procedure with the correct instruments
Preparing for blunders by having a number of "error correction" procedures ready in
case you do make a mistake
Preparing for me to react in a different way from the one you – in fact please do a risk
analysis so that you are ready for me to react in a number of ways and have prepared
procedures and all the team briefed for each of them
Getting your colleagues prepared, get the equipment prepared and tested
Having procedures ready for your errors and for equipment failures
Having written checklists ready, laminated sheets or written up on the wall. The
human memory can retain only so much and frequently fails in pressure situations,
yours and your colleagues' will too
Reading my notes before acting
Writing up my notes accurately and carefully. Putting your signature and ID number
clearly on every page with date and time.
Getting my initial diagnosis correct
Putting me in the right ward
Leaving prescribing and administering the right amounts of the right drugs to suppress
my pain
Giving me all my prescribed medicine at the correct time in the correct amounts
Answering the bell promptly when I ring
Making sure I get all the food I need; feeding me if necessary
Making sure I get all the liquids
Ensuring I get a bedpan when I need it or helping me to get to the lavatory in time
Washing me regularly
Giving me a shave so that I don't feel and look scruffy
Washing and combing my hair
Changing my sheets regularly and immediately if I do soil them
Preventing bedsores from developing
Being helpful to me or my relatives and friends and answering all our questions
Getting help and the proper equipment before moving me
Speaking out when you see your colleagues doing anything harmful or unprofessional.
An organisation which needs “whistleblowers” was in crisis a long time before
Leaving your “daily life” outside my care. Giving me your complete attention and the
increased level of focus that my care needs

And very much more ........................