

<p>1 Monday, 8 November 2010 2 (10.30 am) 3 (Proceedings delayed) 4 (11.50 am) 5 THE CHAIRMAN: First, might I apologise for the late start 6 today. I hope that this will not be repeated, but there 7 was a procedural matter in relation to one member of the 8 public I've had to deal with, and I hope I have. It 9 took longer than expected. 10 I am now going to make some opening remarks, 11 following which Mr Kark will make an opening statement. 12 Opening remarks by THE CHAIRMAN 13 THE CHAIRMAN: It is a pleasure to be able to open the 14 formal hearings of this inquiry. I appreciate that 15 there are many present who have campaigned for it to 16 take place, and for them too it must be a significant 17 milestone. I am sure they are, as I am, pleased that it 18 has proved possible to hold these hearings in Stafford 19 so that those most closely affected by what has happened 20 in their local hospital can hear the evidence for 21 themselves with a minimum of inconvenience. 22 I would liked to thank Stafford Borough Council and 23 its officers for their very considerable assistance in 24 making this possible at the cost, it has to be said, of 25 considerable inconvenience to themselves.</p> <p style="text-align: right;">Page 1</p>	<p>1 in too many cases, these concerned the loss of a loved 2 one. 3 The public should be very grateful to all those in 4 this position who contributed to my last inquiry and 5 have offered to come forward again this time. I would 6 like to pay particular tribute to Julie Bailey, without 7 whose tenacity many of the issues which have been 8 exposed would not have seen the light of day. I would 9 like to offer her and her family my particular sympathy 10 today at the opening of this inquiry, which by sad 11 coincidence is the third anniversary of the death of her 12 mother, whose case it was which propelled her into 13 starting her campaign. 14 I will say a word now about the scope of the 15 inquiry. We know what went wrong in Stafford. The 16 Healthcare Commission report, Professor Alberti, 17 Dr Colin-Thome and my own earlier report disclosed that. 18 This inquiry is required to build on those findings, 19 not to revisit them. In order to do this, I have to do 20 a number of things. I have to find out and tell the 21 story of what these organisations knew, and what, if 22 any, actions they took. To do this I must ask relevant 23 persons responsible for these organisations to give 24 their account of what happened. I must look at why the 25 system of NHS management and regulations external to the</p> <p style="text-align: right;">Page 3</p>
<p>1 We are all here because of the terrible standard of 2 service inflicted on so many of the patients who went to 3 Stafford Hospital for treatment and their families. 4 Last year in my first inquiry I sat and listened to many 5 stories of appalling care. As I did so, the questions 6 that went constantly through my mind were: why did none 7 of the many organisations charged with the supervision 8 and regulation of our hospitals detect that something so 9 serious was going on, and why was nothing done about it? 10 That question was one which many patients and their 11 families and, it is fair to say, healthcare 12 professionals as well wanted to be answered. 13 While we are not here to reinvestigate what went 14 wrong in Stafford Hospital, I think it is important, as 15 we consider the actions and inactions of various 16 management and organisational structures in what will 17 inevitably be some dry detail, that we keep at the 18 forefront of our minds the terrible effect of the 19 systems failings of those it was meant to serve. 20 I would like to pay tribute to the determination and 21 courage of those who have campaigned for this inquiry 22 and the helpful way in which they conducted themselves 23 at my first inquiry. The distress that must be provoked 24 by having to revisit such unpleasant experiences and 25 memories cannot be underestimated, particularly when, as</p> <p style="text-align: right;">Page 2</p>	<p>1 trust did not detect or act on the deficiencies before 2 the intervention of the Healthcare Commission in 2008/9. 3 There was clearly cause for concern before that action 4 was taken. 5 I must then identify the lessons to be learnt from 6 the Stafford experience and suggest how they might be 7 applied to the system as it is today, taking account of 8 the changes that have taken place since then and also 9 the reforms that are now being proposed. In order to do 10 this, I will have to consider a large amount of 11 documentary evidence and other material and to take oral 12 evidence from a wide range of witnesses. 13 I should make it clear that the fact that a person 14 is asked to give oral evidence before me does not mean 15 that I have decided that either they or the organisation 16 in which they worked should be the subject of any 17 criticism, still less that the individuals in question 18 should be blamed in any way for what happened here. 19 They will be invited to give oral evidence, because it 20 is thought that will help the inquiry achieve its 21 purpose. 22 We will hear details of at least some of the cases 23 of poor care which demonstrated the breakdown of systems 24 at Stafford, as it will be necessary to see the context 25 in which the regulators and others were working. Some</p> <p style="text-align: right;">Page 4</p>

<p>1 of these stories I will have heard before and indeed 2 I summarised them in my earlier report. However, others 3 may not have heard them. I ask them to bear in mind two 4 things. 5 Firstly, it is not the role of this inquiry to 6 investigate each complaint and decide whether it is 7 well-founded, although many may be. My job this time is 8 to look at how the system dealt with the complaints and 9 concerns arising out of such experiences and the people 10 who suffered and reported them. 11 The second point is that such experiences are not 12 necessarily representative of what it is like at 13 Stafford Hospital today under its new management. It is 14 inevitable there will continue to be incidents giving 15 cause for concern, both there and in other hospitals as 16 well. 17 Such incidents do not of themselves show that there 18 has been no improvement, any more than that the absence 19 of such incidents would prove everything has been put 20 right. It is not part of my task in this inquiry to 21 judge whether the trust has changed and improved since 22 the events I considered at the last inquiry, but I do 23 know it from evidence I heard then that this new 24 management team set about the daunting task of changing 25 the culture and standards with energy and enthusiasm and Page 5</p>	<p>1 in place to provide better assurance that minimum 2 standards of quality and safety of care will be provided 3 to all who seek healthcare. 4 The terms of reference require me to use my best 5 endeavours to provide the Secretary of State with 6 a report of the inquiry by the end of March next year. 7 Given the huge volume of material the inquiry team will 8 now have to examine, it is clear to me that 9 realistically the hearings and the production of my 10 report cannot be completed by the end of March. 11 Therefore, I have discussed this with the Secretary of 12 State. We have agreed that the importance of my 13 examining the material being made available and the 14 added lessons that are likely to be provided justifies 15 the inquiry taking longer than originally envisaged. It 16 would be wrong and misleading to set a new deadline but 17 it remains important for this inquiry to be concluded as 18 quickly as possible in order to provide assistance in 19 relation to the reforms currently under consideration. 20 It is clearly in the public interest that I should 21 conduct this inquiry with that requirement in mind and 22 I intend to do. Therefore, I hope to conclude most if 23 all not the formal oral hearings before the middle of 24 next year. It will inevitably take some time after that 25 to complete the analysis of the evidence and produce the Page 7</p>
<p>1 I myself have seen examples of good practice there. 2 How long will this inquiry take? The size of its 3 task is formidable. A large number of organisations and 4 individuals have been approached for information and 5 evidence. My inquiry team has identified over 150 6 potential people to approach. Even if not all of these 7 are called to give oral evidence, and it is highly 8 unlikely that all will be required to do so, others will 9 emerge as witnesses as their involvement and 10 significance becomes more clear. 11 We have received what is estimated to be nearly 12 1 million pages of documentation, much of which has not 13 been subjected to any meaningful analysis by the parties 14 providing it. In short, the task I have been set is 15 truly formidable and complex. Nonetheless, it is 16 I believe a very worthwhile and important task. At 17 a time of change in the National Health Service, it is 18 essential that the lessons to be learnt from the 19 Stafford disaster are incorporated into its governance. 20 That requires the story to be told and those responsible 21 for various parts of the system to explain what their 22 organisations did and to identify where their roles 23 might have been performed better. It then requires an 24 analysis of that evidence so that I can consider what 25 safeguards, monitoring and other measures should be put Page 6</p>	<p>1 report. However, it is emphatically in the interests of 2 the patient groups, Stafford Hospital and its staff as 3 well as the National Health Service and the public 4 generally that the lessons to be learnt from this 5 inquiry are identified in the shortest possible 6 timescale and I urge all those involved to recall that 7 in the weeks to come. 8 There are many interested parties represented here 9 today, and I am pleased to see their readiness to 10 participate in this inquiry. No doubt they and the 11 public will understand and accept that these are not 12 proceedings involving adversarial litigation or 13 conclusions about criminal and civil liability. I am 14 not here to try claims made by one party against 15 another. The role of the interested parties is to 16 assist the inquiry to get at the truth of the matter and 17 to assure its effectiveness in fulfilling its terms of 18 reference. They will largely do that by facilitating 19 the production of information and evidential material 20 and by ensuring that counsel to the inquiry is aware of 21 the issues which the parties believe ought to be raised 22 so that he can pursue the relevant lines of inquiry. 23 Today, we're going to hear the opening statement of 24 Mr Tom Kark QC, counsel to the inquiry. I understand 25 this is likely to last at least into tomorrow, if not Page 8</p>

<p>1 into the day after that. I will then hear opening 2 statements from those core participants who have 3 indicated a wish to make such a statement. 4 Finally, may I describe some of the general 5 arrangements that will be followed during these 6 hearings. 7 Sitting times, on Monday we will sit between 8 10.30 and 5.00. Tuesday to Thursdays 10.00 am to 9 4.30 pm. We will break for lunch between as near 10 1 o'clock and 2 o'clock as is practicable, and normally 11 I will take a short 15-minute break at some convenient 12 point in each of the two sessions of the day. 13 Generally, there will be no public hearings on Fridays. 14 A list of the witnesses to be called in any week 15 will, to the extent this is possible, be published two 16 weeks in advance. A transcript of the day's proceedings 17 will be posted on the inquiry's website as soon as 18 practicable after their conclusion. 19 I would remind everyone that filming, photography 20 and recording are not permitted in the hearing room or 21 the press room, mobile phones must be switched off in 22 the hearing room and switched to silent in the press and 23 public section. 24 Can I, please, remind members of the press that they 25 should respect the privacy of members of the public</p> <p style="text-align: right;">Page 9</p>	<p>1 healthcare system as a whole tolerate what were clearly 2 unacceptable standards of care? Why did those who 3 should have been in the right position to take steps not 4 do so? 5 There were numerous national and local agencies 6 which might have been thought to carry some 7 responsibility for the lack of care and the failures 8 which are identified in the first inquiry. Despite the 9 existence of national and local agencies concerned with 10 the regulation of the NHS and the delivery of primary, 11 secondary and acute care services, the appalling lack of 12 care was allowed to continue with little effective 13 intervention. 14 The purpose of this inquiry ultimately is to bring 15 to the attention of the Secretary of State for Health 16 a clear explanation of why the commissioners of 17 healthcare services and the regulators of the trust 18 failed the people of Staffordshire, and how the same 19 sequence of events might be prevented from ever 20 happening again, not only in Staffordshire but in any 21 other part of the United Kingdom. 22 In commenting upon the role of external 23 organisations you wrote in your first report: 24 "Local confidence in the trust and the NHS is 25 unlikely to be restored without some form of independent</p> <p style="text-align: right;">Page 11</p>
<p>1 attending the hearings. Entry to the inquiry premises 2 of both media representatives and the public is solely 3 for the purpose of attending the hearing. Therefore, 4 I must ask the reporters not to approach individuals for 5 interviews or quotes whilst in the inquiry building. If 6 any member of the press or the public has any question 7 about the inquiry, they should not hesitate to contact 8 the secretary to the inquiry, Mr Alan Robson, sitting to 9 my left, or the solicitor to the inquiry, 10 Mr Peter Watkins Jones, he is just behind counsel there. 11 And contact details for them, if you do not wish to 12 approach them personally, or cannot, are available on 13 the inquiry website. That concludes my opening 14 statement, and I now invite Mr Tom Kark to commence his. 15 Opening statement by MR KARK 16 MR KARK: Sir, this public inquiry arises out of the events 17 at Mid Staffordshire Hospital Trust between January 2005 18 and March 2009. As everyone present knows, there has 19 already been one inquiry into those events chaired by 20 you. The purpose of this second and now public inquiry 21 is to focus not on what went wrong, but how it was 22 allowed to go on for so long without appropriate 23 remedial action. 24 Why did no one act to correct the serious errors 25 that were undoubtedly taking place? Why did the</p> <p style="text-align: right;">Page 10</p>	<p>1 scrutiny of the actions and inactions of the various 2 (external) organisations to search for an explanation of 3 why the appalling standards of care were not picked up. 4 It is accepted that a public inquiry would be a way of 5 conducting that investigation." 6 The 16th recommendation of your report was as 7 follows: 8 "The Department of Health should consider 9 instigating an independent examination of the operation 10 of commissioning supervisory and regulatory bodies in 11 relation to their monitoring role at Stafford Hospital 12 with the objective of learning lessons about how failing 13 hospitals are identified." 14 In your open letter to the Secretary of State dated 15 5 February of this year, which introduced your report, 16 you said this: 17 "The inquiry heard and has reported the many 18 concerns expressed about the role that external agencies 19 play in the oversight of the provision of healthcare. 20 There is undoubtedly further work to be done, not only 21 at the trust but elsewhere before public confidence can 22 be assured." 23 And further, at page 415 of your report, you 24 concluded that there was a need for an independent 25 examination of the operation of each commissioning,</p> <p style="text-align: right;">Page 12</p>

<p>1 supervisory and regulatory body with respect to their 2 monitoring function and capacity and identify hospitals 3 failing to provide safe care, in particular:</p> <p>4 (1) what the commissioners, supervisory and 5 regulatory bodies did or did not do at Stafford.</p> <p>6 (2) the methods of monitoring used, including the 7 efficacy of the benchmarks used, the auditing of 8 information relied upon and whether there is a 9 requirement for a greater emphasis on actual inspection 10 rather than self-reporting.</p> <p>11 (3) whether recent changes, including the memorandum 12 of understanding between Monitor and the Care Quality 13 Commission, quality accounts and the registration of 14 trusts by the CQC will improve the process by which 15 failing hospitals are identified.</p> <p>16 (4) what improvements are required to local scrutiny 17 and public engagement arrangements; and.</p> <p>18 (5) the resourcing and support of foundation trust 19 governors.</p> <p>20 On 9 June 2010 Andrew Lansley, the Secretary of 21 State for Health under the current coalition government, 22 wrote to you inviting you to chair a public inquiry and 23 setting out the terms of reference. They are as 24 follows:</p> <p>25 (1) to examine the operation of the commissioning, Page 13</p>	<p>1 regard to the fact that the commissioning, supervisory 2 and regulatory systems differ significantly from those 3 in place previously and the need to consider the 4 situation both then and now.</p> <p>5 (5) to make recommendations to the Secretary of 6 State for Health, based on the lessons learnt from the 7 events at Mid Staffordshire and to use best endeavours 8 to issue a report to him by March 2011.</p> <p>9 In your opening remarks you have dealt with the 10 timing issue already.</p> <p>11 Although this inquiry was requested by the Secretary 12 of State for Health and has been set up under the 13 auspices and funding of the Department of Health, it is 14 totally independent of that department. The process of 15 this inquiry, as with any public inquiry, is your sole 16 responsibility applying the relevant inquiry rules.</p> <p>17 The calling of relevant evidence before this inquiry 18 is my responsibility and that of my team. My role is to 19 assist the inquiry, which means assisting you to meet 20 the terms of reference. To that end, I am supported by 21 an experienced team. To my right, my juniors 22 Mr Ben FitzGerald and Ms Jo Hughes. We are also 23 fortunate to have secure the services of Eversheds 24 Solicitors who are acting as solicitors to the inquiry 25 under the leadership of Peter Watkins Jones has who has Page 15</p>
<p>1 supervisory and regulatory organisations and other 2 agencies, including the culture and systems of those 3 organisations in relation to their monitoring role at 4 Mid Staffordshire NHS Foundation Trust between January 5 of 2005 and March 2009, and to examine why problems at 6 the trust were not identified sooner and appropriate 7 action taken. This includes, but is not limited to, 8 examining the actions of the Department of Health, the 9 local strategic health authority, the local primary care 10 trust, the independent regulator of the NHS foundation 11 trust, Monitor, the Care Quality Commission, the Health 12 and Safety Executive, local scrutiny and public 13 engagement bodies and the local coroner.</p> <p>14 (2) where appropriate to build on the evidence given 15 to the first inquiry and its conclusions, without 16 duplicating the investigation already carried out and to 17 conduct the inquiry in a manner which minimises 18 interference with the Mid Staffordshire NHS Foundation 19 Trust's work in improving its services to patients.</p> <p>20 (3) to identify the lessons to be drawn from that 21 examination as to how in the future the NHS and the 22 bodies which regulate it can ensure that failing and 23 potentially failing hospitals or their services are 24 identified as soon as is practicable.</p> <p>25 (4) in identifying the relevant lessons to have Page 14</p>	<p>1 already been introduced.</p> <p>2 I also introduce the other counsel on behalf of core 3 participants, some of whom are present today.</p> <p>4 On behalf of Cure the NHS Mr Matthias Kelly QC is 5 leading Mr Jeremy Hyam, who I understand is present, as 6 is Kate Beattie.</p> <p>7 On behalf of AvMa and the Patient Association, 8 Ms Shaheen Rahman appears.</p> <p>9 On behalf of the foundation trust, Mr Nick Mullany 10 is here, together with Ms Katie Price.</p> <p>11 On behalf of the PCT Rachel Langdale QC and 12 Mr Rob Harland.</p> <p>13 On behalf of the West Midlands SHA Ms Sally Smith QC 14 and Mr Christopher Mellor.</p> <p>15 On behalf of the Department of Health 16 Mr Tom Richards.</p> <p>17 On behalf of Monitor Karon Monaghan QC and 18 Ms Amelia Walker.</p> <p>19 On behalf of CQC we have Debra Powell and 20 Ms Eleanor Grey.</p> <p>21 On behalf of the HPA Ms Fiona Addison.</p> <p>22 On behalf of the NPSA, I don't think she is here, we 23 have Ms Diane Barber, who will be appearing.</p> <p>24 And on behalf of the NHSLA Mr Owain Thomas.</p> <p>25 The Royal College of Physicians who are core Page 16</p>

<p>1 participants are apparently not attending for a few days 2 and I am afraid we don't know who at the moment 3 represents them.</p> <p>4 In leading the inquiry team I have sought to ensure 5 that we will explore every relevant nook and cranny of 6 the health service. We as a team will do our utmost not 7 to leave a pebble unturned which might reveal material 8 of interest and relevance within the terms of reference.</p> <p>9 As part of the work done by the inquiry team, we 10 have approached over 170 individuals organisations and 11 agencies, and the inquiry team has written to 114 GP 12 surgeries. We have invited the core participants to 13 make suggestions for the witness list so that we obtain 14 different perspectives and such suggestions as have been 15 submitted have been carefully considered, and that 16 request still holds good.</p> <p>17 We have tried hard to think widely, focusing both 18 within the NHS and outside the NHS, and to that end you 19 will also have as assessors to assist you the following 20 individuals.</p> <p>21 Professor David Black, a consultant physician in 22 geriatric medicine and Queen Mary's hospital in Sidcup. 23 Ms Tricia Hart who is the deputy chief executive and 24 director of nursing and patient safety at South Tees 25 Hospital NHS Foundation Trust.</p> <p style="text-align: right;">Page 17</p>	<p>1 the inquiry team can match, will we hope prove to be 2 a valuable assistance to help me and my team formulate 3 appropriate questions for witnesses and identify areas 4 of inquiry.</p> <p>5 As you have already remarked, this is an inquiry and 6 not a trial. It is important that we all bear that in 7 mind throughout these proceedings.</p> <p>8 Section 2 of the Inquiries Act specifically provides 9 that the inquiry panel is not to rule on and has no 10 power to determine any person's criminal or civil 11 liability. However, the panel is not to be inhibited in 12 the discharge of its functions by any likelihood of 13 liability being inferred from facts that it determines 14 or recommendations that it makes.</p> <p>15 We are likely to get better information and 16 cooperation from witnesses who feel inclined to 17 cooperate voluntarily and who do not feel themselves 18 under attack or that they are here simply to be 19 vilified. However, there may be some witnesses who do 20 not volunteer information which they should, either 21 through lack of understanding of the process or -- and 22 we hope this is less likely -- because they are wilfully 23 uncooperative. Equally, there will be witnesses who 24 with the best will in the world unconsciously fail to 25 reveal relevant information which could assist the</p> <p style="text-align: right;">Page 19</p>
<p>1 Professor Peter Hutton a consultant anaesthetist at 2 University Hospital Birmingham NHS Foundation Trust and 3 honorary professor at the University of Birmingham.</p> <p>4 And Sir Adrian Montague, now chairman of the 3I 5 Group and who previously held the post, among many 6 others, of chairman of British Energy when he would have 7 had a close interest in the safety of the UK's nuclear 8 energy programme.</p> <p>9 They will be available to give advice to you as 10 needed and will, we understand, on occasions attend the 11 hearing. We also propose to call expert witnesses both 12 in relation to the structure of the healthcare system 13 and its regulation, as well as from other public bodies 14 responsible for civilian safety.</p> <p>15 We do not hope by this inquiry alone to bring about 16 changes which will ensure no repeat of the Stafford 17 debacle. But we can assist you, sir, in coming to 18 conclusions and recommendations which will assist the 19 government to do so, by bringing as much relevant and 20 helpful information as possible before the inquiry from 21 every quarter.</p> <p>22 The inquiry team will, we hope, be assisted by 23 representations from the core participants, all of whom 24 have an intricate knowledge of their specific area of 25 interest. That specialisation, which is not one which</p> <p style="text-align: right;">Page 18</p>	<p>1 inquiry.</p> <p>2 My purpose and that of my team is to get as much 3 pertinent information out of witnesses as possible and 4 our examinations of witnesses will be conducted 5 throughout with that purpose well in mind.</p> <p>6 Can I say something about what I call the patient 7 voice. This inquiry will not hear from individual 8 patients who were mistreated, nor from their relatives, 9 except insofar as they have relevant evidence to give 10 within the terms of reference. Examining individual 11 cases and giving patients and their relatives the 12 opportunity of revealing their own stories was part of 13 the role of the first inquiry. We will be calling 14 a number of patient relatives to deal specifically with 15 the complaint system and how it worked or failed to work 16 for them.</p> <p>17 That is a topic within the terms of reference and an 18 important one to help us discover where mistakes were 19 made and where the fault lines lay. We have also been 20 in touch with a number of patient groups which 21 represents the patient's voice, and we will be calling 22 a number of witnesses from such groups to provide us 23 with their perspective and their assistance, and there 24 is, as you have already mentioned, of course, a specific 25 patient group, Cure the NHS, who have applied for core</p> <p style="text-align: right;">Page 20</p>

<p>1 participant status and have been granted it and so are 2 here represented and we will come their participation. 3 No one should think that we do not have the patients 4 who were failed by the trust at the forefront of our 5 minds. We are here by reason of the failures in care of 6 those patients. However, what went wrong at the 7 hospital has already been fully examined and the terms 8 of reference to this inquiry specifically require us to 9 ensure we do not duplicate the work of the first. 10 We are aware that some contributors of evidence to 11 this inquiry would wish us to examine the issues of how 12 many unnecessary deaths can be attributed to poor or 13 negligent standards of care at the trust. However, such 14 an inquiry would be outside the terms of reference, 15 would itself be very lengthy and would have the effect 16 of diminishing the purpose and effect of this inquiry. 17 We do not, for one moment, ignore the terrible fact that 18 poor care at this hospital led to early and unnecessary 19 deaths. The prime purpose of this inquiry is to do all 20 that we can to prevent that happening again. 21 The terms of reference specifically require we 22 conduct the inquiry in a manner which minimises 23 interference with the Mid Staffordshire NHS Foundation 24 Trust's work in improving its service to patients. It 25 is important to bear in mind that this inquiry deals</p> <p style="text-align: right;">Page 21</p>	<p>1 Comprehensive care was to be provided free of charge for 2 all on the basis of need funded from taxation. 3 Secondary care in the NHS was to be provided by 4 a national network of NHS-owned hospitals and community 5 services such as district nursing. Public health 6 services and the ambulance services were also to be 7 publicly provided initially by local authorities, until 8 the 1974 reorganisation, when they were run directly by 9 the NHS itself. However, primary care, i.e. general 10 medical, dental and ophthalmic services and 11 pharmaceutical services were to be provided by 12 independent practitioners acting as independent 13 contractors to the NHS. 14 The NHS in its initial form planned services that it 15 provided itself, in particular in hospitals and through 16 a national contract, and local committees procured 17 services from independent providers, which were largely 18 cottage industries run by self-employed clinicians who 19 became, particularly in the case of GPs, closely bound 20 in with the NHS. 21 Before 1980, the only example of a regulator of the 22 NHS was the Health Advisory Service, the HAS, set up in 23 1969 at the insistence of then Secretary of State for 24 Health, Richard Crossman. The HAS reported directly to 25 the Ministry of Health and its primary role was to</p> <p style="text-align: right;">Page 23</p>
<p>1 with events at a hospital which is not very far from 2 here, a few miles up the road, and which continues to 3 treat patients. There are hard working, conscientious 4 and competent staff there now, who will not be assisted 5 in their duties of caring for the sick and frail by this 6 inquiry indulging in further extensive criticism of what 7 has happened there previously. We will not shirk from 8 identifying where problems persist, but we must bear in 9 mind that both staff and patient moral is an important 10 factor in ensuring good quality care and treatment and 11 recovery to health, and we have no wish whatever to 12 damage the morale of the hard working nurses and doctors 13 who are striving hard to make things better. 14 I am going to turn now to the history of the NHS. 15 Before launching ourselves into an examination of the 16 background to the problems at Mid Staffordshire NHS 17 Foundation Trust and why they were not spotted sooner, 18 it is worthwhile spending a little time on the creation 19 of the NHS, its structure through various changes and 20 initiatives, and the effect of the changes wrought by 21 various governments. We all have our own idea as lay 22 people of what the NHS is, but rather like the elephant, 23 actually describing it is harder. 24 At the inception of the NHS, in 1948, a wholly 25 nationalised system of healthcare funding was created.</p> <p style="text-align: right;">Page 22</p>	<p>1 advise and support the health services by spreading good 2 practice and promoting improvement. 3 While health policy for several decades after 1948 4 can be characterised as fairly modest adjustments to the 5 original design of the NHS, the need to restrict public 6 expenditure growth from the mid-1970s, led to an 7 increasing focus on how to make the NHS more efficient. 8 Eventually this resulted in the most significant 9 cultural shift since the inception of the NHS with the 10 introduction of the internal market, outlined in the 11 1989 White Paper Working for Patients and passed into 12 law as the NHS and Community Care Act of 1990. 13 The then government stated that the reforms would 14 increase the responsiveness of the service to the 15 consumer, foster innovation and challenge the 16 monopolistic influence of hospitals. Proposals were 17 made to make hospitals compete for resources in an 18 internal market and to make doctors more accountable and 19 involve them more effectively in management, and these 20 changes were implemented in 1991. That has been 21 referred to in the past as the purchaser/provider split. 22 The 1991 market reforms were based on the 23 purchaser/provider split and it was thought that whereas 24 in the past providers, usually hospital doctors, had 25 largely determined what services would be provided now</p> <p style="text-align: right;">Page 24</p>

<p>1 commissioning bodies would act on behalf of patients to 2 purchase the services which were really needed. 3 Purchasers, health authorities and some family doctors 4 were given budgets to buy healthcare from providers, 5 acute hospitals, community health services, 6 organisations providing care for people with mental 7 health problems. 8 To become a provider in the internal market health 9 organisations became NHS trusts, separate organisations 10 with their own management. This occurred in stages 11 rather like the foundation trust inception at the 12 present time. 13 The role of purchasers came to be defined as 14 commissioning. This term has had numerous definitions 15 over the past two decades and continues to be contested, 16 but it is intended to indicate that being a purchaser 17 is, or should be, about much more than simply 18 contracting with and paying providers for supplying 19 healthcare services. The Department of Health in 20 November 2009 described to the Parliamentary Health 21 Select Committee its understanding of the roles of the 22 health service commissioner in the following term: 23 "To be the advocate for patients and communities -- 24 securing a range of appropriate high quality healthcare 25 services for people in need.</p> <p style="text-align: right;">Page 25</p>	<p>1 development from 1991 to 1997, many family doctors were 2 given budgets with which to buy healthcare from NHS 3 trusts and also from the private sector in a scheme 4 called GP fundholding. The scheme was voluntary but 5 each year more and more GPs joined, and by 1997 6 approximately half of GPs had become fundholders. Those 7 who did not have their own budgets had services 8 purchased for them by health authorities that bought in 9 bulk from NHS trusts. Patients of GP fundholders were 10 often able to obtain treatment more quickly than 11 patients of non-fundholders. 12 During the 1990s some GP fundholder came together in 13 network, multi-funds or fundholding consortia, and this 14 was to enable smaller practices to participate in 15 fundholding schemes and to create organisations which 16 could pool resources and share financial risks. 17 Non-fundholding GPs also started to work together as GP 18 commissioning groups as a means of gaining influence of 19 health authority's purchasing decisions. 20 In 1994 the government decided to develop a primary 21 care led NHS, which included the addition of total 22 purchasing pilot schemes, which gave volunteer 23 fundholding practices a delegated budget to purchase all 24 of their hospital and community services. 25 There were thought to be advantages and</p> <p style="text-align: right;">Page 27</p>
<p>1 "To be the custodians of taxpayers' money -- this 2 brings a requirement to secure best value in the use of 3 resources." 4 The department added: 5 "Commissioners increasingly need to be advocates for 6 health and well-being, encouraging and enabling 7 individuals, families and communities to take greater 8 and shared responsibility for staying healthy and 9 managing their health and conditions. This means 10 understanding better the determinants of health, 11 effective engagement and enablement of people and 12 populations and strengthened partnership working to 13 improve health and well-being. As a result, the role of 14 commissioners has grown from a traditional fairly narrow 15 base of needs assessment and contracting. The challenge 16 is to commissioning capability have risen accordingly." 17 Under the initial model of purchaser/provider split 18 there were two kinds of purchasers: district health 19 authorities, DHAs, and GP fundholders. DHAs had been 20 created in 1982 to run local services, apart from 21 primary care, which meant that they directly managed 22 local acute hospitals. 23 As an NHS trusts broke free from the district health 24 authority control, DHAs became purchasers of healthcare 25 services from the trusts. In successive waves of</p> <p style="text-align: right;">Page 26</p>	<p>1 disadvantages of fundholdings in the 1990s. There were 2 accusations that the NHS was operating a two tier 3 system, contrary to the founding principles of the NHS 4 of fair and equal access for all to healthcare. 5 Supporters said fundholding saved money, was more 6 efficient and engaged the GPs in the planning and 7 purchasing of healthcare. 8 In December of 1997, the Labour government set out 9 a ten-year vision for the English NHS with the White 10 Paper The New NHS Modern Dependable. 11 The purchaser/provider split was retained and 12 overall responsibility for commissioning health services 13 remained with health authorities, but fundholding was 14 abolished, leading to a search for other ways to give 15 primary care power and influence over the use of money 16 in the hospital sector. 17 From around 1999, 481 primary care groups, PCGs, 18 were established. Membership of them was compulsory for 19 all GPs and primary care professionals, and PCGs 20 effectively took on the purchaser role. 21 In 2000, the government announced its intention to 22 bring spending in the NHS up to the EU spending average 23 and launched the NHS plan. Its key reforming principles 24 were a patient focused service, offering patient choice 25 and an expanding independent sector, competitive</p> <p style="text-align: right;">Page 28</p>

<p>1 providers, giving hospitals and GPs incentives to 2 change, including payment by results, money following 3 the patient and the possibility that organisations might 4 fail.</p> <p>5 Active purchasers, including PCTs, who were the 6 successor organisations to PCGs and practice-based 7 commissioning and cost-effectiveness and affordability.</p> <p>8 Under the NHS plan all PCGs were to become primary 9 care trusts by April 2004. Shifting the Balance of 10 Power, which was published in 2001, brought forward that 11 date to April of 2002. In addition, the 100 health 12 authorities were to be abolished and 28 new strategic 13 health authorities, SHAs, were created, essentially 14 local offices of the Department of Health. SHAs were to 15 develop a strategic framework, agree annual performance 16 agreements and build capacity and support performance 17 improvement. The number of SHAs was reduced from 28 to 18 ten in 2006. By 2002 the 481 primary care groups were 19 reduced to become 303 PCTs.</p> <p>20 After the 2002 budget funding increased. 21 Alan Milburn, the then Secretary of State for Health, 22 published Delivering the NHS Plan, which introduced new 23 important ideas: payment by results, PBRs, a change in 24 the pattern of financial flows in the NHS using a tariff 25 system, paying providers for the work they actually did;</p> <p style="text-align: right;">Page 29</p>	<p>1 commissioning. Unlike with GP fundholding, which gave 2 GPs the money, PBC gives GPs only indicative budgets to 3 commission services on behalf of their patients while 4 the PCT still does the contracting and pays providers.</p> <p>5 Moving to 2005, Labour's election manifesto made 6 a commitment to reduce management costs in the NHS by 7 GBP 250 million. Creating a Patient-Led NHS, which was 8 published in March of 2005, promised to move money from 9 management to front line services and reduce the number 10 of SHAs, PCTs and ambulance trusts. Following the 2005 11 general election, a further wave of organisational 12 change began.</p> <p>13 In 2006, there was a reduction in the number of 14 strategic health authorities from 26 to ten. Their new 15 role was to develop plans for improving health services 16 in their local area, performance managing PCTs, 17 improving the quality of these organisations and 18 ensuring that they met national priorities.</p> <p>19 It was decided to reduce the number of PCTs from 303 20 to 152 in May 2006, as the Department of Health realised 21 that there were insufficient skilled personnel for so 22 many PCTs and in order to reduce costs. New chairmen 23 were appointed and the new PCTs were established from 24 1 October 2006.</p> <p>25 PCTs were central to the running of the NHS, but</p> <p style="text-align: right;">Page 31</p>
<p>1 foundation trusts, hospitals established as public 2 interest companies outside Whitehall control; patient 3 choice, where patients would be given information on 4 alternative providers, will be able to switch hospitals 5 to have shorter waits; and primary care trusts freed to 6 purchase care from the most appropriate provider, 7 public, private or voluntary.</p> <p>8 Since 2003 the primary care trust, PCT, have been 9 the main local public health commissioning organisation 10 in England. Early criticisms included their 11 increasingly management focused or corporate strategy 12 and culture and a falling away of clinical engagement 13 and support. PCT staff had many differing backgrounds 14 and skills. PCTs had to develop new and commercial 15 commissioning skills, as their decisions were open to 16 challenge, particularly when independent contractors 17 tendered.</p> <p>18 These criticisms were attempted to be addressed with 19 the introduction in 2005 of practice-based 20 commissioning, which was designed to reignite clinical 21 enthusiasm and involvement by giving GPs a greater role 22 in commissioning.</p> <p>23 While GP fundholding had been abolished in 1997, in 24 2005 the government introduced practice-based 25 commissioning to give GPs a larger role in</p> <p style="text-align: right;">Page 30</p>	<p>1 concern about their weaknesses remained. To bring about 2 improvement, the government introduced its World Class 3 Commissioning initiative in 2007.</p> <p>4 In 2008 Lord Darzi's Next Stage Review established 5 as key objectives promoting health and improving the 6 quality of care. The review announced the introduction 7 of CQUIN, continuous quality improvement network, 8 quality accounts and patient reported outcome measures, 9 or PROMs, as ways of being about improvement in quality.</p> <p>10 In terms of regulation, in the late 1990s the 11 Hospital Advisory Service was wound up, and in 1999 the 12 Commission for Health Improvement, CHI, or CHI, was 13 established with the remit of a new NHS Inspectorate. 14 The CHI had four main statutory functions: To undertake 15 a four-year rolling programme of clinical governance 16 reviews of NHS organisations; to investigate serious 17 service failures in the NHS when requested to do so; to 18 monitor progress and the implementation of standards set 19 by the National Institute for Clinical Excellence, or 20 NICE; to provide advice and guidance to the NHS on 21 clinical governance. NICE had been set up to provide 22 national guidance and direction on clinical practice and 23 technology assessment, and in essence it still performs 24 that role.</p> <p>25 In 2002, just two years after it had been</p> <p style="text-align: right;">Page 32</p>

<p>1 established, CHI was merged into a new organisation with 2 remit to cover both the work of the CHI and the NHS and 3 the regulation of private healthcare service to be 4 called the Commission of Healthcare Audit and 5 Inspection, or CHAI. This was to become just a year 6 later, the HCC and it came into being following primary 7 legislation in 2003.</p> <p>8 In April 2009 the Healthcare Commission was 9 abolished and replaced in terms of its core functions of 10 healthcare regulation by the body that we have now, 11 which is the CQC, the Care Quality Commission.</p> <p>12 The history just related may be thought to reveal 13 that a series of changes, initiatives and drives each 14 aimed to ensure that the funding of the NHS is focused 15 upon the needs of the patient and improve the health of 16 the nation have not universally had that effect. Both 17 those who work within the service and external experts 18 all appear to be in agreement on one issue, and that is 19 that constant change, such as has occurred to the NHS, 20 is detrimental to the service and to the regulation of 21 it.</p> <p>22 I turn now to previous inquiries and reports into 23 other trusts and doctors. Since 1969 there have been no 24 less than 40 private and public inquiries and 25 investigations into hospitals, trusts and doctors across Page 33</p>	<p>1 Improvement into high death rates and the way in which 2 complaints were handled at the Epsom and St Helier NHS 3 Trust. The key area for action and recommendation were 4 as follows:</p> <p>5 (1) action was required to ensure a cohesive 6 approach to information use, and the involvement of 7 clinical staff and the public in determining how 8 information is gathered and used to enhance the patient 9 experience.</p> <p>10 (2) urgent action was required to implement 11 a trust-wide untoward incident reporting policy and to 12 ensure that clinical incidents report could be made with 13 the relevant forms easily available.</p> <p>14 (3) urgent action was required to install compatible 15 IT systems.</p> <p>16 (4) action was needed to ensure a strategic approach 17 to involving both patients and the public in setting the 18 quality agenda and ensuring safe and adequate care for 19 patients.</p> <p>20 (5) action was required to develop systems to ensure 21 that complaints were dealt with expeditiously and 22 sensitively, and were shared with staff and used to 23 improve clinical standards.</p> <p>24 (6) urgent action was required to ensure that 25 clinical risk management policy was implemented and all Page 35</p>
<p>1 the UK. We have as a team reviewed the conclusions of 2 those reports in an effort to ensure that we do not 3 constantly retread old ground. We have drawn particular 4 assistance from the inquiry into the Bristol Royal 5 Infirmary. Many of the inquiries dealt with discrete 6 issues, in relation to specific clinical matters or 7 specific doctors. Others, however, had national 8 significance, with wider implications than the immediate 9 local problems which had given rise to the inquiry or 10 investigation. It is upon those that we will now, 11 briefly, focus.</p> <p>12 Looking at the recommendations of each inquiry, some 13 of them certainly appear to be pertinent to the terms of 14 reference of this inquiry, and indeed mirror many of the 15 issues which were raised in your first inquiry. It is 16 worth spending a moment to review the conclusions of 17 some of those reports and to examine the similarity of 18 the complaints.</p> <p>19 In making recommendations to the Secretary of State 20 in due course, it may be of importance to be aware of 21 recurring trends of complaints and recommendations as we 22 will see that there have been.</p> <p>23 The first is the Epsom and St Helier investigation, 24 which was in 2001, and that was by way of a clinical 25 governance review by the Commission for Health Page 34</p>	<p>1 staff understood its principles.</p> <p>2 (7) urgent action was needed to ensure that staff 3 felt safe to raise concerns, and to ensure that the 4 staff understood and could apply the whistle-blowing 5 policy and harassment at work policy.</p> <p>6 (8) action was required to ensure that patients were 7 involved in the clinical audit process.</p> <p>8 (9) action was required to ensure that there was 9 a centrally-based approach to implementing 10 evidence-based care.</p> <p>11 (10) action was required to implement NICE 12 guidelines and produce plans for implementing those in 13 clinical care.</p> <p>14 One can see immediately the similarity of many of 15 the issues which were uncovered back in 2000 with those 16 that were uncovered at the Mid Staffordshire NHS 17 Foundation Trust in your first report.</p> <p>18 The inquiry into Mr Rodney Ledward, the specific 19 details of that inquiry were widely reported and are not 20 essential here. However, the independent confidential 21 inquiry into Mr Rodney Ledward, which reported again in 22 2000 at the South Kent Hospital NHS Trust, made the 23 following recommendations, which again are pertinent to 24 our considerations here.</p> <p>25 (1) each Royal college should identify a minimum Page 36</p>

<p>1 list of untoward nonclinical events which should trigger 2 the filing of an incident report form. 3 (2) any NHS employee should be required to fill in 4 an incident report form if they are aware of an untoward 5 incident. 6 (3) the clinical risk manager should be proactive in 7 ensuring that the practice of the filling in and filing 8 of untoward incident reports forms is followed by each 9 department. 10 (4) absence of an untoward incident form in respect 11 of a complaint should immediately be investigated. 12 (5) each trust should develop a list of untoward, 13 nonclinical events which should trigger a report. 14 (6) discussions should take place at directorate 15 meetings in relation to all untoward incidents that have 16 been recorded and practice decided upon to implement 17 change. 18 (7) time for audit should be allowed in each 19 doctor's contract and all doctors, including 20 consultants, must participate in clinical audit. 21 (8) each trust must have a clinical head of audit. 22 (9) the Department of Health should consider ways to 23 audit long-term outcomes following inpatient care. 24 (10) all complaints should be dealt with by a single 25 department within each trust, the manager of which</p> <p style="text-align: right;">Page 37</p>	<p>1 (1) there was no agreed means of assessing quality 2 of care. 3 (2) there were no standards for evaluation of 4 performance. 5 (3) there was confusion as to who was responsible 6 for monitoring care. 7 (4) there were concerns raised at the hospital but 8 not taken seriously by staff. 9 (5) there was a lack of openness at the trust. 10 (6) there was a lack of candour towards patients. 11 (7) there was no traditional culture that the trust 12 board should be involved. 13 (8) there was no external system for monitoring the 14 quality of care. The supra regional services advisory 15 group thought the Royal colleges were doing it and vice 16 versa. 17 (9) the Department of Health national database, the 18 hospital episodes statistic database was not recognised 19 as a valuable tool for analysing performance. 20 (10) there was no mechanism of surveillance to 21 ensure that patterns of poor performance were recognised 22 and addressed. 23 (11) clinical negligence litigation may act as 24 a barrier to openness. That is a specific issue upon 25 which we will be inviting comment from experts in this</p> <p style="text-align: right;">Page 39</p>
<p>1 should be directly answerable to the chief executive and 2 be a member of the clinical governance committee. 3 (11) patients must be able to raise complaints 4 whilst they are in a hospital and be given a prompt, 5 full and proper response. 6 (12) the collection of full accurate data is crucial 7 to good quality care. 8 (13) a confidential hotline should be set up in 9 every trust which can be used to notify concerns about 10 any member of staff to an appropriate person. 11 It is perhaps obvious that many of these 12 recommendations made in 2000 were still not being acted 13 upon in 2005, and thereafter at the Mid Staffordshire 14 trust. It would be wrong to assume that the Mid 15 Staffordshire trust was alone in this failing. 16 The Bristol Royal Infirmary inquiry report in 2001 17 was an independent investigation into the care of 18 children receiving complex cardiac surgery at the 19 Bristol Royal Infirmary. The inquiry made 20 recommendations in relation to securing high quality 21 care across the NHS. Again, it is surprising perhaps 22 that many of the themes bear a remarkable resemblance to 23 those raised in your first report. 24 The findings in relation to failings at Bristol 25 could be summarised in this way:</p> <p style="text-align: right;">Page 38</p>	<p>1 hearing. 2 The recommendations that were made, which may be 3 thought to be particularly pertinent to this inquiry, 4 were as follows: 5 (1) that doctors, nurses and managers must work 6 together as healthcare professionals with comparable 7 terms of employment and clear lines of accountability. 8 That was attempted to be brought in by the Code of 9 Conduct for NHS Managers in 2002. 10 (2) there must be agreed and published standards of 11 clinical care for healthcare professionals to follow so 12 that patients and public know what to expect. There 13 should be a single coherent and coordinated standard, 14 now the work of NICE, National Service Frameworks, NPSA 15 Never Events guidelines in 2008 and the NHS constitution 16 are in place. 17 (3) hospitals which do not meet set standards should 18 not be able to operate within the NHS. 19 (4) there must be effective systems to monitor 20 standards of clinical performance. Well, now, again 21 there are the national clinical assessment service, part 22 of NPSA, Monitor and now the CQC, and the use of 23 Dr Foster data. 24 (5) the system of inspections of trusts and PCTs 25 should be replaced in with a system of validation and</p> <p style="text-align: right;">Page 40</p>

<p>1 revalidation under the auspices of a single body. Well, 2 now, of course, we have the CQC and Monitor for 3 foundation trusts. 4 (6) clinical audit should be compulsory for all 5 healthcare professionals and should be at the core of 6 a system of local monitoring and performance. Now one 7 of the core standards of the CQC healthcare check but 8 still not mandatory is a requirement for a clinical 9 negligence scheme for trusts. 10 (7) a single system of data collection should be 11 adopted from which information about both clinical and 12 administrative performance can be derived. There is now 13 the annual healthcare check and the NHS league tables. 14 (8) the hospital episode database should be 15 supported as a major national resource, which can be 16 used reliably. This was hoped to be actioned by the 17 setting up of the NHS Information Centre in 2005. 18 (9) quality of healthcare would be enhanced by 19 greater respect and honesty between healthcare 20 professionals and patients. The CQC Registration 21 Regulations have a duty to report incidents, but in fact 22 there's no statutory duty to inform patients. 23 Similarly, GMC Good Practice Guidelines require honesty 24 between healthcare professionals and a duty to confess 25 immediately when something has gone wrong to the Page 41</p>	<p>1 events and near misses. Confidential reporting should 2 be provided for and a failure to report should attract 3 disciplinary action. Again, there's the work of the 4 NPSA and CQC regulations making it a requirement to 5 report adverse events. 6 The National Patient Safety Agency should bring 7 together interested parties to tackle persistent causes 8 of unsafe practices. There is now the National Clinical 9 Assessment Authority within the NPSA. 10 The NPSA should be responsible for publishing 11 regular reports on patterns of sentinel events and 12 remedial action, the NPSA, of course, publishes safety 13 alerts. 14 (17) NICE should set standards of clinical care and 15 draw on the expertise on the Royal colleges. It does, 16 but we query the extent to which it draws on the 17 experience of the Royal colleges and we will hearing 18 from the Royal colleges about that. 19 (18) data must be collected as the by-product of 20 clinical care and there should be a single, unified 21 accessible system for reporting and analysing sentinel 22 events, which should be managed by the patient safety 23 agency. 24 (19) Staff should have immunity from disciplinary 25 action by an employer or regulator if they report an Page 43</p>
<p>1 patient. 2 There should be a clear, one-stop shop in every 3 trust for addressing concerns of patients about the care 4 provided and the conduct of healthcare professionals; 5 the Commission for Patient and Public Involvement in 6 Health created in 2006 but abolished in 2008, and 7 Patient and Public Information Forums, created in 2006 8 and then PALS, and Links from 2007. 9 (11) trust boards must be able to lead healthcare at 10 the local level. 11 (12) there should be an independent and overarching 12 body. The Council for Quality of Healthcare to 13 coordinate the activity of NICE and the Commission for 14 Health Improvement which should report To the Department 15 of Health and to Parliament. 16 (13) there should be an overarching mechanism to 17 coordinate the regulatory bodies, such as the GMC and 18 the NMC, the Council for the Regulation of Healthcare 19 Professionals and, of course, the creation of the 20 Council for Healthcare Professionals and then the 21 Council for Healthcare Regulatory Excellence had been 22 brought into effect. 23 (14) a culture of safety requires the creation of an 24 open, free and nonpunitive environment, in which 25 healthcare professionals can feel safe to report adverse Page 42</p>	<p>1 event within 48 hours. Well, already in existence in 2 fact was the Public Interest Disclosure Act 1998, which 3 was supposed to protect whistle-blowers, but again 4 during the course of this inquiry we will have to see 5 how effective that is. 6 (20) failing to report such an event should be 7 a disciplinary offence. 8 (21) the public voice should be embedded into all 9 organisations concerned with quality of performance 10 rather than be represented on the outside, and the 11 widest public voice should be encouraged. We will be 12 hearing about patient and public information forums, 13 PALS, Links and also, of course, the oversight and 14 scrutiny committees. 15 (22) there should be an NHS appointments commission 16 responsible for the appointment of nonexecutive 17 directors of NHS trusts, health authorities and PCTs. 18 This was acted upon by way of the setting up of the 19 Appointments Commission, which is about to be abolished. 20 (23) nonexecutive directors should be provided with 21 training and support to ensure that they play an 22 effective role. 23 And this comment in the Bristol inquiry was also 24 made of general application to our work here, and it is 25 a comment upon public inquiries: Page 44</p>

<p>1 "A public inquiry [they said] should seek to restore 2 public confidence by carrying out a full, fair and 3 fearless investigation into the relevant events. 4 Second, a public inquiry should identify the lessons to 5 be learned. A public inquiry should attempt to promote 6 understanding of what went on and what led to certain 7 events. The public inquiry should offer a form of 8 public catharsis and not be adversarial in nature. The 9 approach should be inquisitorial and non-adversarial." 10 Those comments we have taken firmly on board. 11 In relation to the Bristol report, there were 12 fundamental and structural changes made within the NHS, 13 which were broadly in line with many of the 14 recommendations, central to which was the setting up of 15 the Commission for Health Improvement and the various 16 patient forums in their various forms. Those additions 17 to the spectrum changed the landscape of regulation, and 18 we must bear in mind that many of those organisations 19 were relatively new at the time of the events at 20 Stafford which we are now considering. 21 Can I turn to Lord Darzi of Denham High Quality Care 22 For All report of 2008. In 2008 an important review was 23 published with input from clinical leads from ten 24 strategic health authorities, which in fact included 25 Professor Cooke from the West Midlands, Professor Page 45</p>	<p>1 independent quality standards, and the new National 2 Quality Board would offer transparent advice to 3 ministers. 4 Information about the quality of care will be 5 systematically measured and published, and that 6 information should include patients' views on the 7 success of their treatment and the quality of their 8 experience. 9 There should be clear measures of safety and 10 clinical outcomes. 11 All registered healthcare providers working for the 12 NHS will be required to publish what were called quality 13 accounts, just as they publish financial accounts. 14 Funding for hospitals that treat NHS patients should 15 reflect the quality of care that patients receive. 16 Drawing on the experience of healthcare in the 17 United States, the NPSA should work with stakeholders, 18 draw up a list of never events and payment should be 19 withheld should they occur. 20 PCTs should challenge providers to provide high 21 quality care and there should be a stronger clinical 22 engagement in commissioning. 23 Each strategic health authority should appoint 24 a medical director to be responsible for overseeing 25 implementation of the local clinical provisions and Page 47</p>
<p>1 Lakhani and Dr McLean from the East Midlands. There 2 were also contributions from some 2,000 other clinicians 3 and other health professionals. 4 Again, without going into great detail, we think 5 it would be helpful to provide a summary of the 6 conclusions and recommendations of that report such as 7 are pertinent to this inquiry. 8 The report recognised that despite good intentions 9 there were significant variations in the quality of care 10 provided across the NHS. While the NHS needs to be 11 flexible to respond to the needs of local communities, 12 people needed to be confident that standards were high 13 across the board. This meant tackling the variations 14 and giving the patients greater information and choice. 15 The comments and recommendations included: patients 16 repeatedly expressed the view that they wanted greater 17 control and influence over their healthcare. 18 The new NHS constitution was to include the right to 19 choose both treatments and providers and to have access 20 to information on quality so that patients could make 21 informed choices. 22 The service should continuously seek improvements in 23 safety and reductions in healthcare associated 24 infections. 25 NICE should be expanded to set and approve more Page 46</p>	<p>1 providing leadership to all NHS organisations in the 2 area. They will have professional accountability to the 3 Department of Health. 4 The CQC should have a stronger focus on compliance 5 and more flexible enforcement powers. 6 It was noted -- and this perhaps is a reflection of 7 a comment that I made earlier -- that there was amongst 8 staff in the NHS an element of change fatigue. Staff 9 were fed up with upheaval when the change was driven top 10 down. 11 The core of the recommendations, so far as that 12 report is concerned, is the achievement of universal 13 minimum standards strengthened by the setting of 14 independent quality standards by NICE. The extent to 15 which that aspiration has been met, or has at least been 16 tackled by the Department, will have to be considered 17 here. 18 I am about to turn to the issue of previous 19 inquiries into Mid Staffs NHS Trust and I wonder, given 20 it is 1 o'clock, if that would be a convenient moment. 21 THE CHAIRMAN: I think that is. We will resume at 2. Thank 22 you very much, Mr Kark. 23 (1.00 pm) 24 (The short adjournment) 25 (2.00 pm) Page 48</p>

<p>1 THE CHAIRMAN: Good afternoon, everybody. Do we have 2 a technical problem? (Pause). 3 Mr Kark, I think you can start. They have at least 4 one machine working on their desk. 5 MR KARK: Thank you, sir. 6 Sir, prior to your first inquiry there had, of 7 course, been a prior series of other investigations and 8 report into what had gone wrong at the trust. Those 9 were taken into account within report 1, and I do not 10 need to go into those in any detail now. Nevertheless, 11 some of the recommendations, which had a wider remit 12 than merely local, may be pertinent to our function here 13 and ought to be recognised as such. Again, the learning 14 from those reports is of some use and should not been 15 thought to have been ignored. 16 I start with the Commission for Health Improvement. 17 In 2002, the Commission for Health Improvement, the 18 precursor to the Healthcare Commission, carried out 19 a clinical governance review of the trust. Its report, 20 published in December of that year, advised the key 21 issues to be addressed: resolving problems with a high 22 number of emergency admissions, patients needed to be 23 put into appropriate wards with fewer transfers of 24 patients between wards, the low number of nurses was 25 a cause for concern, the trust needed to improve</p> <p style="text-align: right;">Page 49</p>	<p>1 assessed may be thought to be overdue. 2 Whether or not there are issues in relation to the 3 performance of the HCC and how it went about performing 4 its function, it did conduct an investigation in 5 relation to the trust, the findings of which are 6 pertinent to the inquiry. 7 Between April of 2008 and October of 2008 the 8 Healthcare Commission conducted an investigation at the 9 trust, focusing primarily on emergency admissions. 10 Their investigation was triggered in 2007 by high 11 mortality rates for specific conditions at the hospital. 12 The hospital standardised mortality ratio or HSMR is 13 a comparative measure of an acute trust's overall 14 mortality developed by the Dr Foster Research Unit. It 15 focuses on a group of diagnoses which account for 16 approximately 80 per cent of all deaths in hospitals in 17 England. The HSMR accounts for the case mix of patients 18 adjusting for a number of factors, including primary 19 diagnosis, age, sex and co-morbidities. 20 As you, sir, are aware the Department of Health 21 published last week a new method, known as the Summary 22 Hospital-level Mortality Indicator, following a national 23 review, which resulted in fact from your recommendation 24 in report 1. 25 A value of HSMR of 100 indicates a mortality rate</p> <p style="text-align: right;">Page 51</p>
<p>1 provision for the privacy and dignity of its patients, 2 the trust was advised to adopt an open and learning 3 culture. 4 The report also found that the quality of clinical 5 data was poor. Almost all of these criticisms and 6 recommendations were to find themselves reflected as 7 criticisms in the subsequent report by the HCC seven 8 years later and by the subsequent reports. 9 In 2004/2005 the trust was awarded one star by the 10 Healthcare Commission in its annual performance star 11 ratings. 12 In 2005 to 2006, the trust was rated as fair in 13 relation both to quality of services and use of 14 resources. 15 In 2006/2007 the trust was rated as fair in terms of 16 quality of service, and good in relation to the use of 17 resources. 18 In that same review, core standards were said to be 19 fully met. The trust was rated as good against existing 20 standards but weak against the new national target 21 score. 22 When one considers the litany of complaints about 23 the standards of the trust during the period that the 24 HCC was reporting, an examination of the quality of the 25 assessment and how foundation trusts may be better</p> <p style="text-align: right;">Page 50</p>	<p>1 that is equal to what one would expect given the case 2 mix. A value of higher than 100 indicates a higher than 3 expected mortality rate. 4 In April of 2007, the Dr Foster's Hospital Guide 5 showed that the trust had a standardised mortality ratio 6 of 127 for 2005 to 2006, and over a three-year period of 7 2003 to 2006, the HSMR was 125. 8 The raised mortality rates was a particular concern 9 in relation to emergency admissions. Although the trust 10 responded and laid the blame for the excessive figures 11 at the door of poor coding of clinical data, the HCC was 12 ultimately unpersuaded and the investigation proceeded. 13 It is disturbing, of course, that more effort appears to 14 have been spent by the trust defending its position than 15 seeking to identify and remedy the underlying problems. 16 The nature of the HCC investigation included 300 17 interviews and a review of over 30 patient case notes. 18 The results of their investigation are set out in their 19 report, which unfortunately took a considerable time to 20 publish. Eventually they published their report on 21 18 March 2009. 22 As a matter of record, Monitor had awarded the trust 23 foundation trust status as recently as February 2008. 24 The lack of communication between those two 25 organisations will have to be the subject of some</p> <p style="text-align: right;">Page 52</p>

<p>1 analysis in this inquiry.</p> <p>2 In any event, the conclusions of the HCC</p> <p>3 investigation were damning. They found that there were</p> <p>4 deficiencies at virtually every stage of the pathway of</p> <p>5 emergency care. The numerous deficient features which</p> <p>6 they found could, in their view, have contributed to</p> <p>7 poor outcomes for patients. They found that serious</p> <p>8 problems of care, which required consideration and</p> <p>9 resolution, were rarely being considered by the trust</p> <p>10 board, which seemed to be ignorant of the issues. They,</p> <p>11 the board, appeared to be insulated from the realities</p> <p>12 within the hospital and the culture did not encourage</p> <p>13 open reporting.</p> <p>14 Those findings are mirrored by other reports</p> <p>15 elsewhere, and by the findings of your first inquiry,</p> <p>16 and where relevant I have dealt with them in this</p> <p>17 opening under the various areas of care and management</p> <p>18 upon which they touched.</p> <p>19 Although we must be careful not to retread the same</p> <p>20 ground in this inquiry, the issue of the failure by the</p> <p>21 trust board will be of importance to an understanding of</p> <p>22 how boards should be structured and operated to ensure</p> <p>23 that such failures do not recur either at Stafford or</p> <p>24 elsewhere within the NHS.</p> <p>25 A further issue highlighted by the HCC report was</p> <p style="text-align: right;">Page 53</p>	<p>1 briefly as I properly can.</p> <p>2 We are fortunate enough to be able to call</p> <p>3 Professor Alberti and to use the findings and</p> <p>4 conclusions of his report as indeed was the first</p> <p>5 inquiry. Professor Alberti published his report on</p> <p>6 29 April 2009, some 19 months ago. It is sufficient for</p> <p>7 me to summarise his key findings.</p> <p>8 His terms of reference were to carry out a review of</p> <p>9 emergency admission and treatment at the Mid</p> <p>10 Staffordshire NHS Foundation Trust, to review the trust</p> <p>11 progress since the HCC's report in March and link</p> <p>12 closely with Dr David Colin-Thome who was reporting on</p> <p>13 practice by the PCT and SHA and lessons to be learnt by</p> <p>14 commissioners.</p> <p>15 In Professor Alberti's view, there were improvements</p> <p>16 at the trust in terms of the number of A and E</p> <p>17 consultants and the quality of care provided in A and E.</p> <p>18 There were now three acute physicians who had greatly</p> <p>19 improved the timeliness of care of medical emergencies.</p> <p>20 There were still issues in relation to the flow of</p> <p>21 patients through the hospital, too few surgeons working</p> <p>22 in each surgical speciality, equipment deficiencies</p> <p>23 identified by the HCC were still apparent, there were</p> <p>24 still too few qualified nurses, patients and the public</p> <p>25 were not included sufficiently in discussion and</p> <p style="text-align: right;">Page 55</p>
<p>1 the way in which the trust went about making savings in</p> <p>2 the year 2006/2007 of some GBP 10 million. The</p> <p>3 reorganisation of the wards and the loss of staff</p> <p>4 following little consultation was badly managed and</p> <p>5 damaged care of patients.</p> <p>6 The issue of the relationship between those who</p> <p>7 managed the budget and the clinical staff responsible</p> <p>8 for ensuring that appropriate level of care in the face</p> <p>9 of staff cuts will be one for this inquiry to consider.</p> <p>10 One of the most damning comments in the HCC report</p> <p>11 was this. It was clear from the minute of the trust</p> <p>12 board that it became focused on promoting itself as an</p> <p>13 organisation with considerable attention given to</p> <p>14 marketing and public relations. It lost sight of its</p> <p>15 responsibilities to deliver acceptable standards of care</p> <p>16 to all patients admitted to its facilities. It failed</p> <p>17 to pay sufficient regard to clinical leadership and to</p> <p>18 the experience and sensibilities of the families. Its</p> <p>19 strategic focus was on financial and business matters,</p> <p>20 at a time when the quality of care of its patients</p> <p>21 admitted as emergencies was well below acceptable</p> <p>22 standards.</p> <p>23 Three further reports followed that of the HCC. The</p> <p>24 Alberti report, the Colin-Thome report and the National</p> <p>25 Quality Board report. I will deal with each in turn as</p> <p style="text-align: right;">Page 54</p>	<p>1 decision-making, and the PCT needed to ensure that the</p> <p>2 quality and safety indicators were built into all</p> <p>3 commissioning and performance management arrangements.</p> <p>4 The trust needed a coherent five-year plan to identify</p> <p>5 where it fitted into the overall health economy and be</p> <p>6 clear about what it can do well and safely and what</p> <p>7 should be handed on to others.</p> <p>8 A recommendation that the PCT needed to ensure that</p> <p>9 quality and safety indicators were built into all</p> <p>10 commissioning and performance management arrangements is</p> <p>11 of particular significance to the terms of reference of</p> <p>12 this inquiry. Whether the system is about to change as</p> <p>13 a result of the coalition government's White Paper,</p> <p>14 there is likely always to be a system of commissioning</p> <p>15 health services. Certainly, there is no sign of any</p> <p>16 government inclination to return to the system pre-1991.</p> <p>17 Professor Alberti's recommendations were no doubt a</p> <p>18 reflection of his disappointment that in his meetings</p> <p>19 with the PCT their focus appeared to be more on patient</p> <p>20 throughput and business than patient care. Accordingly,</p> <p>21 one issue that this inquiry must examine is how the</p> <p>22 commissioning system could be better structured so that</p> <p>23 quality and safety indicators are a necessary part of</p> <p>24 setting budgets and awarding contracts. As</p> <p>25 Professor Alberti put it, all organisations involved,</p> <p style="text-align: right;">Page 56</p>

<p>1 the trust, the PCT, the strategic health authority, 2 Monitor and the Healthcare Commission must learn from 3 the previous problems that have beset Stafford, 4 particularly regarding prompt diagnosis and solutions to 5 problems that emerge.</p> <p>6 It will be of interest to this inquiry to discover 7 to what extent that sensible and worthy aspiration has 8 been converted into reality.</p> <p>9 Dr David Colin-Thome also published his report on 10 29 April 2009. His report sought to look beyond the 11 hospital and to make recommendations directed towards 12 other relevant organisations that also act to safeguard 13 the quality of care of patients. His terms of reference 14 from the Secretary of State for Health were to review 15 the circumstances surrounding Mid Staffordshire NHS 16 Foundation Trust prior to the Healthcare Commission's 17 investigation, to learn lessons about how the primary 18 care trust and strategic health authority within the 19 commissioning, performance and management system that 20 they operate failed to expose what was happening at the 21 hospital.</p> <p>22 It focused on the period between the HCC report, 23 between 2002 and 2007. As Dr Colin-Thome put it: 24 "A key lesson is that all organisations (including 25 the PCT and SHA) should be focused on prioritising high Page 57</p>	<p>1 (4) lack of patient involvement engagement was a key 2 to why the hospital continued to provide poor care for 3 such a long period of time.</p> <p>4 (5) accountable and clinical leadership was lacking 5 at all levels and could have been more effective at the 6 PCT and SHA.</p> <p>7 (6) he was concerned that in his view the public and 8 patient involvement forum had been largely uncritical of 9 the hospital and was, therefore, ineffective.</p> <p>10 (7) more use should be made of GPs, the eyes and 11 ears of their communities.</p> <p>12 (8) there was a lack of clarity about the roles of 13 the PCT and SHA and what the accountability of each was.</p> <p>14 (9) there was over-reliance by the PCT and the SHA 15 on Monitor and the Healthcare Commission, and there was 16 an assumption that regulation of quality would be 17 fulfilled by those organisations.</p> <p>18 (10) the Department of Health should describe the 19 roles of the PCT, the SHA and the regulators and explain 20 how they are different and how they interrelate.</p> <p>21 Those questions posed by Dr Colin-Thome are at the 22 heart of the issues with which this inquiry has to 23 grapple.</p> <p>24 I am going to turn then to the government response 25 to those reports.</p> <p style="text-align: right;">Page 59</p>
<p>1 quality patient care as judged by outcomes, and whilst 2 process targets are very helpful on the journey, they 3 must not become a distraction from the bigger picture."</p> <p>4 Again, he identified, as had the HCC report, that 5 striving for FT status meant an over-allowance on 6 process measures and targets at the expense of focusing 7 on quality of service of patients.</p> <p>8 He was critical in his report of both the PCT and 9 the SHA for failing to seek out information and data 10 from the trust. They were unaware, for example, that 11 the reporting of patient complaints to the hospital 12 trust board had been suspended for three years between 13 2003 and 2006.</p> <p>14 The key criticisms and recommendations were as 15 follows:</p> <p>16 (1) a closed culture within the trust and a lack of 17 willingness to share data outside the trust.</p> <p>18 (2) the reconfigurations of those organisations led 19 to failures to act on poor quality, but he did think 20 that the reconfiguration of the PCTs and the SHAs had 21 been effective in pooling expertise and strengthening 22 the management of the health system.</p> <p>23 (3) foundation trusts must still be answerable to 24 their PCTs as commissioners, performance managers of the 25 service and guardians of high quality care.</p> <p style="text-align: right;">Page 58</p>	<p>1 On 30 April 2009 in a written Ministerial statement 2 the government issued its response to the Alberti and 3 Colin-Thome reports, and the government accepted the 4 recommendations made and indicated their proposed 5 response.</p> <p>6 The key elements of that response were as follows:</p> <p>7 (1) the government declared that it accepted all of 8 the recommendations in the two reports and would work to 9 implement them in full.</p> <p>10 (2) Monitor, it declared, would oversee the 11 implementation by the foundation trust of the 12 recommendations made by Dr Colin-Thome and by 13 Professor Alberti as well as the recommendations made by 14 the HCC.</p> <p>15 (3) the response identified the significant changes 16 adopted by the trust in response to the criticisms. The 17 CQC, Monitor and the PCT were to take stock of the trust 18 in three months -- that would make it late July/early 19 August -- and the CQC would undertake a follow-up 20 investigation in six months, October.</p> <p>21 (5) Monitor would continue to hold the trust to 22 accountable for its progress based on the CQC's 23 assessment.</p> <p>24 (6) NHS organisations would be required henceforth 25 to publish a new annual statement of involvement to Page 60</p>

<p>1 demonstrate how they are implementing the legal duty to 2 involve patients and the public, which would include 3 a statement from the relevant local organisation such as 4 LINK and the local oversight and scrutiny committee. 5 (7) the complaints system was to be reformed and 6 strengthened. Hospitals were, as it was put, to do 7 better at resolving complaints at a local level, and 8 a Parliamentary and Health Service Ombudsman was 9 established as the ultimate arbiter on patient 10 complaints. 11 (8) hospitals were to be required to publish 12 annually how many complaints they received and how they 13 were resolved. 14 (9) the government said that it would convene 15 a summit on best practice in delivering A and E standard 16 with patient representatives. NICE, CQC, the College of 17 Emergency Medicine, and other Royal colleges and other 18 key stakeholders. 19 (10) working tandem with CQC and Monitor the 20 government intended to tighten up the quality of 21 aspirants for foundation trust status and give the CQC 22 a greater role in agreeing that there are no significant 23 concerns about the level of quality that trusts are 24 delivering before they can be authorised as foundation 25 trusts.</p> <p style="text-align: right;">Page 61</p>	<p>1 at the trust by Dr Foster's mortality figures. 2 On 21 July 2009 the Secretary of State, 3 Andy Burnham, issued a further Ministerial statement 4 announcing a further independent inquiry under the 5 chairmanship of you, sir. 6 Before turning to the first report, we need to deal 7 briefly with a further limited investigation of events 8 at the hospital, which took place before your inquiry, 9 and that was the independent case notes review performed 10 by Dr Laker. Unfortunately, his review is not regarded 11 by some to be independent, but nevertheless, his report 12 threw up relevant issues for this inquiry. 13 In April of 2009 Dr Laker was approached to 14 undertake the role of lead clinician in an independent 15 case notes review that the trust was offering to 16 patients and their families who had concerns regarding 17 the care that they had received. Dr Laker agreed to 18 undertake the review on the basis that he would commit 19 to three days per week, and estimated that the task 20 would take some six months to complete. His tasks 21 included meeting with patients and families, providing 22 guidance to assessors on the review process, editing 23 final reports and participating in feedback meetings 24 with relatives. But within a few weeks of starting the 25 review, a number of problems emerged:</p> <p style="text-align: right;">Page 63</p>
<p>1 (11) HSMRs were to be published on the NHS Choices 2 website. 3 (12) all NHS acute providers would be required to 4 publish what would be called quality accounts and the 5 government intended to impose a legal requirement for 6 commissioners to validate those accounts prior to 7 publication. This was said to "ensure commissioners 8 have a central role in overseeing and improving the 9 quality of care provided to their patients." 10 (13) finally, the new National Quality Board was to 11 look at the issues of how to ensure that early signs 12 that something is going wrong in the NHS are picked up 13 immediately, that the right organisations are alerted, 14 that action is taken quickly. The NQB were to review 15 key issues relating to alignment and co-ordination at 16 a system level and were to report by the end of 2009. 17 (14) Sir David Nicholson, the NHS chief executive, 18 was to write to all NHS organisations to bring the 19 reports to their attention and Monitor was to do the 20 same in relation to foundation trusts. 21 (15) however, the failures discovered at Stafford 22 were described as a "local failure", and it was stressed 23 that the HCC had no similar concerns about any other NHS 24 organisations. As an aside, one might comment that this 25 was the same HCC which was only alerted to the problems</p> <p style="text-align: right;">Page 62</p>	<p>1 (1) the trust believed that the written reports of 2 the families would be the end of the process and did not 3 think that there was a need for face-to-face feedback, 4 and Dr Laker disagreed. The trust then altered their 5 position and wanted Dr Laker to conduct the feedback 6 sessions. Dr Laker considered that this was a role 7 which was beyond his clinical competence and that 8 someone with a genuine governance background would be 9 better suited to the task. That issue was never 10 resolved. 11 (2) Dr Laker had to intervene to prevent the head of 12 governance at the trust from seeing the case review 13 reports before they were sent to the families. 14 (3) the trust allocated, says Dr Laker, inadequate 15 resources to the review. 16 (4) within a few weeks it was readily apparent that 17 the task was beyond the capacity of a single lead 18 clinician. The trust agreed but took no action to 19 resolve the issue. 20 (5) the notes of meetings with families contained 21 action points for the trust. These were not acted upon. 22 (6) some of the families questioned Dr Laker's 23 independence because he was appointed and paid by the 24 trust and this could have been avoided had the Strategic 25 Health Authority or PCT commissioned the review.</p> <p style="text-align: right;">Page 64</p>

<p>1 In order to progress to be made with the reviews, 2 the management of the ICNRs was passed to South Staffs 3 PCT and Dr Laker considers that the PCT managed the 4 process in a highly professional manner, and that from 5 that point on the process was adequately resourced.</p> <p>6 Most of the issues identified in the HCC and your 7 report were apparent from the ICNR process. Dr Laker's 8 view of the lessons to be learned is informed by his 9 knowledge of the principles of clinical governance and 10 clinical leadership and he believes that these are key 11 to the prevention of future occurrences.</p> <p>12 In Dr Laker's view, lower priority is given to 13 safety and quality due to the immediacy of financial 14 pressures and this is especially so when services have 15 been reorganised. Dr Laker believes that clinical 16 governance should be apparent throughout all levels of 17 an organisation. It was not effective at Stafford, and 18 the issue that arises in terms of prevention of 19 a recurrence is how NHS organisations are accountable 20 for the quality of their services.</p> <p>21 Dr Laker has concerns that the development of the 22 current assurance mechanism through the CQC is unlikely 23 to address fully the concern regarding the safety and 24 quality of services. In his view, assuring safe and 25 high quality care requires the involvement of the local</p> <p style="text-align: right;">Page 65</p>	<p>1 Dr Laker is keen that the difficulties with 2 interpreting hospital standardised mortality rates are 3 recognised and addressed.</p> <p>4 In his written statement to the House, accepting the 5 conclusion of the two rapid reviews by 6 Professor Sir George Alberti and Dr David Colin-Thome, 7 the minister, Andy Burnham, said this: 8 "It is clear from listening to those affected that 9 rebuilding local confidence and restoring trust will 10 take time. The full impact of what happened at Mid 11 Staffordshire is revealed through personal stories of 12 those affected and it is clear to me that these 13 experiences need to be properly aired if the local NHS 14 is to learn and in time move on. I have therefore 15 decided, following detailed discussion between my 16 department and the new management of the trust, that it 17 would be appropriate to set up a further independent 18 inquiry. I do not believe it is necessary for this to 19 be a full public inquiry, given the thoroughness of the 20 reports already produced by the HCC, 21 Professor Sir George Alberti and David Colin-Thome as 22 well as the availability of an independent clinical 23 review to those who have concerns about the care they or 24 a loved one received at the hospital. 25 "This inquiry's focus will be on ensuring that</p> <p style="text-align: right;">Page 67</p>
<p>1 health economy in addition to a national system.</p> <p>2 Dr Laker has two major concerns about the recent 3 White Paper and the developments intended to prevent a 4 future major failure in healthcare provision. The first 5 is the danger that explicit standards of care will 6 continue to drive the target culture that the current 7 reforms are trying to get away from, and the second is 8 that service-based standards are unlikely to explore 9 standards in all areas of clinical governance.</p> <p>10 With regard to clinical leadership, Dr Laker 11 considers that it is the responsibility of the medical 12 director and director of nursing to champion the 13 clinical quality agenda at board level. He does not 14 believe that this happened at Stafford and considers 15 that problems are likely to occur in other organisations 16 if clinical leadership is poor.</p> <p>17 Dr Laker considers that the roles of the SHA and PCT 18 should be investigated, because the problems at Stafford 19 were long-standing and, in his opinion, the local health 20 economy should have been aware of them. Dr Laker is 21 also keen that the role of the Royal colleges and 22 deaneries should be investigated.</p> <p>23 Dr Laker rejects the suggestion that the ICNR 24 process is capable of identifying the excess deaths 25 believed to have occurred at Stafford.</p> <p style="text-align: right;">Page 66</p>	<p>1 patients or their families have an opportunity to raise 2 their concerns. It is important, given the events of 3 the past, for those who depend upon the care provided by 4 the trust to be confident that they have been listened 5 to and that any further lessons not already identified 6 by the thorough inquiries that have already occurred be 7 learned."</p> <p>8 The brief terms of reference to that inquiry were: 9 (1) to investigate any additional case relating to 10 the care provided by the trust between 2005 and 2008 11 that in its opinion causes concern and to the extent 12 that it considers appropriate.</p> <p>13 (2) in the light of such investigation, to consider 14 whether any additional lessons are to be learned beyond 15 those identified by the inquiries conducted by the HCC, 16 Professor Alberti and Dr Colin-Thome; and if so 17 (3) to consider what additional action is necessary 18 for the new hospital management to ensure the trust is 19 delivering a sustainably good service to its local 20 population.</p> <p>21 The minister continued: 22 "The Mid Staffordshire case has also illustrated 23 that the current regulatory framework for the foundation 24 trusts needs updating. The FT model is a key plank of 25 reform in the NHS successfully rewarding high</p> <p style="text-align: right;">Page 68</p>

<p>1 performance with greater freedom and autonomy. The 2 policy is based on the premise that the FT status is 3 a privilege to be earned and valued. An incentive to 4 drive up quality, innovation, productivity and local 5 accountability. However, it is clear that in some 6 exceptional circumstances where an FT has failed to live 7 up to this standard and public confidence has been 8 damaged, it may be right for the privileges of the FT 9 status to be withdrawn. That is why I intend to consult 10 on legislative proposals to enable Monitor to 11 de-authorise a foundation trust, subject to agreement by 12 the Secretary of State, where it is clear an 13 organisation has forfeited its right to the freedom and 14 flexibilities afforded by FT status." 15 Well, we note that to date, although the powers of 16 de-authorisation have been enacted under section 15 of 17 the Health Act 2009 by way of an amendment to the NHS 18 Act 2006, by inserting section 52B of the Act, the 19 legislation is not yet in force. No trust has been 20 de-authorised. Monitor does not yet have the power to 21 do so, although a consultation document was published in 22 March of this year. 23 Nevertheless, thus was your first inquiry brought 24 into life. 25 Prior to your inquiry commencing, yet a further</p> <p style="text-align: right;">Page 69</p>	<p>1 strengthened by a new revalidation system for doctors. 2 The writers opine: 3 "To create a self-improving and responsibility NHS, 4 we need to aim for a culture of open and honest 5 co-operation. This means individuals and organisations 6 being open and honest about the quality of care being 7 provided to patients and the whole system working 8 collaboratively to address concerns and raise standards. 9 This means staff having confidence to raise concerns 10 about before performance and unacceptable levels of 11 care, rather than waiting for patients or their families 12 to notice the fault lines." 13 A summary of their findings: 14 (1) the systems of monitoring and performance 15 managing the quality of care of patients is almost 16 entirely dependent upon the values and behaviour of the 17 staff working in the system. Strong leadership is 18 needed at every level. 19 (2) the NHS needs to embrace a culture of open and 20 honest cooperation, particularly where there are 21 shortfalls in quality. 22 (3) an open and honest culture requires a two-way 23 dialogue between patients and the public and the NHS. 24 We need to shift the culture of the system from one of 25 reluctance and blame, where failings automatically</p> <p style="text-align: right;">Page 71</p>
<p>1 report was commissioned, this time from the National 2 Quality Board, to review specifically the systems and 3 processes in place in the NHS for safeguarding quality 4 and preventing serious failures. 5 The National Quality Board began operating in 2008, 6 with a specific remit in relation to health to: 7 "... align the system around quality, advise on 8 priorities for quality improvement and overseeing the 9 development of tools and system levers to support front 10 line NHS in bringing continuous quality improvement." 11 The report was presented in early 2010 by 12 Sir David Nicholson, NHS chief executive and chair of 13 the National Quality Board, Dame Jo Williams, acting 14 chair CQC and member of NQB, and Christopher Mellor, who 15 is acting chair of Monitor and member of the NQB, and 16 written so as to describe how the system should work in 17 the future to prevent and where necessary respond to 18 serious failures in quality. 19 They comment that there were to be changes by 20 April 2010 to improve regulation by providing the CQC 21 with new powers of enforcement and a new system of 22 registration for providers of healthcare, a new 23 performance framework within the NHS supporting swift 24 detection of underperformance in the NHS and 25 professional standards and obligations to be</p> <p style="text-align: right;">Page 70</p>	<p>1 result in a race to point a finger to one of openness, 2 learning and continuous improvement. 3 (4) listening to patient experiences and concerns is 4 a key part of the early warning system, but relying on 5 patients alone is insufficient, so there must be 6 a robust performance and regulatory framework in place 7 to safeguard quality. 8 (5) NHS staff and clinical teams are the first line 9 of defence in preventing serious failure in the NHS. It 10 is their duty and responsibility to speak up when they 11 have a concern as well as striving to deliver continuous 12 improvements. 13 (6) the ultimate responsibility for safeguarding the 14 quality of care provided to patients rests with the 15 provider organisations through its board. 16 (7) PCTs and SHAs and the Department of Health are 17 responsible for securing provision of high quality care 18 at local, regional and national levels. 19 (8) the regulators must ensure that providers are 20 adhering to their statutory obligations. 21 (9) in the event of failure, a single organisation 22 needs to take responsibility for ensuring that the 23 management and regulatory responses remain aligned and 24 coordinated at all times. The report recommended that 25 the SHA take on that role.</p> <p style="text-align: right;">Page 72</p>

<p>1 Particular importance was placed upon the role of 2 PCTs in managing contracts and ensuring robustest 3 contract monitoring was in place, and this should 4 include clear performance measures. 5 Similarly of Strategic Health Authorities. It was 6 said that they hold the PCTs to account by ensuring that 7 they are effectively managing the contract with the PCT 8 and they have a role in driving up the capability of 9 PCTs through the World Class Commissioning assurance 10 process. 11 Well, we will need to explore whether that 12 aspiration or any resemblance to reality in Stafford and 13 what World Class Commissioning is meant to mean. 14 It is important to bear in mind that under the White 15 Paper setting out the coalition government plans for the 16 restructuring of the NHS, both the PCTs and SHAs as 17 organisations will be abolished. 18 The role played by the public is set out and 19 comments that PCT should take account of concerns raised 20 about providers, and goes on to deal with the role that 21 Links play in this scenario. The inquiry will we 22 anticipate hear that Links in Staffordshire was 23 a particularly ineffective organisation to bring 24 concerns of the public to the notice of the trust 25 concerned.</p> <p style="text-align: right;">Page 73</p>	<p>1 whether the new system would work better than the old, 2 which appears to have led to such a fundamental failure 3 of communication between one body so concerned about the 4 hospital that it decided to investigate serious failings 5 there, and the other granting it foundation trust status 6 in the same period. 7 A diagram is produced in the report demonstrating 8 how the NHS early warning system is intended to work. 9 As is clearly accepted within the NQB report, there 10 are critical factors which will decide the effectiveness 11 of the early part of the warning system: 12 (1) it depends on a culture of open and honest 13 cooperation being in place within the provider 14 organisation. 15 (2) healthcare professionals need to be confident 16 that if they raise concerns, they will be listened to 17 and not punished. 18 (3) clinical teams should be measuring and 19 benchmarking quality of services and being open and 20 honest about where improvement is needed. 21 (4) the board should be scrutinising quality and 22 fostering an open and learning culture throughout the 23 organisation. 24 (5) the organisation as a whole should be listening 25 to and acting upon feedback and complaints from patients</p> <p style="text-align: right;">Page 75</p>
<p>1 Similar importance is placed upon health oversight 2 and scrutiny committees, which the writers believe bring 3 democratic accountability to healthcare decision and 4 make the NHS more publicly accountable and responsive to 5 local communities. The effectiveness of the local 6 oversight scrutiny committee will be examined with care 7 in due course. On one view of the evidence, which we 8 expect the inquiry will hear, they singularly failed 9 either to oversee or scrutinise the trust in question in 10 any effective way at all. 11 The National Quality Board report also delved into 12 the newly developed system within the CQC to assess 13 quality and risk known as the quality and risk profile 14 system. This is intended to provide a more up-to-date 15 system for collating information on risks to quality of 16 care presented by providers. The sources of information 17 listed are wide and varied, and QRPS is intended to 18 enable the CQC to share information on provider risks 19 across the NHS system, to help risks and failures to be 20 rapidly identified. 21 One of the causes of continuing failure at the 22 hospital examined in inquiry 1 was whether there was 23 a failure by the Healthcare Commission to share the 24 information in relation to the trust with Monitor. It 25 will be of importance to this inquiry to establish</p> <p style="text-align: right;">Page 74</p>	<p>1 and public. 2 The first inquiry established failures of each of 3 those five criteria in the hospital, but the real issue 4 is: how can that sort of failure be avoided in the 5 future? Part of the answer to which may come from 6 asking and answering the question: how does one 7 establish and nourish an open, honest, self-reflective 8 culture throughout each hospital? 9 The diagram demonstrates that unless such a culture 10 is established at the levels of providers A, then there 11 will be a lack of information flowing from A to B. What 12 is needed then is a strong and robust regulatory power 13 to ensure compliance with national standards. This is 14 a critical area for this inquiry to examine and report 15 upon. 16 Turning now to your first inquiry, sir. There was, 17 as you know, some criticism of the fact that the first 18 inquiry was a private one and that evidence was heard in 19 private. Although the criticism is understandable in 20 personal terms, so too was the decision to hold that 21 inquiry in private session. There was much greater 22 cooperation than there might otherwise have been from 23 individuals who, as a consequence of being able to do so 24 privately, were able to speak their minds and find their 25 voice. We have the benefit of that body of evidence</p> <p style="text-align: right;">Page 76</p>

<p>1 from the first inquiry in the form of the conclusions 2 produced in the report. Because of that it is not 3 necessary now to revisit issues on that level.</p> <p>4 There is by contrast no reason for this inquiry not 5 to receive the vast majority of this evidence in public. 6 There are still some patient relatives who would wish to 7 remain anonymous, and there may be whistle-blowers 8 giving evidence to whom the same considerations would 9 apply. It is important that everything is done to 10 ensure that the inquiry receives the material it needs 11 and if that requires anonymity orders, then we will 12 apply to you, sir, for that to be granted.</p> <p>13 There were, as we have seen, prior to your first 14 inquiry into Mid Staffordshire NHS Foundation Trust 15 a number of other investigations and consequent reports 16 but it was the first inquiry, your inquiry, which 17 examined the trust overall and heard the detail of the 18 patient stories. Your first inquiry made a series of 18 19 recommendations, and we intend to examine the extent to 20 which those recommendations have been taken up and 21 complied with.</p> <p>22 Some of the recommendations were for the internal 23 use of the trust, but other recommendations had a wider 24 audience, and it is those which we find particularly 25 pertinent to the role of this public inquiry. It is</p> <p style="text-align: right;">Page 77</p>	<p>1 experiences as a body could be put to better use in both 2 identifying failings and in providing guidance and 3 training in areas where failings are identified.</p> <p>4 Recommendation 5 referred to the use of audit in all 5 clinical departments and making participation in audit 6 a requirement for all relevant staff. The board should 7 review audit processes and outcomes on a regular basis.</p> <p>8 The underuse of accurate audit seems to have been 9 one of the failings at the hospital and this inquiry 10 will need to examine the use of audit across the NHS. 11 How is the relative value of audit from one hospital 12 assessed as compared to another?</p> <p>13 How can audits be homogenised and standardised 14 within various specialities?</p> <p>15 Whether there is value in doing so?</p> <p>16 Who should undertake such a task if is valuable?</p> <p>17 And, how can the results of audit be better used?</p> <p>18 Recommendation 6 referred to the handling of 19 complaints and among other suggestions recommended that 20 full information is given to the board, the governors 21 and the public of complaints made and the action taken 22 to resolve deficiencies.</p> <p>23 Recommendation 7 and 8 refer to policies in relation 24 to complaints, oversight and discipline of staff and the 25 treatment of whistle-blowers, what steps can be taken to</p> <p style="text-align: right;">Page 79</p>
<p>1 worth, therefore, briefly examining some of the 2 recommendations made.</p> <p>3 Your third recommendation, the trust together with 4 the PCT should promote the development of Links with 5 other NHS trusts and foundation trusts to enhance its 6 ability to deliver up-to-date and high class standards 7 of service provision and professional leadership.</p> <p>8 First, we will want to examine the ways in which the 9 trust has sought to meet that recommendation and, 10 secondly, we want to look at the issue of whether 11 communication and constructive links between hospital 12 trusts are a way to ensure an increase of standards 13 across a particular area and a method by which the 14 shortcomings of one hospital might be identified by 15 comparison with another apparently more successful 16 hospital.</p> <p>17 Recommendation 4 suggests that the trust, in 18 conjunction with the Royal colleges, the Deanery, and 19 the Nursing School of Staffordshire University should 20 review its training programmes for all staff to ensure 21 that high quality professional training and development 22 is provided the at all levels at that a high quality 23 service is recognised and valued.</p> <p>24 We in this inquiry will be examining the role played 25 by the Royal colleges to see if their wisdom and</p> <p style="text-align: right;">Page 78</p>	<p>1 ensure that staff are not frightened for themselves or 2 others of reporting untoward incidents, and how is the 3 standard set and homogenised in terms of the threshold 4 for reporting an event as untoward incident. How can 5 staff who do complain be best protected, if protection 6 is needed?</p> <p>7 Recommendation 9 was that the Secretary of State and 8 Monitor should review the arrangements for the training, 9 appointment, support and accountability of executive and 10 nonexecutive directors of NHS trusts and foundation 11 trusts, with a view to creating and enforcing uniform 12 professional standards for such costs by means of 13 standards formulated and overseen by an independent body 14 given powers of disciplinary sanction.</p> <p>15 This inquiry will want to know: what action has been 16 taken to follow this recommendation? What action has 17 been taken to increase the relevant skills and standards 18 of appointed executives so that they have a real role to 19 play and are willing to use the powers that they have 20 independently?</p> <p>21 Recommendation 15 related to the use of comparative 22 mortality statistics and recommended that an independent 23 working group be set up by the Department of Health to 24 examine and report upon the methodologies used. The 25 group should make recommendations as to how such</p> <p style="text-align: right;">Page 80</p>

<p>1 statistics should be collected, analysed and published 2 both to promote public confidence and understanding of 3 the process, and to assist hospitals to use such 4 statistics as a prompt to examine particular area of 5 care.</p> <p>6 Well, as already mentioned, the Department of Health 7 has responded to that recommendation and they published 8 last week a new method known, as I've said, as Summary 9 Hospital-level Mortality Indicators. This inquiry has 10 received submissions from the Department of Health and 11 we will be calling witnesses from that department to 12 provide us with information as to how these statistics 13 are now being used and how it is proposed that they 14 could be better used under the new system.</p> <p>15 Let me turn, perhaps before we break, to the general 16 issues of relevance to this inquiry.</p> <p>17 It is important that we bear in mind that part of 18 the terms of reference include these words: 19 "To examine why problems at the trust were not 20 identify sooner and appropriate action taken." 21 That necessarily entails some examination of what 22 the problems were, but we must be astute to avoid 23 retreading old ground. Again, we take the issues 24 identified in report 1 and the conclusions flowing there 25 from as our starting point.</p> <p style="text-align: right;">Page 81</p>	<p>1 patient safety and the numerous clear examples of a lack 2 of care leading to the conclusion in certain areas that 3 the trust was not a safe place for patients to be.</p> <p>4 Some of the issues referred to in the first report 5 were falls leading on occasion to serious injury, a lack 6 of cleaning in the wards, lack of good hygiene practices 7 among the staff themselves, hospital-acquired 8 infections, lack of control over confused and sometimes 9 aggressive patients, lack of attendance to patient's 10 personal and oral hygiene, a failure to address the 11 needs of patients in relation to nutrition and 12 hydration, a failure to keep proper records of fluid 13 balance and nutritional intake, poor keeping of notes 14 generally, a lack of care in relation to the avoidance 15 and treatment of pressure source, a failure to respect 16 patient's privacy and dignity, misdiagnosis by medical 17 staff and unacceptable delays in diagnosis, lack of 18 follow-up.</p> <p>19 As was said in the first report, what has been shown 20 is more than can be explained by the personal failings 21 of a few members of staff, so it is not our intention to 22 single out for blame individuals. The problem seems to 23 have been a systemic one of culture across a number of 24 specialities.</p> <p>25 The first inquiry identified a number of themes</p> <p style="text-align: right;">Page 83</p>
<p>1 In order to examine the regulation of the hospital, 2 and why things were allowed to get into the state which 3 they did, we may have to examine a number of different 4 clinical specialities and areas in particular to 5 discover what has changed since your first report, and 6 what systems have been put in place to ensure the 7 recurrence of those events does not take place. These 8 will include those areas which were specifically 9 highlighted by the first report A and E, the emergency 10 assessment unit, and wards 6, 7, 8, 10, 11 and 12.</p> <p>11 On these wards there appears to have become 12 established a particularly poor standard of care, of 13 basic nursing skills and on occasion plain human 14 compassion. There were references to witnesses of 15 a bullying attitude.</p> <p>16 In this inquiry, as I've said repeatedly, we do not 17 intend to retread the established ground, but the 18 question we have to try to answer is: what can be done 19 to prevent such a culture establishing itself?</p> <p>20 What can the hospital management do to ensure that 21 nurses are trained to recognise this type of culture? 22 What can the nurses' regulators do to spot problem 23 wards in hospitals?</p> <p>24 Patient safety.</p> <p>25 The first report deals extensively with the issue of</p> <p style="text-align: right;">Page 82</p>	<p>1 which I have termed "themes of failure". Each one is an 2 example where a different approach may have led to 3 a different outcome.</p> <p>4 We will have to examine some of those failures, not 5 to identify what they were -- as a result of the work 6 done by inquiry 1, we know what they were -- but to 7 identify why these failures were allowed to continue and 8 who should have identified them sooner and changed 9 things.</p> <p>10 What role did the commissioners of the service have 11 in contributing to these issues?</p> <p>12 And what part could others outside the trust have 13 better played to prevent the failures persisting?</p> <p>14 The themes were identified in paragraph 80 of your 15 report, and those themes which it has seemed appropriate 16 for us to investigate are:</p> <p>17 A corporate focus on process at the expense of 18 outcomes.</p> <p>19 A failure to listen to those who have received poor 20 care through proper consideration of their complaints.</p> <p>21 Staff disengagement from the process of management.</p> <p>22 Insufficient attention to the maintenance of 23 professional standards.</p> <p>24 A weak professional voice in management decisions.</p> <p>25 A lack of external and internal transparency.</p> <p style="text-align: right;">Page 84</p>

<p>1 False reassurance taken from external assessment. 2 And disregard of the significance of the mortality 3 statistics. 4 One issue we will have to examine is the degree to 5 which finance dominated the management thinking. The 6 financial crisis which pertained at the end of 2006/2007 7 financial year led to the perceived need to find 8 financial cuts of GBP 10 million. Whilst this may have 9 been seen as an internal management issue, if it led to 10 a reduction in the quality of the care provided, which 11 it did, then the question needs to be asked: what could 12 have been done to safeguard the essentials of care in 13 this context and why weren't appropriate measures taken 14 to do so? 15 The first inquiry report broadly accepted that the 16 pursuit of foundation trust status had in fact been 17 deleterious to patient care. The focus of management 18 appears to have been on the financial criteria which 19 would drive the application through: 20 Did the organisation responsible for examining and 21 approving that application, Monitor, appreciate what the 22 effect of this application might be? 23 What was its, Monitor's, role? 24 Did it in fact contribute to the loss of standards 25 of care at the hospital it was monitoring?</p> <p style="text-align: right;">Page 85</p>	<p>1 admission of fault be encouraged so that there is a low 2 threshold for reporting untoward incidents and the 3 appropriate action taken by staff and management in 4 response? 5 What are the factors which militate against 6 a culture of open admission of fault? 7 Is there in fact a culture of punishment of fault 8 rather than learning from errors which then drives 9 admission and discussion underground? 10 Do the professional regulators help this process or 11 hinder it? 12 What is the role of litigation in this process? 13 Is the fear of litigation beneficial by improving 14 standards, or does it lead to a denial of 15 responsibility, such that lessons are never learned? 16 Warning signs. Another area we will examine is what 17 were the warning signs which were not picked up, or if 18 not noticed not reacted to in an appropriate manner. 19 The hospital mortality statistics for the hospital 20 were significantly above the national average. Although 21 it was this figures that attracted the attention of the 22 HCC and caused it to launch an investigation, the 23 reaction of the management of the hospital was to claim 24 that these were caused by so-called coding issues. 25 In your first report it was accepted that there is</p> <p style="text-align: right;">Page 87</p>
<p>1 This issue is crucial and the lessons learned must 2 be acted upon, given that it is the present government's 3 intention to give every NHS trust foundation trust 4 status. 5 The same factors which appear to have driven 6 standards down rather than up must be identified and 7 prevented from having the same effect in the future, and 8 we will be hearing expert evidence to assist the inquiry 9 panel to make recommendations. 10 We turn to the heading of complaints and 11 whistle-blowing. 12 The culture of the hospital does not appear to have 13 encouraged the reporting of untoward incidents and the 14 inquiry found that a number of deaths had not been 15 reported in the appropriate way. The investigation of 16 complaints resulted in reports which lacked credibility 17 and remedial action was not carried out when it should 18 have been. Complaints did not find their way to the 19 board, and if the chief executive knew about them, he 20 does not appear to have responded appropriately to them. 21 Whistle-blowing was not encouraged and whistle-blowers 22 do not appear to have received the support which their 23 actions deserved. 24 One of the issues this inquiry will be invited to 25 examine is, how can a culture of openness and frank</p> <p style="text-align: right;">Page 86</p>	<p>1 strong evidence to suggest that these figures mandated 2 a serious investigation of the standards of care being 3 delivered, rather than reliance on the contention that 4 they had been caused by coding, and recommendation 15 of 5 your rep was that an independent working group be set up 6 to examine the methodologies used. 7 But as part of this inquiry we will also look at 8 other warning signs which might have been picked up and 9 alerted management to difficulties which could have been 10 created. We have accepted as part of the foundation for 11 this inquiry the findings of your first report in 12 relation to the specific areas of care where significant 13 failings were found. Now we need to examine what 14 signals there were that were missed both internally and 15 by those looking at the trust from without. 16 One central issue for this inquiry is why so many 17 regulatory bodies failed to spot what was going on and 18 act upon it sooner. Once the HCC report was published, 19 the trust was swamped with interested parties peering at 20 the hospital and examining the data, but where, we need 21 to ask, were all of these organisations through 2005, 22 2006, 2007 and 2008? 23 One question that requires an answer is whether 24 there were simply too many bodies, none of which were 25 focusing on the right things. In terms of organisations</p> <p style="text-align: right;">Page 88</p>

<p>1 which either had a role in commissioning, regulation, 2 advice-giving or training there was at the time the HCC, 3 Monitor, the PCT, the SHA, the various patient support 4 bodies, both the charitable and governmental AvMA, PALS, 5 PPIF, LINK, POHWER, the oversight and scrutiny 6 committees, the NHSLA, the GMC, the NMC, the HSE, 7 National Confidential Inquiry into Patient Outcome and 8 Death, National Patient Safety Agency, Patients 9 Association, the deaneries responsible for training 10 graduate doctors, the PMETB, the universities 11 responsible for training nurses, the relevant you 12 unions, the Royal colleges, the coroner, the 13 Parliamentary Ombudsman. There were, of course, others. 14 Is there a strong argument for rationalising these 15 bodies and providing them with a better focus and 16 specific role so that everyone knows whose job it is to 17 inspect and assess hospitals? 18 Is there are a simple answer to the question: who do 19 I call when I want to call the regulator of my local 20 hospital? The diagram that is now showing on the screen 21 may demonstrate there is no simple answer to that 22 question. 23 Would that be an appropriate moment to take a short 24 break? 25 THE CHAIRMAN: If I look at that diagram for too long, Page 89</p>	<p>1 In phase 1 we will hear first from a series of 2 experts who will set out the structure of the NHS and 3 the regulation of it and also to speak about concepts of 4 safety and good clinical care and how those issues can 5 best be approached. 6 We will then begin to hear evidence from patients' 7 relatives and patient groups to examine specifically how 8 their complaints were dealt with or more frequently not 9 dealt with. 10 We will gradually shift the focus of the evidence 11 outwards from patients to hear from local and national 12 patient groups, whether government funded or charitable, 13 the PPIF, LINKs, PALS, POHWER, AvMA, and the Patient 14 Association and like groups, and those who are charged 15 with role in protecting patient interests. 16 We then have a period for the doctors outside the 17 trust, the local consortia, and those who may in the 18 future be charged with commissioning services. We will 19 examine their communication with the trust and how it 20 worked or failed to work and why. How do they perceive 21 their role in the future? 22 Then in phase 2 we will move on to hear from those 23 who might or should have had specific information 24 flowing from the trust, the local area medical 25 committee, the Royal College of Nursing and the unions. Page 91</p>
<p>1 I will need more than a cup of tea. But we will have a 2 break for 15 minutes. Thank you. 3 (3.01 pm) 4 (A short break) 5 (3.15 pm) 6 THE CHAIRMAN: Yes, Mr Kark. 7 MR KARK: Sir, the terms of reference required this inquiry, 8 among other things, to examine the operation of the 9 commissioning supervisory and regulatory organisations 10 and other agencies, including the culture and systems of 11 those organisations in relation to the monitoring role 12 at Mid Staffordshire NHS Foundation Trust between 13 January of 2005 and March of 2009, and to examine why 14 problems at the trust were not identified sooner and 15 appropriate action taken. This includes, but is not 16 limited to, examining the actions of the Department of 17 Health, the local Strategic Health Authority, the local 18 primary care trust, the independent regulator of NHS 19 foundation trust, Monitor, the CQC, the Health and 20 Safety Executive, local scrutiny and public engagement 21 bodies and the local coroner. 22 In order to meet the terms of reference, the inquiry 23 intends to meet a step-wise approach and to build 24 a foundation of evidence early on, which will inform the 25 debate early on in the proceedings. Page 90</p>	<p>1 Why was there silence from them, or were the doctors and 2 nurses whom they were representing silent? 3 We will move on to examine the working of the local 4 authority oversight and scrutiny committees, which came 5 in for considerable criticism from patient groups. How 6 was the system intended to work, and why did it not, how 7 could things be better arranged? 8 Again under the coalition government plans, local 9 councils appear to have an even greater role than 10 previously. How will this work in reality? Will it 11 work? And what is needed to make it work? 12 We then move on to the role of the coroner. Could 13 the information which the coroner received have been 14 better used? What is the system for alerting a wider 15 audience if there is recognised to be an outlier number 16 or pattern of fatalities at a particular hospital. 17 A number of patients complained to their Members of 18 Parliament with very varying degrees of success. What 19 was the reality from the MP's standpoint? Were those 20 who did complain able to make their voices heard by the 21 hospital, the Department of Health or by the government? 22 We will then move into phase 3 of the inquiry when 23 we will hear from some of those with responsibility now 24 for looking after the patients at the hospital, from the 25 clinical lead in emergency medicine and some of the Page 92</p>

<p>1 consultants who work with him, how have things changed, 2 if they have, and what are the systems that work better 3 and still do not work? 4 We will then hear from the management of the 5 hospital, both old and new. We will resist any 6 temptation or pressure to call witnesses simply to 7 vilify. That is not the point of this public inquiry. 8 However, it is important to hear from people who made 9 mistakes to try to find out why those mistakes were 10 made. We hope to find some introspection and reflexion. 11 We will then hear from the commissioners of the 12 service, the PCT and the SHA. 13 How were their roles defined for them and how did 14 they carry them out? 15 In amongst peering at the finances, were they 16 keeping a weather eye on the quality of service? 17 Was that part of their role and did they see it as 18 such? 19 Is there a buffer or a divide between the 20 commissioning of the contract for service in the 21 financial sense and the provision of the terms of the 22 contract in terms of the quality of care meted out to 23 patients? 24 Should the commissioners of the future be better 25 equipped to assess the quality of the care which it is</p> <p style="text-align: right;">Page 93</p>	<p>1 and those responsible or with the capability of data 2 collection. The National Health Service Litigation 3 Authority, the National Patient Safety Agency, the 4 National Clinical Assessment Service, the Audit 5 Commission, the National Audit Office, and we hope to be 6 hearing from Professor Jarman at the Dr Foster Unit at 7 Imperial College. 8 We will examine the issue of data collection. What 9 data is collected from primary and secondary care 10 trusts? How is it collected? Who looks at it? Who is 11 meant to react to it? 12 In phase 6 we hope to hear from regulators in other 13 fields of life. The Civil Aviation Authority sometimes 14 held out as a beacon of good regulation, how do they try 15 to instil a culture of open admission of fault, 16 introspection and correction? 17 We hope to hear a perspective from the Prison 18 Inspectorate. How do they ensure that their inspection 19 work properly and are effective in spotting signs of 20 weaknesses or failure where the prisoners' lives or 21 well-being or the safety of the wider public may be at 22 stake. Those organisations are in the process of being 23 contacted. 24 Phase 7 is the final phase of the formal 25 evidence-gathering process and in that phase we will be</p> <p style="text-align: right;">Page 95</p>
<p>1 their responsibility to commission? 2 Then we move to phase 4A to look at the various 3 regulators who had responsibility for preventing the 4 failures at this hospital. We will be hearing from 5 representatives of the Healthcare Commission, as it was, 6 the Care Quality Commission and Monitor. 7 Was there sufficient communication between those 8 bodies? 9 How did it come about that Monitor was granting to 10 a hospital the accolade of foundation trust status just 11 at the time when the HCC was so seriously concerned that 12 they were starting a formal investigation into the same 13 hospital, which was a year later, to produce such 14 a damning report? 15 In phase 4B we will hear from all of the relevant 16 regulators, both of the system, the professionals within 17 it and those responsible for training, the Health 18 Protection Agency, the Health and Safety Executive, the 19 Postgraduate Medical Education Training Board, the GMC, 20 the General Medical Council, the Health Professions 21 Council, the National Institute for Clinical Excellence, 22 or NICE. And finally in that section we'll hear from 23 the Royal colleges, the Nursing and Midwifery Council 24 and the British Medical Association. 25 In phase 5 we turn to the national advisory bodies</p> <p style="text-align: right;">Page 94</p>	<p>1 hearing from the representatives of the organs of the 2 state, the Department of Health itself, the chief 3 medical officer, the chief nurse and those in government 4 responsible in the past and present for designing the 5 system of healthcare and regulation in the UK. 6 We expect that after phase 7 there will need to be 7 a short period of introspection for ourselves, 8 a consideration of which witnesses might need to be 9 recalled during phase 8, in the light of all of the 10 evidence given and to think about what we might have 11 covered but have not. If witnesses are to be 12 criticised, there may then be an opportunity for a small 13 number of witnesses to return and clarify their evidence 14 if that is deemed appropriate by you, sir. 15 That is the intended structure of the inquiry. Some 16 witnesses will not be able to give evidence when we 17 would like them to, no doubt, and we will be as flexible 18 as we properly can to accommodate them. We understand 19 that many of our witnesses are busy and have 20 high-powered and important jobs but they will all no 21 doubt recognise the importance of the business of this 22 inquiry and the importance of helping you meet your 23 terms of reference. 24 We will all recognise as well the importance of 25 concluding the inquiry in as efficient a timeframe as</p> <p style="text-align: right;">Page 96</p>

<p>1 possible, with a particular view to contributing the 2 lessons to be learned from Mid Staffordshire to the 3 current process of healthcare reform proposed by the 4 government. 5 I am going to turn to deal in a little more detail, 6 therefore, with the phases of the inquiry and the 7 witnesses who will be actually giving evidence. 8 Phase 1A is headed "Overview of the service expert 9 evidence". To set the foundation stone of this inquiry, 10 we will, first of all, hear from Professor 11 Christopher Newdick. Professor Newdick is a barrister 12 and the professor of health law at Reading University. 13 His special interests concerns the right sand duties 14 arising within the National Health Service. 15 Dr Judith Smith has co-written a report with 16 Professor Newdick. She is head of policy at the 17 Nuffield Trust and is an experienced health services 18 researcher, who has studied healthcare organisation and 19 management in the UK and internationally. Before 20 joining the Nuffield Trust in 2009, she was based at the 21 Health Services Management Centre in Birmingham for 14 22 years where she both carried out research and taught on 23 health commissioning and purchasing, as well as the 24 organisation of primary care and health management. 25 Professor Newdick and Dr Smith have assisted the Page 97</p>	<p>1 Following the evidence intended to give us a solid 2 grounding in the foundation of the NHS structure and its 3 regulation, we will then begin to hear the lay evidence, 4 the patient evidence. We will begin the task of hearing 5 evidence about people's experience within the trust. 6 During the course of this part of the opening, you 7 will see some photographs appear on the screens. These 8 are all photographs of patients who died at Mid 9 Staffordshire NHS Trust and other relatives and 10 witnesses from whom we obtained statements. We wanted 11 to show some of the photographs of patients to bring 12 a strong sense of reality and purpose to this inquiry. 13 I am very conscious that there are many patient 14 relatives watching these proceedings. Some may have 15 given statements and others will not have done. 16 Everyone will appreciate that we cannot show the 17 photographs of all who died at the hospital, and many 18 witnesses have not wanted their relative's photograph 19 displayed. 20 By not making reference to all of the patient 21 evidence or by not displaying a photograph, no one 22 should think that their role in this inquiry is 23 diminished. We are not ignoring the death of any 24 relative or loved one, which inevitably brings with it 25 a huge sense of loss, which is made far worse if there Page 99</p>
<p>1 inquiry by providing a report which deals with the 2 structure of the NHS, how it has transformed into the 3 organisation that it is today and how the commissioning 4 supervision and regulation of health services within the 5 NHS is intended to work. 6 In addition to Professor Newdick and 7 Dr Judith Smith, we will call at the beginning of the 8 inquiry Professor Charles Vincent. We have been very 9 fortunate in securing the assistance of Professor 10 Vincent, who is one of the world's leading experts on 11 patient safety and author of a book by that title. His 12 evidence, which is to be called early in the 13 proceedings, will help to set the foundation stone from 14 which we can properly examine and test the evidence of 15 those who are called later in the proceedings. He will 16 set out where the difference lies between safety and 17 good care and the different ways that there are in 18 approaching these fundamental issues. 19 A further expert we propose to call in the inquiry 20 is Dr Kieran Walshe. His expertise is medical 21 regulation and he will assist us both as to how the 22 system of medical regulation is meant to work and 23 compare it with how it works in reality and practice. 24 Let me turn to phase 1B and what I have headed as 25 "Patient relative evidence". Page 98</p>	<p>1 is a belief that the loss was unnecessary. 2 The whole focus of this inquiry is ultimately 3 patients. We must, however, avoid this becoming a forum 4 simply to relate the history of ills which befell 5 individual patients. What we need to do is to examine 6 what happened when individuals complain. 7 How were their complaints dealt with? 8 Who did they see? 9 And, where did the blockages occur? 10 Did they know to whom they could complain or was the 11 system simply too complex? 12 How fair is the system? 13 And, how well does it respond to the vulnerabilities 14 of people who have to grapple with it who are themselves 15 either ill or closely related to those who are ill, 16 dying or to those who have died? 17 If their complaints were taken up, did they see any 18 change of practice? 19 One of the themes of complaint in inquiry 1 was that 20 there were plenty of action plans, but not a lot of 21 action. We have to find out what could have been done 22 better both to resolve the complaints which will 23 inevitably arise in even the best run healthcare system, 24 but also to ensure that there is a system of feedback 25 and learning from cases where a complaint is found to be Page 100</p>

<p>1 genuine.</p> <p>2 We will start by hearing evidence from the witnesses</p> <p>3 from Cure the NHS, the people who brought the issues at</p> <p>4 a local hospital to the national debate. A number of</p> <p>5 patient relatives will wish to give evidence anonymously</p> <p>6 and you may feel it is important that they are able to</p> <p>7 give evidence as in comfortable and secure an</p> <p>8 environment as possible.</p> <p>9 I am not going to deal with individual patient</p> <p>10 relative evidence in any detail, but as the first</p> <p>11 inquiry found, there are themes which flow from the</p> <p>12 written material we have received and the complaints</p> <p>13 covered many areas of the hospital, including the</p> <p>14 following:</p> <p>15 The lack of nurses at night and weekends.</p> <p>16 The paucity of numbers of nurses generally.</p> <p>17 Poor basic hygiene.</p> <p>18 Leaving patients lying in their own urine and</p> <p>19 faeces.</p> <p>20 Lack of staff to assist patients when needed whether</p> <p>21 to eat, to wash or to go the lavatory. Sometimes the</p> <p>22 staff were there but seemed not to bother unless</p> <p>23 requested, and even then to react slowly if at all.</p> <p>24 Meals left for patients out of reach or with no</p> <p>25 communication to the patient that the meal was there.</p> <p style="text-align: right;">Page 101</p>	<p>1 There was a lack of basic humanity when dealing with</p> <p>2 bereavement.</p> <p>3 What was the reaction to the complaints when they</p> <p>4 were made? Again, I summarise some of the stories again</p> <p>5 rather than going into any detail.</p> <p>6 Nurses themselves very often ignored the complaint</p> <p>7 and carried on as before.</p> <p>8 The nursing director, Helen Moss, refused to accept</p> <p>9 that there were problems with the standards of nursing</p> <p>10 care.</p> <p>11 Complainants were fobbed off with action plans which</p> <p>12 were used as a mere sop to cure the complaint but not</p> <p>13 the underlying problem.</p> <p>14 Action plans were not followed through, and the same</p> <p>15 complaints arose again and again.</p> <p>16 Relatives complain of general confusion about who to</p> <p>17 complain to, there being so many bodies to which one</p> <p>18 could complain but none of them being very prominent.</p> <p>19 One witness described how it was impossible to find</p> <p>20 anyone who would take ownership of the complaint.</p> <p>21 Many patients and relatives simply did not know who</p> <p>22 they could complain to, and did not know of the</p> <p>23 existence of many of the organisations which were there</p> <p>24 to assist.</p> <p>25 A perception that following a complaint by</p> <p style="text-align: right;">Page 103</p>
<p>1 This often resulted in meals being taken away untouched</p> <p>2 by the patient.</p> <p>3 Confused and agitated patients were allowed to</p> <p>4 wander the wards, disturbing, threatening and at least</p> <p>5 on one occasion attacking other patients; nurse</p> <p>6 assistance when summoned often arrived too late.</p> <p>7 Even where patients had had serious accidents such</p> <p>8 as falling out of bed, it proved difficult to get the</p> <p>9 attention of the nurses.</p> <p>10 Lack of care generally.</p> <p>11 A failure to give drugs when required, including</p> <p>12 pain relief.</p> <p>13 Rudeness and bullying towards patients.</p> <p>14 A lack of basic equipment such as mattresses,</p> <p>15 blankets, pillows, hoists. Even once the HCC</p> <p>16 investigation started the complaints about similar</p> <p>17 issues continued.</p> <p>18 There was a culture of bullying between the senior</p> <p>19 nurses and the junior nurses.</p> <p>20 Patients were transferred or discharged without</p> <p>21 their relatives being informed.</p> <p>22 There were difficulties in communication between</p> <p>23 doctors and nurses because of foreign accents.</p> <p>24 Notes were made but were inaccurate or were not</p> <p>25 properly filled in or lost.</p> <p style="text-align: right;">Page 102</p>	<p>1 a relative and on being given conducted tours of the</p> <p>2 hospital to demonstrate that issues had been resolved,</p> <p>3 the tours were in fact themselves staged.</p> <p>4 A lack of openness and accountability at board</p> <p>5 level.</p> <p>6 An inability to communicate effectively with the HCC</p> <p>7 until all local avenues of complaint had been exhausted.</p> <p>8 Over-technicality when dealing with complaint such</p> <p>9 that the HCC would not deal with secondary complaints</p> <p>10 unless they had been mentioned in the first complaint.</p> <p>11 The local GP consortia seemed to some patients to be</p> <p>12 too close to the chief executive of the hospital and</p> <p>13 very supportive despite the serious complaints that</p> <p>14 there were about the running of the hospital.</p> <p>15 Patient relatives found the PPIF were actually</p> <p>16 hostile and wholly supportive of the hospital.</p> <p>17 The chief executive of the PCT did not respond</p> <p>18 effectively to complaints about the hospital.</p> <p>19 When complaints were made to the HCC the process was</p> <p>20 very drawn out and they appeared themselves to have</p> <p>21 difficulty getting information from the hospital.</p> <p>22 One complaint to the HCC in April of 2007 in</p> <p>23 relation to a death at Stafford Hospital in</p> <p>24 December 2006 eventually resulted in the production of</p> <p>25 an action plan but it related to Cannock Hospital. The</p> <p style="text-align: right;">Page 104</p>

<p>1 HCC report upholding the complaint did not come out 2 until March of 2008, 11 months after the complaint had 3 been made.</p> <p>4 Some letters of complaint written to the hospital 5 simply went unanswered. Other responses which came from 6 the PCT seemed to be in a standard form, which did not 7 address specific issues which was in itself annoying and 8 upsetting.</p> <p>9 A number of patients and relatives sought out Cure 10 the NHS and obtained considerable comfort from being 11 part of that group.</p> <p>12 It is worth pausing in this somewhat technical 13 narrative to consider for a moment one or two of the 14 actual experiences of patients and their relatives who, 15 first of all, suffered poor care and then suffered again 16 when they tried to make their way through to what to 17 some appeared to be labyrinthine system which more often 18 than not failed to work.</p> <p>19 The story of the following patient relatives are 20 typical examples of many that we have read. The witness 21 is June Chell, the patient was Ronald Chell, her 22 husband.</p> <p>23 Mr Chell was taken ill on 26 July 2007, having 24 covered a stroke. He was admitted to the hospital via A 25 and E and subsequently moved to the emergency assessment</p> <p style="text-align: right;">Page 105</p>	<p>1 Although she now knows that there were a number of 2 patient forums and patient liaison organisations, she 3 did not know nothing about them at the time and saw and 4 heard nothing of their existence. She regards the 5 governors and the trust board as being of equal use of 6 the patient forums:</p> <p>7 "They did not seem to want to be bothered or to be 8 part of it. For example, after the action plan was sent 9 to us following our complaint, we never heard anything 10 again. That is why it was so useless. We have no means 11 of knowing if anything was done."</p> <p>12 Well, Mrs Chell is a member of Cure. She has 13 attended meetings and protests with them and she 14 believes that the hospital should be closed. She sees 15 the presence of the staff who were working there 16 previously as a barrier to change.</p> <p>17 The next witness I am going to refer to as 18 Christine Dalziel. The patient was Thomas Dalziel. 19 Mr Dalziel was diagnosed with bowel cancer in June 2007. 20 He was informed of this in an offhand and distressing 21 manner by a consultant who appeared not to have read the 22 notes prior to the consultation. He was admitted to 23 hospital on 17 July 2007 for an operation on the 18th. 24 After his operation he complained of pain but 25 Mrs Dalziel was told he could not be in pain because he</p> <p style="text-align: right;">Page 107</p>
<p>1 unit and then to ward 10.</p> <p>2 There was a lack of basic equipment on the wards, 3 pillows. Cleaners were attending to patients. Patients 4 were left to wet themselves. Medication was given late. 5 Mrs Chell felt that the nurses resented her being there 6 with her husband. Mr Chell was assaulted by another 7 patient who climb on to his bed and tried to strangle 8 him. The hospital refused to provide any information 9 about the assault, insisting that it made no difference 10 to his death. The family were treated poorly by staff 11 following his death.</p> <p>12 Dr Laker's independent case note review into 13 Mr Chell's case subsequently confirmed that the standard 14 of nursing care on ward 10 was unacceptable.</p> <p>15 The family wrote to the hospital in September 2007. 16 In response they received a copy of an action plan, 17 signed by a sister. The hospital apologised for the 18 poor standard of nursing care, but Mrs Chell felt that 19 she was being fobbed off and the family received no 20 further communication from the hospital.</p> <p>21 About a year later she wrote to the HCC. She did 22 not have a clear understanding of the HCC's role at the 23 time and still does not. She received a letter back 24 from them to say that her letter would be considered as 25 part of their investigation.</p> <p style="text-align: right;">Page 106</p>	<p>1 was on an epidural. In fact, the epidural was wrongly 2 sited and he was left in considerable pain, despite both 3 he and his wife telling the nurses. He, therefore, did 4 not receive any pain relief for three days post surgery.</p> <p>5 He was left for many days wearing the same 6 blood-stained pyjamas from after he had had his 7 operation. He was not washed. He lost a lot of weight. 8 The nurses didn't treat him with compassion. Many did 9 not know how to use the equipment on the ward and basic 10 equipment such as walking frames and pillows were not 11 there. He developed bedsores and his limbs became very 12 swollen. Mrs Dalziel was not informed that in fact the 13 critical care team had to attend to her husband on eight 14 occasions prior to his death.</p> <p>15 The hospital attempted to discharge him while he 16 was still faecal vomiting and was incontinent. He pain 17 relief was inadequate. On one occasion Mrs Dalziel 18 found her husband rolling around in pain; he had been 19 waiting for a nurse for some 20 minutes.</p> <p>20 After his death on 1 August 2007, the staff did not 21 prepare Mr Dalziel's body before allowing the family to 22 see him. The sight of him was horrific with a tube in 23 his mouth, tape on his throat and his eyes wide open. 24 No one at the hospital was able to tell Mrs Dalziel when 25 her husband had died.</p> <p style="text-align: right;">Page 108</p>

Pages 105 to 108

<p>1 The family wrote to the hospital and it took several 2 months for them to receive a response. They were not 3 satisfied and, therefore, continued to correspond with 4 the hospital.</p> <p>5 The family noted that the responses appeared to have 6 been cut and pasted. Mrs Dalziel met with the nurse 7 from the PCT to whom she told her story. The nurse was 8 unable to obtain an answer to all of the questions 9 asked. The family have pursued a successful claim for 10 damages against the hospital.</p> <p>11 At the inquest hearing Mr Dalziel's consultant 12 apologised saying there was a culture at the hospital 13 where "no one tells anyone anything".</p> <p>14 She says this: 15 "I appreciate that Martin Yeates is a scapegoat but 16 he is answerable. He cut down the number of nurses in 17 order to get foundation trust status. That is where the 18 danger came in."</p> <p>19 She feels let down by other organisations, including 20 the HCC the PCT and Monitor. In her view, PALS appears 21 to keep everything in-house. During her time at the 22 hospital she had not even heard that PALS existed there.</p> <p>23 Her comment is: 24 "If you ask me, PALS should go. They are a waist of 25 time."</p> <p style="text-align: right;">Page 109</p>	<p>1 advised to contact PALS. Eventually Mr Kidney contacted 2 the PCT on Mrs A's behalf and requested a case note 3 review. Mrs A did not find PALS to be helpful and felt 4 she was having, as she puts it, to fight the system.</p> <p>5 The next witness, Jeffrey Guest, his wife 6 Irene Guest. Mrs Guest suffered from Alzheimer's 7 dementia. She was taken to hospital on 2 January 2008 8 with suspected urine infection and was suffering with 9 dehydration. The hospital discharged her at 3.30 in the 10 morning -- it was January -- the next morning, wearing 11 only a nightie, and it was only through the assistance 12 of her son, who was a paramedic, that they managed to 13 get her home. When they got her home they found that 14 a cannula had been left in her.</p> <p>15 She was readmitted on 7 January 2008, again 16 suffering the effects of dehydration. Following her 17 admission she was moved to ward 7, which is described as 18 being disastrous. She was often left in a urine-soaked 19 bed. Mr Guest was concerned that she was not being fed.</p> <p>20 She was transferred from Stafford to Cannock 21 Hospital on 5 February without Mr Guest being informed. 22 When he arrived at Stafford to visit his wife, there was 23 someone else in her bed. By the time he found out where 24 she had gone, he had missed visiting hours at Cannock 25 and was only able to see her very briefly.</p> <p style="text-align: right;">Page 111</p>
<p>1 Mrs Dalziel is a founder member Cure has attended 2 meetings and protests. She also advocates closing the 3 hospital down and restarting it.</p> <p>4 The next witness, wishes to remain anonymous. I am 5 going to refer to her as Mrs A and her husband as 6 patient A.</p> <p>7 Mr A was admitted to the hospital on 8 21 December 2008 by A and E with symptoms, including 9 shortness of breath, a cough and swellings to his legs. 10 He was discharged on 6 February 2009 but died six days 11 later at home on 12 February.</p> <p>12 In essence, Mrs A's concerns were about the lack of 13 basic care afforded to her husband, his hygiene needs 14 were not attended to and basic equipment was missing 15 from the wards. She did not raise a complaint formally 16 immediately following her husband's death. She did not 17 believe that it would be straightforward; describes lack 18 of information about how to make a complaint.</p> <p>19 Sometime later Mrs A received a letter from 20 Mr David Kidney MP. He sent a letter to all his 21 constituents inviting them to tell him about concerns at 22 the hospital. At this point Mrs A decided to draw 23 attention to her experiences. She wrote to David Kidney 24 enclosing details of her concerns. There was delay in 25 receiving a response, and in the meantime she was</p> <p style="text-align: right;">Page 110</p>	<p>1 Mr Guest says he complained to the staff at Stafford 2 hospital when his wife there on a daily basis, but his 3 complaints were never recorded. He did not know how to 4 make a formal complaint.</p> <p>5 Mr Guest wrote three letters to the hospital. The 6 first two received no response. The third was responded 7 to by the PCT, who apologised on behalf of the hospital 8 but it seemed to him that the letter was a standard one. 9 He did not feel it amounted to an apology.</p> <p>10 Mr Guest met with Sharon Llewellyn and Liz Onions 11 from the PCT, who explained how things had improved and 12 offered him the opportunity to come and visit. A visit 13 was arranged, which was supposed to be unannounced but 14 upon arrival on the ward Mr Guest was suspicious that it 15 was being staged and he felt deceived.</p> <p>16 He also describes himself as a core member of Cure 17 and is very proud of their work. He has participated in 18 a number of protests. He disagrees that Cure's 19 objective is to close the hospital. He describes the 20 LINK as: 21 "... being hostile to Cure and appeared to want to 22 support the hospital rather than wanting to listen to us 23 or do something about the issues that we had raised", as 24 he puts it.</p> <p>25 The next witness, Deborah Hazeldine, whose mother</p> <p style="text-align: right;">Page 112</p>

<p>1 was Ellen Linstead. Mrs Linstead was admitted to the 2 hospital on 27 July 2006 following a fall at home. She 3 was suffering from bone cancer. She remained there 4 until she died on 13 December 2006. She lost a lot of 5 weight whilst in hospital. The standard of care she 6 received was very poor and she suffered a number of 7 infections, in particular cleanliness was an issue. 8 There was confusion as to whether she had C.difficile 9 when she died. She was therefore buried in a sealed 10 body bag, which caused her family great distress. 11 Following her death the family complained to the 12 chief executive. At that time Mrs Hazeldine also 13 contacted the HCC but was told she had to go through the 14 hospital complaints process first. The family met with 15 Martin Yeates, Dr Suarez and Sharon Llewellyn on 20 16 December 2006. The family's impression was that 17 Mr Yeates had not read the notes and knew little about 18 the case. She describes the meeting as being very 19 tense. 20 Following the meeting, she contacted the HCC again 21 on 28 April 2007 and got their details from the CAB, as 22 it was not clear from the HCC's website what their 23 functions were or how she should go about contacting 24 them. The Healthcare Commission upheld the family's 25 complaint.</p> <p style="text-align: right;">Page 113</p>	<p>1 "If the hospital had a half decent complaints 2 system, none of this would have happened. That is the 3 one thing I would change and I would do it now but 4 I could not find anyone to take ownership of the 5 complaint. You would think once Monitor or the 6 Strategic Health Authority or the PCT and Westminster 7 are aware of it it would be better but it was not. Who 8 else can you go to?" 9 The next witness again wishes to remain anonymous. 10 I will refer to her as relative B, and patient B her 11 husband. 12 Mr B was admitted to the hospital on 4 July 2008 and 13 died the same day. His wife's complaint relates to the 14 callous treatment he received on the day of his death. 15 There were not enough nurses and water was placed out of 16 her husband's reach. His body was simply left as it was 17 after his death, which caused distress to the family. 18 They were treated in an unsympathetic and uncaring 19 manner by staff. 20 Mrs B received several letters from the trust where 21 he died addressed to her husband. Mrs B did not raise 22 her concerns with the hospital until after the inquest 23 into her husband's death had taken place in 24 February 2009. 25 The inquest was concerned with whether asbestos had</p> <p style="text-align: right;">Page 115</p>
<p>1 The trust sent a letter to the family in May 2007 2 that purported to enclose a report. The family did not 3 in fact receive the report until it was requested by the 4 HCC. 5 At the previous inquiry the family were shown a copy 6 of a letter sent to them by the trust, which included 7 a section about how to complain to the HCC but the 8 family had not previously seen that section, which was 9 not included in the copy of the letter that was sent to 10 them. Eventually the trust sent them an action plan. 11 It was for the wrong hospital. It was for Cannock and 12 not for Stafford. 13 Mrs Hazeldine spoke to the PCT at a meeting in early 14 2008 but did not get a response from them. She met with 15 Bill Cash MP who took the cause forward for her. She 16 was frustrated at the amount of time this took. 17 She says this: 18 "You have to be bloody minded and focused in order 19 to pursue a complaint through the HCC." 20 She thinks it needs to be easier to complain. 21 She is a founding member of Cure. She has 22 participated in protests and attended meetings with the 23 group. She is of the view that the HCC investigation 24 lacked teeth. She describes it as being fluffy. 25 She says in her statement:</p> <p style="text-align: right;">Page 114</p>	<p>1 played a role in his death and Mrs B did not raise her 2 concerns about the standards of care at the hospital. 3 She would have welcomed the opportunity to make 4 a private statement at the inquest but was uncomfortable 5 with the public nature of the proceedings. She 6 contacted David Kidney with her concerns in March of 7 2009. She met with him in April. 8 Mr Kidney endeavoured to progress matters with the 9 hospital on her behalf and a meeting was arranged which 10 took place in May of 2009, involving Eric Morton and 11 Helen Moss. Helen Moss expressed sympathy and 12 acknowledged that there were problems. She did not 13 apologise, which is what Mrs B wanted. Mrs B felt that 14 the only way she could get anywhere with the hospital 15 was by enlisting the help of David Kidney MP. 16 In July 2009 she referred her complaint to the PCT, 17 as she did not feel she was getting anywhere with the 18 trust. Following discussion with the PCT, it was 19 decided that Mrs B would go down the independent case 20 note route before pursuing her complaint with the PCT, 21 as she did not want to do both at the same time. 22 Following the independent review, she did not pursue 23 her complaint with PCT as matters were superseded by the 24 first inquiry. She was disappointed in the way that the 25 first inquiry was handled and the apparent pressure to</p> <p style="text-align: right;">Page 116</p>

<p>1 get everything done so quickly. She has found the 2 number of different people and organisations involved in 3 the process of complaining to be confusing and 4 frustrating, and she is in favour of a system of 5 independent monitoring, akin to the system in the Prison 6 Service.</p> <p>7 The next witness is Janet Robinson who's son was 8 John Moore-Robinson. John Moore-Robinson was 20 years 9 old when he was taken to A and E at Mid Staffs on 10 1 April 2006, following an accident on his mountain bike 11 on Cannock Chase. He was an extremely fit young man. 12 The Ambulance Service triaged his case as being 13 potentially life-threatening but moved him across rough 14 terrain on his mountain bike. He was in great pain. He 15 was given morphine by the Ambulance Service.</p> <p>16 Once admitted to hospital he was left alone and left 17 untreated for an hour. There was no consultant on duty 18 that Saturday. Mr Moore-Robinson was seen by a one-year 19 qualified junior doctor who ordered an extra of John's 20 chest but failed properly to examine his abdomen. He 21 was told he had bruised ribs and was discharged from the 22 hospital whilst still vomiting and still in great pain. 23 He could not walk. He was given a wheelchair. His 24 friends had to request painkillers for him. His friends 25 drove him home.</p> <p style="text-align: right;">Page 117</p>	<p>1 treatment of John had been negligent. Attempts were 2 made by the trust solicitor to have that report amended.</p> <p>3 The trust made no contact with the family to offer 4 any explanation of what had gone wrong. The family did 5 not want compensation. They wanted an explanation. 6 They wanted to know why their son had died needlessly.</p> <p>7 A firm of solicitors corresponded with the trust on 8 the family's behalf. They were advised by their 9 solicitor that if they wanted to pursue claim for 10 damages against the trust, then they should not utilise 11 the trust's own complaint procedure.</p> <p>12 The family accepted an offer of GBP 13,000 in 13 compensation from the trust on the understanding the 14 trust admitted liability for negligence. But it 15 subsequently became clear that the trust was not 16 admitting liability. The family would never have 17 accepted the compensation if they had known that the 18 trust was not admitting liability.</p> <p>19 A letter of apology signed by Martin Yeates dated 20 28 January 2008, nine months after their son had died, 21 was, as they later found out, written by a solicitor 22 acting for the trust.</p> <p>23 The Robinson family do not live in the Stafford area 24 and so were unaware of the wider problems at the 25 hospital until the time of the inquest and the</p> <p style="text-align: right;">Page 119</p>
<p>1 Later that evening he called an ambulance himself. 2 He was taken to Leicester Infirmary. He died the 3 following day having suffered a ruptured spleen.</p> <p>4 Following the tragic and unnecessary loss of their 5 son, the family were then let down at almost every stage 6 of the process thereafter. The family were unhappy with 7 the way in which the inquest in April of 2007 into 8 John's death was conducted, in particular the decision 9 not to call either the supervising doctor in A and E or 10 the friend who was with John when he died. The trust 11 solicitor is accused of demonstrating a complete lack of 12 respect to the family. They regarded the inquest itself 13 as a sham. When they wrote to the coroner to complain, 14 their correspondence was, they felt, ignored.</p> <p>15 At the first inquiry the family discovered a report 16 prepared by an A and E consultant, Mr Phair, which had 17 not previously been made available to them. The report 18 was damning of the treatment provided at the hospital 19 and Mr Phair was asked to alter its conclusion by the 20 trust solicitor. It appears that the report was not 21 sent to the coroner by the trust solicitor. It has been 22 suggested that it was deliberately concealed. A police 23 investigation is, we understand, ongoing.</p> <p>24 A second report, written by the same consultant, 25 suggested there was a high probability that the trust</p> <p style="text-align: right;">Page 118</p>	<p>1 publication of the HCC report. The family have had some 2 contact with Cure and have also enlisted the help of 3 their MP in order to obtain further information about 4 what happened.</p> <p>5 The family went through the independent case review 6 process and reported the report in March of 2010.</p> <p>7 The family have had no contact from any of the 8 regulatory bodies. From contacting the GMC themselves 9 they have established that the doctors involved are 10 under investigation.</p> <p>11 The family are currently pursuing a complaint 12 against the HSE, as they consider their refusal to get 13 involved in the events of Mid Staffordshire was 14 unacceptable. The family felt very let down by the 15 whole process. They regret not having gone public about 16 the case a lot sooner and they say this:</p> <p>17 "It is our belief that the bodies responsible for 18 regulating the trust failed in their duty with such 19 tragic consequences for many people and families. 20 Patient safety at the trust was such a low priority. In 21 the period following John's death, none of the following 22 regulatory bodies have contacted us: PALS, Strategic 23 Health Authorities, Patients Association, Health and 24 Safety Executive, GMC or any other body."</p> <p>25 The next witness I am going to refer to is</p> <p style="text-align: right;">Page 120</p>

<p>1 Dr Mark Whitehouse, whose grandmother was Joan Morris. 2 She died at Stafford Hospital and he has since that time 3 qualified as a doctor. 4 He was completing his training at the time of the 5 first inquiry, and decide not then to become involved 6 but he has now qualified and he says he is conscious of 7 the vulnerability of his position in deciding to speak 8 out. He has been told by colleagues to be careful of 9 what he says. If that is accurate, then it reflects, 10 you may think, appalling badly on the culture within the 11 NHS and it runs directly contrary to the legislation 12 protecting whistle-blowers and contrary to the GMC's own 13 guidance for good medical practice. 14 THE CHAIRMAN: Can I just interrupt there, Mr Kark, and say 15 this seems to be a convenient point to say that if I get 16 to hear that any attempt is made to deter any witness 17 from coming before this inquiry by threats or implicit 18 threats, then I will ensure that relevant action against 19 them is taken. 20 MR KARK: I am grateful. 21 Dr Whitehouse believes that there were not enough 22 staff on the wards at the time his grandmother was at 23 the hospital, either nurses or healthcare assistants. 24 He says this: 25 "The current setup at the NHS is like a Swiss cheese</p> <p style="text-align: right;">Page 121</p>	<p>1 interests of brevity, I will summarise these complaints 2 but many of them are of central importance to this 3 inquiry and will underline much of the questioning of 4 the witnesses to come. 5 Concerns have been raised as far back as 2001 by 6 a consultant within the trust about junior doctors and 7 nurse numbers. Those concerns were never acted upon and 8 nurse numbers subsequently went down. Even before then, 9 in 1999, the general secretary of the Royal College of 10 Nursing warned the government about cutting nurses staff 11 and to be cautious about diluting the skill mix too 12 much. This was one of the fundamental problems which 13 affected the quality of nursing at Stafford just a few 14 years later. 15 The complaint system, as it was applied at Stafford, 16 is variously described as manipulation and humiliation, 17 the object being to wear down patient complainants and 18 relatives in the hope they will go away. The complaints 19 process is designed to fob off the complainants with 20 a whole range of meaningless meetings and processes, 21 action plans. The process is extraordinarily lengthy 22 and is designed to obfuscate and protect the NHS, the 23 hospital and its staff rather than genuinely making 24 redress to victims and relatives. It is said to be 25 extremely difficult for patients and relatives to</p> <p style="text-align: right;">Page 123</p>
<p>1 model. There are any number of organisations that are 2 monitoring responsibility. However, there is no clear 3 communication between them. There are too many people 4 monitoring too many aspects." 5 He also expresses concern about the fact the 6 hospital is usually tipped off about so-called 7 unannounced visits. They are not, he says, a realistic 8 way of assessing the care or culture within a hospital. 9 We will, in due course, hear more about the lack of care 10 in relation to the treatment of his grandmother, Joan, 11 from his mother who is also a witness. 12 Let me turn to Cure the NHS, who have made a number 13 of useful submissions, in particular through the 14 statements of Mrs Julie Bailey and Mr Ken Lowndes. 15 Julie Bailey will be our first patient relative witness 16 and we will be taking her through a number of documents 17 that she has gleaned over the years of complaint and 18 investigation. It is largely as a result of their 19 insistence that both the first inquiry and this public 20 inquiry is taking place. 21 In their document entitled "This is our truth, now 22 tell us yours" Cure set out a series of complaints 23 against individuals and organisations who are either 24 represented here as core participants or who will be 25 giving evidence before the inquiry. Again in the</p> <p style="text-align: right;">Page 122</p>	<p>1 believe that the Patient Advice and Liaison Service, 2 PALS, based at the hospital are really on their side 3 when they are employed by the hospital. At 4 Stafford Hospital that organisation is said to have been 5 in effective. It is only fair to point out that PALS is 6 now under new management at the hospital and appears to 7 have a far more visible and we believe and hope 8 effective presence, but we will hear evidence from them. 9 Even an MP, David Kidney, who spent some time 10 working at the hospital is said to have missed the true 11 state of care on some wards. 12 Another MP Tony Wright who received a number of 13 complaints from constituents and passed them on to the 14 trust was fobbed off with supposedly reassuring action 15 plans. 16 Peter Carter, the chief executive of the Royal 17 College of Nursing, who sent a day at the hospital wrote 18 a letter in May of 2008 to the local press praising the 19 nursing at the hospital as "of an exceptionally high 20 standard." 21 The board was wholly in effective, say Cure, and 22 filled with nodding nonexecutive directors who kept 23 changing. Various government ministers have either 24 ignored the complaints about Stafford or tried to assure 25 the public that the failure was purely one of the</p> <p style="text-align: right;">Page 124</p>

<p>1 management of the hospital and that it was in effect 2 a one-off event confined to Stafford.</p> <p>3 Members of Cure entirely reject that as an 4 unrealistic head in the sand approach. They are 5 convinced there are many other trusts in the NHS with 6 similar problems.</p> <p>7 The PPIF chairman is accused of colluding with the 8 hospital to suppress the complaints properly raised by 9 members of the forum. The activities of the forum in 10 relation to the hospital are described as being 11 "useless".</p> <p>12 The oversight and scrutiny committee of the local 13 council accepted what they were told by the hospital 14 management and failed to make further inquiry.</p> <p>15 Cure ask whether the coroner built up any 16 statistical picture of deaths at the hospital and asked 17 "If he didn't, why didn't he?" They criticise the 18 government for making the claim that foundation trust 19 status would increase local accountability, whereas in 20 the Stafford case, they describe such a claim as being 21 totally false.</p> <p>22 Contact with the Primary Care Trust produced the 23 response that the complainer should talk to the 24 management of the trust. Cure ask the question: why did 25 the PCT not question the standard of healthcare when</p> <p style="text-align: right;">Page 125</p>	<p>1 board of Monitor held a board-to-board challenge and 2 raised 46 questions. Cure are critical of the fact that 3 only nine of those questions touched upon clinical 4 matters. Monitor is further criticised for failing to 5 take action as soon as it received the HCC's damning 6 draft report at the end of 2008.</p> <p>7 In relation to the patient forums and local 8 oversight and scrutiny committees, Cure take the view 9 that any hope of challenge to what was going on from 10 either the PPIF or the OSC or LINK was misplaced. Cure 11 implicitly and explicitly reject any notion that the 12 failings at Stafford Hospital were attributable simply 13 to the failings of local management.</p> <p>14 They do not accept that Stafford was an isolated 15 case. They do not accept any suggestion that similar 16 problems are not happening or are not capable of 17 happening elsewhere in the NHS.</p> <p>18 Cure have this to say, and it is a clear and 19 important reminder of the importance of the work of this 20 inquiry:</p> <p>21 "Stafford Hospital is probably at the very end of 22 the tail of the poor performers but the big question is: 23 how many more poor performance have been missed? The 24 difficulty and the challenge for the Department of 25 Health and the NHS is that they have no mechanism for</p> <p style="text-align: right;">Page 127</p>
<p>1 they were concluding their service level agreements with 2 the hospital's management each year?</p> <p>3 They ask of the SHA: why when a major deficit at 4 Stafford was found in 2005 was there not some 5 intervention, if only by way of guidance and support? 6 Why, we will ask, did no one seemingly recognise the 7 impact upon service and healthcare that the consequent 8 cuts would inevitably effect? Why was the Royal College 9 of Nursing not more active?</p> <p>10 Particular criticism is reserved for 11 Sir David Nicholson in his role of chief executive of 12 Shropshire and Staffordshire NHS SHA, or SASSHA, in 2005 13 and 2006, when he presided over what Cure describe as 14 "chaos" in the West Midlands as the PCT and SHAs were 15 restructured resulting in those organisations 16 completely, as they put it, "taking their eye off the 17 ball".</p> <p>18 In December 2005 the board of SASSHA and the board 19 of the Stafford NHS trust conducted a board-to-board 20 challenge, apparently to help the trust prepare its 21 application for foundation trust status.</p> <p>22 David Nicholson wrote a letter to Martin Yeates with 23 a list of points which the hospital needed to address.</p> <p>24 In December 2007, just before the trust was granted 25 foundation trust status, the board of the trust and the</p> <p style="text-align: right;">Page 126</p>	<p>1 finding out; they have not developed and implemented 2 modern safety and quality systems to guarantee high 3 quality care for all, for every minute of every day of 4 every patient's stay; systems designed and implemented 5 by front line hospital carers with the help of patients. 6 We are all patients and potential patients."</p> <p>7 Let me turn, please, to the organisations which are 8 there to support patients, both charitable and 9 non-charitable.</p> <p>10 Beyond the patients there is, of course, a system 11 intended to assist in their complaints and to provide 12 support or advocacy services to patients and their 13 relatives.</p> <p>14 There are a large number of both statutory and 15 non-statutory bodies which exist, any number of which 16 are intended to have a role to play both to protect 17 patients from things going wrong and to provide an 18 advocacy service when they have already done so. They 19 did not prevent what happened at Stafford and there is 20 a complaint that they were either compliant with the 21 trust, complacent, naive or toothless. A brief 22 examination of the recent history of these bodies is 23 worthwhile.</p> <p>24 Patient and public involvement is an umbrella term 25 used to describe a wide range of activities and</p> <p style="text-align: right;">Page 128</p>

<p>1 interactions between the public, patients and the NHS. 2 It has a variety of purposes, including improving the 3 quality of services and securing the accountability for 4 the NHS decision-making. Patient and public involvement 5 are distinct and are achieved in different ways. 6 Current or recent NHS patients are likely to bring 7 different perspectives to bear to those held by the 8 general public. Independent patient and public 9 involvement structures are therefore intended to attend 10 to the differing needs to NHS patients and to the wider 11 public. 12 Community health councils. The first formal 13 structures to represent the public interest in the NHS 14 were Community Health Councils or CHCs. They were 15 created in 1974 and were in place for almost 30 years 16 before being abolished in 2003. CHCs had a duty to 17 represent the interests of the public, to monitor local 18 health services and to advise and be consulted by local 19 authorities on health-related matters. They also had 20 a duty to handle patient complaints and advocacy issues 21 within the NHS trusts. CHCs had the power to veto 22 proposals involving service redesign, to inspect and 23 monitor services, and to refer matters directly to the 24 Secretary of State. CHCs were criticised for lacking 25 independent and for failing to attract younger members</p> <p style="text-align: right;">Page 129</p>	<p>1 members, such that forums often consisted of a very 2 small number of people. Following a public consultation 3 entitled a Stronger Local Voice, it was decided that 4 PPIFs would be abolished, less than three years after 5 coming into existence. 6 The rationale behind the abolition of PPIFs appears 7 to have much in common with the rationale behind the 8 abolition of the CHCs. The performance of PPIFs was 9 considered to be variable and there was a perception 10 that they were not representative of the community, as 11 they had failed to attract young people and ethnic 12 minorities. There was also a concern that PPIFs were 13 overly bureaucratic and failed to provide good value for 14 money. The abolition of PPIFs may also have been driven 15 by a desire to strengthen the role of patient and public 16 involvement in commissioning, in response to the 17 increasing emphasis on primary care within the NHS. 18 The evidence we have obtained from those who are 19 within the local PPIF tends to support the criticisms. 20 Mr Robin Bastin has provided a statement dealing with 21 his involvement, which began in March 2006. His 22 criticisms of the PPIF structure are relevant to our 23 purpose now, in providing information to avoid the same 24 mistakes that he suggests were made previously. His 25 criticisms were:</p> <p style="text-align: right;">Page 131</p>
<p>1 and people from ethnic minority backgrounds. 2 In 2001 legislation was passed to abolish them and 3 divide their functions between a number of 4 organisations. In particular section 1 of the Health 5 and Social Care Act 2001 placed a duty on Primary Care 6 Trusts, NHS trusts and Strategic Health Authorities to 7 make arrangements to involve and consult patients and 8 the public. 9 Patient and public involvement forums were set up in 10 response to the section 11 duty and were intended to 11 replace the representative and inspection elements of 12 CHCs' work. PPIFs came into existence on 13 1 December 2003. One PPIF was aligned to each NHS trust 14 and PCT in England. PPIFs were made up entirely of 15 unpaid volunteers. 16 They had a number of statutory powers, including: 17 the right to access some healthcare premises; the right 18 to request written information from trusts and PCTs; the 19 right to refer matters to the local OSC; and typically 20 the work of PPIFs involved patient surveys, service 21 review reports, membership of the PCT and the hospital 22 trust boards and committees, and visiting premises. 23 The transition from CHCs to PPIFs was not a smooth 24 one, and reportedly result in the loss of expertise and 25 experience. There was a difficulty in recruiting</p> <p style="text-align: right;">Page 130</p>	<p>1 (1) the membership of the forum was too small. 2 (2) meetings were not advertised, so that the public 3 did not appear to know of its existence. 4 (3) the chairman at the time was overly defensive of 5 the trust, having been successfully treated there. 6 (4) criticisms of the hospital in meetings were 7 either toned down or quashed. 8 (5) reports from the trust were not shared openly 9 with members of the forum. 10 (6) when complaints from patients were passed on to 11 the hospital, such as patients not being helped with 12 their meals, there was no follow-up to see if things had 13 improved. 14 (7) when Mr Bastin made complaints to the county 15 council Oversight and Scrutiny Committee, he was told 16 these were matters to be dealt with by the PPIF, which 17 did not then deal with them. 18 (8) the PPIF was reliant upon the information 19 provided to it by the trust, rather than inspecting for 20 themselves or seeking out harder more granular 21 information than they were getting. 22 PPIFs were replaced by local involvement networks, 23 or LINKs, which it was envisaged would give people 24 a stronger voice in how their local health and social 25 care services are planned and delivered and provide</p> <p style="text-align: right;">Page 132</p>

<p>1 better value for money.</p> <p>2 LINKs were established under the Local Government</p> <p>3 and Public Involvement in Health Act 2007. And pursuant</p> <p>4 to section 221 of that Act, LINKs are responsible for:</p> <p>5 obtaining the views of people about their needs for and</p> <p>6 their experience of local services; promoting and</p> <p>7 supporting the involvement of people in the</p> <p>8 commissioning provision and scrutiny of local care</p> <p>9 services; enabling people to monitor the standard of</p> <p>10 provision of local services; consulting people as to</p> <p>11 whether and how local services could be and ought to be</p> <p>12 improved; and reviewing the provision of local care</p> <p>13 services.</p> <p>14 Well, LINKs are made up of individuals and community</p> <p>15 groups, such as faith groups and residents associations,</p> <p>16 said to be working together to improve health and social</p> <p>17 care services. 152 Local Involvement Networks were set</p> <p>18 up across England. They were designed to consult people</p> <p>19 about the local healthcare services, and to give them</p> <p>20 the opportunity to make suggestions to help to improve</p> <p>21 services, investigate specific issues of concern, hold</p> <p>22 services to account, ask for information, carry out spot</p> <p>23 checks to see if services are working well, make reports</p> <p>24 and recommendations, and receive a response and refer</p> <p>25 issues to the local OSC.</p> <p style="text-align: right;">Page 133</p>	<p>1 meetings were held with Helen Moss, the director of</p> <p>2 nursing. Although good intent to work with LINK to</p> <p>3 improve patient care was mentioned, there was no</p> <p>4 evidence of actual activity. It appears that LINK did</p> <p>5 not or could not identify its specific role within the</p> <p>6 trust. Once the HCC had been published, the trust was</p> <p>7 under intense scrutiny from so many other bodies that</p> <p>8 they could not find time to work with LINK.</p> <p>9 (5) there were significant internal problems within</p> <p>10 the members of LINK and also between LINK and the host</p> <p>11 Staffordshire University, so much so that in May 2009</p> <p>12 the Department of Health had to commission an</p> <p>13 independent report, which was not published until</p> <p>14 September 2009, during which four months LINK was in</p> <p>15 limbo.</p> <p>16 In short, it appears that LINK between 2008 and 2009</p> <p>17 was a pretty ineffective force, and failed to perform</p> <p>18 the sort of scrutiny and public representation function</p> <p>19 that was envisaged for it. Mr Bastin was elected</p> <p>20 a member of the Stafford district committee of LINK when</p> <p>21 it got going in September of 2008, having been intended</p> <p>22 to start operating in April of that year. Again, he is</p> <p>23 critical of that organisation as being undemocratic and</p> <p>24 inadequately monitored by the county council. He also</p> <p>25 speaks of the internecine politics and the difficulties</p> <p style="text-align: right;">Page 135</p>
<p>1 The Local Involvement Networks Regulations 2008</p> <p>2 describe the duties to service providers to respond to</p> <p>3 recommendations made by a LINK and the powers of LINK to</p> <p>4 enter and review premises. The Staffordshire LINK was</p> <p>5 set up under the auspices of Staffordshire University,</p> <p>6 which had no previous experience of running such a body.</p> <p>7 Linda Seru is the LINK director and sets out the</p> <p>8 problems which beset its organisation. The</p> <p>9 Staffordshire LINK was launched in December 2008,</p> <p>10 although a subgroup had already started work, and they</p> <p>11 held a meeting with Cure on 21 October 2008, and Cure</p> <p>12 had raised a number of urgent issues, in particular the</p> <p>13 care of vulnerable patients of all ages.</p> <p>14 In summary, the problems which inhibited effective</p> <p>15 action by LINK, as Linda Seru sees it, were:</p> <p>16 "(1) the HCC investigation was already underway in</p> <p>17 Staffordshire and the HCC did not feel therefore that</p> <p>18 LINK could contribute to it.</p> <p>19 (2) LINK asked the HCC to make a presentation to</p> <p>20 them as how patients' views and experiences could be</p> <p>21 better used to help LINK inform commissioning planning</p> <p>22 and delivery of services by the PCT. However, the HCC</p> <p>23 did not feel they could assist with this.</p> <p>24 (3) there were problems establishing formal contact</p> <p>25 with the hospital, and when contact was made the</p> <p style="text-align: right;">Page 134</p>	<p>1 with the host university.</p> <p>2 Let me turn to POHWER and ICAS, the Independent</p> <p>3 Complaints Advisory Service. The complaints and redress</p> <p>4 function of the CHCs were divided between the Patient</p> <p>5 Advice and Liaison Service, PALS, and the Independent</p> <p>6 Complaints Advisory Service.</p> <p>7 Section 12 of the Health and Social Care Act 2001</p> <p>8 imposed upon the Secretary of State a duty to arrange</p> <p>9 for the provision of independent advocacy services to</p> <p>10 assist individuals in making complaints about NHS</p> <p>11 services. The funding and management of ICAS services</p> <p>12 is undertaken by the Department of Health, who have</p> <p>13 awarded ICAS contracts to several providers, including</p> <p>14 the Citizens Advice Bureau, the Carers Federation, the</p> <p>15 South of England Advocacy Project and POHWER, which in</p> <p>16 fact stands for "People of Hertfordshire Want Equal</p> <p>17 Rights". Well, POHWER is a register charity, whose aim</p> <p>18 is to address injustice and social exclusion. It has</p> <p>19 contracts with more than 20 local authorities to provide</p> <p>20 ICAS services.</p> <p>21 The aim of ICAS is to steer people through the</p> <p>22 formal NHS complaints procedure. It is not able to deal</p> <p>23 with other bodies, for example, coroners or the GMC.</p> <p>24 ICAS is free, confidential and independent of the NHS.</p> <p>25 In addition to providing advice, ICAS advocates assist</p> <p style="text-align: right;">Page 136</p>

<p>1 in writing letters, accompanying patients and relatives 2 to meetings, and assist in making decisions about how 3 best to take complaints forward. 4 In common with PALS, ICAS services have come in for 5 criticism for being provided in an inconsistent way 6 across the country. ICAS does not have any formal links 7 to patient forums, which can mean that valuable 8 information gained through a service is not passed to 9 LINKs. 10 ICAS has also attracted criticism for lacking 11 a public profile and lacking capacity. According to 12 Carol Johnson, the executive director of POhWER, who has 13 provided a statement to the inquiry, between April 2006 14 and March 2009 102 people contacted POhWER/ICAS with 15 concerns about Mid Staffordshire trust. Of those, 74 16 received advocacy support. POhWER have sent with their 17 statement a number of case studies that typify the 18 delays and frustrations associated with making 19 complaints to the trust. And POhWER have also submitted 20 with their statement comments from advocates about their 21 experience of complaints handling procedures. 22 Well, following the publication of the Healthcare 23 Commission report in April 2009, POhWER launched an 0845 24 telephone number to support people with concerns about 25 their experience of the trust. In November 2009 POhWER</p> <p style="text-align: right;">Page 137</p>	<p>1 formal manner, while the local formal complaints 2 procedure would be covered by ICAS. 3 PALS was intended to provide patients with an 4 identifiable person to turn to for advice and 5 information, who would also be able to act as an 6 independent facilitator to handle patient and family 7 concerns, with direct access to the chief executive and 8 the power to negotiate immediate solutions. 9 According to the Department of Health supporting the 10 implementation of Patient Advice and Liaison Service, 11 a resource pack published in 2002, the core functions of 12 PALS are: to be identifiable and accessible to patients, 13 their carers, friends and families; provide on-the-spot 14 help in every trust with the power to negotiate 15 immediate solutions or speedy resolutions of problems; 16 act as a gateway to appropriate independent advice and 17 advocacy support from local and national sources; 18 provide accurate information to patients, carers and 19 families about the trust's services and about other 20 health-related issues; to act as a catalyst for change 21 and improvement by providing the trust with information 22 and feedback on problems arising and gaps in services; 23 operate within a local network with other PALS in their 24 area and work across organisational boundaries; and 25 support staff at all levels within the trust to develop</p> <p style="text-align: right;">Page 139</p>
<p>1 delivered a customer care training session entitled 2 "Listening and responding" to 16 members of staff at the 3 trust, and POhWER have provided the inquiry with 4 summaries of the trainers' evaluations of the delegates. 5 In January of this year POhWER provided the trust 6 with a series of proposals for ideas for helping the 7 trust to improve patient experience. POhWER expressed 8 frustration at the fact that there has been no response 9 to these proposals, and the fact that they have never 10 been approached by either the HCC or the CQC to explore 11 the experiences of their advocates of working with the 12 trust. POhWER's analysis of current complaints handling 13 at the trust is that it still seems unable to respond 14 appropriately when told that things have gone wrong. 15 Clients and advocates continue to be frustrated by 16 defensiveness, miscommunication and delays. POhWER 17 remain concerned that the organisations charged with 18 overseeing the quality of services and compliance with 19 standards failed to seek the views of the clients and 20 organisations that are uniquely placed to offer a view 21 on progress. 22 Let me turn to the Patient Advice and Liaison 23 Service, PALS. PALS was introduced across England in 24 2002, and it was established in every NHS trust with the 25 aim of resolving problems reported by patients in an</p> <p style="text-align: right;">Page 138</p>	<p>1 a responsive culture. 2 Well, as PALS is part of the trust it cannot be said 3 to be truly independent and PALS perceived lack of 4 independence has been criticised by some. It has been 5 suggested that PALS has become marginalised as 6 a consequence of not being linked into other structures. 7 And further criticisms we will hear include the 8 under-resourcing of PALS services, confusion between 9 PALS and the formal complaint system, and reluctance by 10 PALS staff to provide patients and families with 11 information about independent sources of advice. 12 Let me turn to non-statutory bodies. AvMA, the 13 Action Against Medical Accidents, is an independent 14 registration charity established in 1982 to promote 15 better patient safety and justice for people affected by 16 medical accidents. They run a helpline and a casework 17 service, an accreditation scheme for clinical negligence 18 solicitors, and working to bring about change to the 19 health and legal system that promote patient safety. 20 AvMA believes itself to be the only organisation 21 offering these services, and that the NHS and the 22 Department of Health has a duty to promote its services. 23 AvMA was not aware of the issues at the trust until 24 the publication of the HCC report in March 2009. 25 Although AvMA did receive contact directly from patients</p> <p style="text-align: right;">Page 140</p>

<p>1 relatives affected by the trust and 45 were subsequently 2 supported by AvMA caseworkers. There are, according to 3 AvMA, lessons to be learned. With that sentiment we can 4 no doubt all agree. 5 They set out their perspective on lessons to be 6 learned as follows: 7 There needs to be greater awareness of the services 8 AvMA can provide, since it is the only independent 9 charity offering such support. Other bodies failed to 10 advise patients' families about AvMA until very late in 11 the day. The Department of Health and the NHS need to 12 engage with AvMA. 13 Regulation of trusts. They say there must be 14 joined-up thinking in who should monitor and regulate 15 NHS trusts. This is a need to define clearly the roles 16 of regulatory and commissioning bodies. The White Paper 17 "Librating the NHS" proposes that Monitor concentrates 18 on financial matters and the CQC is sole national 19 regulator dealing with quality and safety, with an NHS 20 commissioning board replacing PCTs, SHAs and 21 National Patient Safety Agency. 22 This poses both opportunities and threats. NPSA 23 issues vital patient safety alerts, but currently lacks 24 teeth and cannot do anything to monitor or regulate 25 implementation. An NHS commissioning board may have</p> <p style="text-align: right;">Page 141</p>	<p>1 indicators. This tool, say AvMA, may be too blunt. 2 They need to be more proactive. If a trust is out of 3 line on a single indicator, it should prompt questions 4 and closer scrutiny. 5 Fragmentation of family/patient support and advice. 6 Community Health Councils were abolished by the 7 government, as we know, controversially, they say. They 8 had been a one-stop shop for advising about patient 9 rights within the NHS, providing help in making 10 complaints within the NHS, raising issues of concern for 11 CHCs to follow-up within their monitoring role as 12 a national body. From 2004, say AvMA, they replaced 13 with a confused and fragmented range of bodies, PALS, 14 ICAS and LINKs. 15 AvMA say of PALS that because it is part of the 16 trust it not seen as truly independent. It is sometimes 17 poorly resourced and there is confusion between PALS and 18 the complaints system. Often PALS fails to advise 19 patients' families of independent sources of advice. 20 ICAS, in AvMA's view, the contractual relationship 21 between the Department of Health hinders independence. 22 ICAS aims to steer people through the normal complaints 23 procedure, but it is not sufficiently specialist or able 24 to deal with other bodies, such as the GMC and the 25 coroners.</p> <p style="text-align: right;">Page 143</p>
<p>1 more teeth, but will lack the pure focus on patient 2 safety. 3 Data. There must be a consistent approach to 4 dealing with data that comes to the attention of 5 regulators and commissioners, such as high mortality 6 rates. The Department of Health has set up a working 7 party, as we know. 8 Regulation. There is a reluctance within the NHS, 9 AvMA say, to interfere with the trust until the problems 10 were so severe that there was no option but to do so. 11 There were opportunities for the Strategic Health 12 Authority and the Healthcare Commission to intervene 13 much earlier. The reluctance to intervene persists in 14 respect of the CQC, SHAs, PCTs and Department of Health, 15 shown by their continued failure to intervene over the 16 non-implementation of patient safety alerts. 17 AvMA research shows large numbers of outstanding 18 patient safety alerts, despite the Department of Health 19 writing to all trusts saying they must complete the 20 required actions in the alerts by the given deadline. 21 AvMA has made enquiries with the CQC and found it has 22 taken no action at all in relation to the non-compliance 23 with patient safety alerts. 24 The CQC is developing a system for quality and risk 25 profiles for each trust, combining a whole range of</p> <p style="text-align: right;">Page 142</p>	<p>1 The White Paper: Trust, Assurance and Safety 2007 2 recommended a specialist independent service to advise 3 and support people who may wish to report concerns about 4 health professionals, but that was not taken forward. 5 LINKs, say AvMA, failed to have a sufficiently 6 strong patient voice in the trust. They are separate 7 from the complaints function, lack their own paid staff 8 and have no national association, all weakening their 9 ability to act effectively. AvMA supports the proposal 10 for HealthWatch to replace LINKs, as proposed in the 11 Librating the NHS White Paper, but is concerned that 12 housing it within the CQC will weaken its independence 13 and force. 14 There must be a culture, say AvMA, of openness and 15 transparency: (1) to enable staff to report problems 16 without fear of reprisal; and (2) to ensure that NHS 17 bodies are open in dealing with complaints. AvMA 18 suspects that a critical report was suppressed by staff 19 at the trust in one case that AvMA is supporting, where 20 the report only came to light as a result of the first 21 Mid Staffs inquiry. I suspect we know which that is. 22 We will wait to hear from AvMA. 23 The Department of Health recognises, they say, that 24 there is a culture of denial within the NHS. Librating 25 the NHS says the government will require hospitals to be</p> <p style="text-align: right;">Page 144</p>

<p>1 open and honest with patients when things go wrong. 2 AvMA proposes a statutory duty of candour. They propose 3 that foundation trust boards should not be able to sit 4 in Private. It is essential to promote accountability 5 and transparency, and they also propose that there 6 should be clear guidance on when a public inquiry should 7 be held.</p> <p>8 AvMA was disappointed by the lack of involvement it 9 was allowed in planning the independent case notes 10 review by Dr Laker, despite its offers of help to the 11 Department of Health.</p> <p>12 Use of information from clinical negligence claims 13 should be used to inform work on patient safety and 14 regulation. The NHS Litigation Authority, NHSLA, should 15 play a major role in this through its clinical 16 negligence scheme for trusts. The recent development of 17 sending anonymised risk assessments to NHS trusts to 18 inform their risk management processes is welcomed.</p> <p>19 Clinical and non-clinical staff should be 20 accountable without there being a blame culture. Within 21 the trust between April 2005 and August 2009, only two 22 doctors had been referred to the GMC and one nurse to 23 the NMC. No accurate records were held by the trust for 24 these figures. Other trusts also do not hold accurate 25 records. Trusts must be more aware and involved in such</p> <p style="text-align: right;">Page 145</p>	<p>1 see a preliminary statement from the Patients 2 Association. But, sir, I have been told today that that 3 is in the making, as it were. We should have that this 4 week and we will be grateful for it.</p> <p>5 We hope to hear from the director of the Patients 6 Association, Katherine Murphy. The Patients Association 7 has been involved recently in a number of national 8 initiatives, directed towards ensuring increased and 9 more effective patient involvement, including the 10 institution of patient ambassadors, designed to be their 11 eyes and ears across the UK, but of whom there are 12 currently only 20, and the formation of local patient 13 focus groups. We look forward to receiving the 14 submissions of the Patients Association.</p> <p>15 The functions previously undertaken by CHCs were 16 divided into three distinct areas of responsibility: 17 representation and inspection; scrutiny; and complaints 18 and redress. The representation and inspection 19 functions were initially undertaken by PPIFs, which were 20 then replaced by LINKs. The scrutiny function passed to 21 the Oversight and Scrutiny Committees, whilst the 22 complaints and redress function was divided between PALS 23 and ICAS.</p> <p>24 At present, patient and public involvement in the 25 NHS is the shared responsibility of LINKs, the OSCs,</p> <p style="text-align: right;">Page 147</p>
<p>1 referrals and to be aware of problems arising. The fact 2 that non-clinical staff with senior management roles in 3 trusts are not bound by a professional code or 4 a regulatory body is, they say, a flaw in the system.</p> <p>5 Well, AvMA have therefore posed a number of 6 questions for the inquiry and made some helpful 7 suggestions which frequently find support elsewhere. 8 What, perhaps, those at AvMA need to address themselves 9 is the issue of why there was a lack of public awareness 10 about their activities and the help that they could 11 offer, and whether there was more that they could have 12 done and could do to increase that awareness.</p> <p>13 Let me turn to the Patients Association. The 14 Patients Association is an independent charity that 15 highlights the concerns and needs of patients. It works 16 with the government and a broad range of individuals and 17 organisations with a view to developing better and more 18 responsive health services. It aims to reduce health 19 inequalities by helping patients to be better informed 20 and by campaigning for patients to have the right to be 21 involved in decision-making.</p> <p>22 The Patients Association produces a range of guides 23 and advice booklets, and provides a helpline to support 24 patients with any challenges of any kind they experience 25 in health or social care. Now, we are still waiting to</p> <p style="text-align: right;">Page 146</p>	<p>1 PALS and ICAS. Foundation trusts also have a duty to 2 engage with their local community and encourage local 3 people to become members of the organisation. 4 Foundation trusts, therefore, also form part of the 5 public and patient involvement landscape. The extent, 6 however, that the organisations listed above were 7 effective in the roles they were intended to play is for 8 us to examine.</p> <p>9 Sir, I am about to turn on to local professionals 10 and quasi-regulatory evidence. I am your hands whether 11 you want me to continue at this stage or break now. 12 I have asked, just so that you know, for a short meeting 13 with the core participants when we rise, but if you 14 would like me to --</p> <p>15 THE CHAIRMAN: Having the advantage of your (a) speaking 16 note, which you have more or less been loyally 17 following, I can see you are nearly halfway through what 18 you have to say.</p> <p>19 MR KARK: Everybody in the room will be relieved, I expect, 20 of that. Not quite halfway, but nearly halfway.</p> <p>21 THE CHAIRMAN: Not quite halfway. But on the other hand we 22 do possibly have a little more time tomorrow if we start 23 on time than we have had today.</p> <p>24 MR KARK: Yes.</p> <p>25 THE CHAIRMAN: It is a long day and it must feel even longer</p> <p style="text-align: right;">Page 148</p>

1 for you, being the only person to have said anything so
 2 far. So I think it would be a convenient moment for us
 3 to stop and we will resume again at 10 o'clock tomorrow.
 4 MR KARK: I am grateful.
 5 THE CHAIRMAN: Thank you very much.
 6 (4.38 pm)
 7 (The inquiry adjourned until 10.00 am
 8 on Tuesday, 9 November 2010)
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