The Mid Staffordshire NHS
Foundation Trust Inquiry

Independent Inquiry into care provided by
Mid Staffordshire NHS Foundation Trust:
January 2005 - March 2009
Chaired by Robert Francis QC

SUMMARY OF ORAL EVIDENCE

This week the Inquiry has heard evidence from 17 people regarding Stafford Hosptial between Januray 2005 and March 2009.

This is a summary of the transcripts provided by the Inquiry Secretariat. It does not reflect the views or opinion of either Counsel to the Inquiry or the Chairman of the Inquiry who will rely on the full transcripts.

All names have been removed to protect confidentiality.

Witness A11 – Monday

On Monday, the Inquiry heard from a former Medical Director (2003-2006) of the Trust. The Witness explained that the main role of a Medical Director is to provide medical advice to the Trust Board and to act as a bridge between the consultant body and Trust Board.

When asked whether the consultant body was able to provide a clear view and voice Witness A11 said that it was like “herding cats”. Witness A11 explained that there used to be a Consultant Staff Committee that was at one time considered powerful as it carried executive powers. However, with various NHS changes it has lost its power. The Witness stated that today the committee only has 100% attendance when there is something contentious on the agenda.

Witness A11 told the Inquiry that he spent half his time as a clinician and the other half fulfilling managerial responsibilities. In the view of the Witness, the Medical Director should be clinically active, as this helps gain credibility from colleagues, as you are aware first hand of the pressures your team faces.

The Witness could not remember a time when the hospital was not under financial pressure. The Witness recollected that there were very few occasions when there was spare money to spend. The hospital’s management had to devote much of its time to attempting to balance the books because of “an imperative from above”. The impression the Witness had was you “balance the books or clear your desks”.

When asked about the budget Witness A11 said “It was always late……. we had to go into the year, as I recall, guesstimating what our budget would be and therefore what our financial problems would be”. The Witness could not remember a time when the hospital was informed of its budget prior to the new finical year.

Witness A11 explained to the Inquiry that when the hospital was awarded three stars by the Healthcare Commission (HCC) in financial year 2002/2003 it was pressured to apply for Foundation Trust (FT) status. Witness A11 said that it was a “double-edged sword”, and there was a feeling that the hospital already had its “head well above the parapet”. The Witness recalled that it took some time for the management to find any advantages to applying for FT Status. The incentive of financial independence convinced the management board to apply. Previously, if the hospital made a saving, it would be deducted the following financial year. Yet if the hospital were a FT, it would be allowed to reinvest any savings it produced according to the Witness.

The Witness spoke about the blame culture associated with targets. He recalled that if targets were not met you were required to explain this ‘failure’ to the Strategic Health Authority (SHA) and to report to them regularly until the problem was rectified. In the Witness’s mind, if a colleague had behaved in a similar way to their staff then they would have been accused of bullying. The Witness recalled that clinicians ran extra clinics in order to ensure targets

were met. In the Witness's view this creates a domino effect, as the more patients you see, the more work you do; and if you do not have the money to appoint the consultants to do the work, then more pressure is put on the existing consultants.

In 2004, a decision was taken to incorporate two wards into the Emergency Assessment Unit (EAU); which at the time was just a 12-bedded bay. The decision was taken after the hospital failed to meet its 4-hour waiting time target. The Inquiry heard that this was partly down to insufficient consultant staff.

The Witness explained that the hospital had an admissions ward for many years which they tried to clear on a daily basis; but as the number of patients built up, clearing it each day became difficult. The creation of a bigger EAU meant that the hospital was then able to meet its 4 hour waiting time target, but it also meant that every day there would need to be a ward round on EAU where you were moving patients on to a ward or discharging them home.

Colleagues of Witness A11 strongly opposed the clinical floors project. The Witness did not see the problem in the floors principle; the Witness felt that it was the same system, just with a different name. The point of contention for the Witness was the question of an appropriate skills mix. One of the drivers of the floor principle was that you could manage as effectively with less qualified nursing staff because you delegated non-nursing duties to staff with lesser skills. The other cause of disagreement the Witness's colleagues had was that it reduced the number of senior nurses. The idea was to have one nurse manager or sister between two wards. The Witness raised these concerns with the Board, but the view was that if they allowed the floor principle to run its course, and got appropriate staff in place, then the system would work. The Witness thought that it was essentially driven as a nursing project as it was about the nursing of patients on wards.

The Witness spoke about the risks of the surgical floors. One of the attractions for implementing the floors initiative was that it would allow you to ring-fence surgical beds that were being blocked by medical patients. This would therefore reduce the number of surgical patients who were deferred or delayed. The key was the management of acute emergencies in the Witness's mind.

According to the Witness when the hospital reduced bed numbers for financial reasons this combined with the ring fencing meant the hospital did not have the flexibility required to allow it to effectively manage patients.

In 2006, a workforce reduction programme was initiated. This involved reducing the existing workforce by around 160 members of staff. Witness A11 said that it was financially driven and that the Trust was trying to predict what the financial situation was going to be going forward the following year. The Trust was concerned that they were going to be in a similar position as before; trying to play catch-up to correct a financial problem halfway through the year when it had already spent half of its budget.

Monday – Witness B11

On Monday, the Inquiry heard from a member of the Executive team who worked in legal services.

The Witness said that shortly after joining the hospital in 2006 concerns arising from inquests and litigation were identified. It was not possible for the Witness to identify any process by which initial incidents were being formally reported. The Witness raised concerns about incidents relating to nursing care with the Director of Nursing but reports that she did not receive a satisfactory response. Concerns were also raised by the Witness to the Chief Executive who recognised that there was a problem with governance arrangements at the hospital.

Witness B11 said it was also apparent that incident reports were not being completed and reported that information on the number of incidents was not presented to the Board. These included instances of cases that had gone to inquest but had not been recorded as Serious Untoward Incidents (SUIs).. The Witness felt that staff were not aware of the procedure to follow. The Witness told the Inquiry that a procedure was put in place for reporting incidents in 2007 and that the legal services team began to investigate those that were recorded as SUIs. When the Witness became aware of incident that in her opinion, should have been reported as SUI she would recommend that this happened. In the Witness' mind whilst these recommendations were generally accepted, there remained reluctance at the hospital to raise SUIs because of the resource implications.

Complaints were not being reported to the Board when Witness B11 joined the hospital. A new reporting system was later implemented. The Witness recalled raising concerns that the data presented to the Board did not provide a comprehensive picture of the complaints , which prevented the Board from taking necessary action as a result. For a short period, the Witness reviewed the hospital's response to complaints. In her view often, the responses were too narrative and failed to address the specific concerns that had been raised.

Many of the complaints related to concerns about basic care in Accident and Emergency (A&E), according to Witness B11. The Witness stated that the Board had been told that staffing in A&E was suboptimal but had received reassurances from members of the executive team that these problems could be managed.

When the Witness took up post, the board meetings were held in private. The Witness recalled being asked to reduce the length of Board minutes as it was felt it should be a record of decisions rather than the discussion which led to the decisions.

In the Witness's opinion, there was a degree of challenge at the Board meetings and non-executive members would raise issues persistently. However, theses concerns could often not be addressed by the executive members and would therefore require no further action. The Witness reports

that it was rare for proposals put forward by the executive team not to be approved by the Board.

Discussions at the Board meetings were largely related to financial issues rather than clinical care, which the Witness felt was partly because some members of the Board needed greater support in understanding the way the hospital's finances were managed. These discussions were recorded in more detail in the minutes and the Witness understood this was done to demonstrate to Monitor that the Board were taking a rigorous approach to financial matters.

The expectation was that the FT application process would help the hospital implement good governance and finance arrangements Witness B11 recalls. According to the Witness there was a concern that if the application was unsuccessful the hospital would be taken over by an outside organisation.

The Witness did not recollect any discussion at the Hospital Management board (HMB) or Trust Board about the potential impact on care of the proposals to change the ratio of skilled to unskilled nurses on the medical wards or to reduce the number of staff at the hospital. Witness B11 was not aware that there had been any compulsory redundancies because of this process at the hospital. Further, no legal advice on the workforce reduction plan was sought by the hospital according to Witness B11.

The records relating to disciplinary action were poor and information on such issues was not reported to the HMB, the Witness states. Witness B11 told the Inquiry that she suggested disciplinary action be taken in some cases where incidents or claims had been made but that these suggestions were not taken forward. In the Witness's mind, incidents were often viewed as the result of system failure as such no individual could be seen to have responsibility. The Witness said that they had reported information to divisional governance groups to consider, including concerns relating to certain clinicians, but that it was only when these were reported directly to the Medical Director that action was taken.

The HMB and the Executive team were aware that staffing levels were an issue, according to Witness B11. According to the Witness the Chief Executive did met some people personally who had raised serious complaints. Yet there was not a great sense of urgency about the concerns as the Witness reports that the senior management team were not aware of the seriousness of the situation until the Healthcare Commission (HCC) embarked on their investigation.

Counsel asked the Witness about a report into the death of a patient following discharge from A&E, in which the consultant had indicated that the quality of care had been at fault. According to the Witness, she suggested certain amends to the report as some of the details would not have been fully investigated or communicated to the family in advance. The report was not submitted to the coroner for his inquest into the death. The Witness could not recall if the hospital had been asked to submit the report in question but

accepted that it should have been provided and said she was surprised it had not.

Witness B11 described the events surrounding the departure of the Chief Executive following the Healthcare Commission's investigation. The Chief Executive had offered to step aside and was subsequently suspended while an independent report into his conduct was commissioned. Following this report the Chief Executive offered his resignation. This was accepted by the Trust and a compromise agreement was reached. The Witness said that disciplinary proceedings were not pursued in order to enable a replacement to be appointed because it would have been unlikely that the Chief Executive would have been able to participate in an investigation for health reasons.

Monday Witness C11

On Monday, the Inquiry heard evidence from the Trust's Chief Operating Officer. The Witness was responsible for operations and the delivery of national targets including Accident and Emergency waiting times.

The Witness recalled being surprised when she took up her post in 2006 to find that governance arrangements at the hospital were poor. An example cited by the Witness was the failure of the hospital to have a completed risk register. She had been of the view that the governance at the hospital was strong as it had a strong reputation regionally and had a Level 3 Clinical Negligence Scheme for Trusts CNST rating which the Witness states was challenging to achieve.

A wealth of data was provided to the hospital management board (HMB), yet in the Witness's mind, it lacked substance. The HMB did not receive any analysis or information on current trends at the hospital. Complaints for example were summarised and presented to the board, yet neither the actual complaints nor their substance was ever reviewed. The Witness accepted that none of the indicators considered by the board reflected the actual quality of care that was delivered.

The Witness reports that the Trust's non-executives had high delivery expectations of the hospital executives. The board was not, in Witness C11's view, a rubber stamp exercise.

The Witness was asked about the allegations that staff working in the Accident and Emergency (A&E) department were put under extreme pressure and sometimes bullied to meet the four-hour waiting target. The Witness's view was that "We were all under pressure to meet the target". The Witness did not believe anyone used bullying tactics.

The four-hour waiting target did not determine the treatment provided to patients in A&E. As according to the Witness, if that were the case the hospital would have "met the target 100 per cent of the time as opposed to 98 per cent of the time".

Witness C11 was asked for her view on whether the staffing levels in A&E affected its ability to meet the four-hour waiting target. She stated that steps had been put in place "to bring the (staffing) numbers up". In the Witness's view when A&E only had one consultant it was not overly problematic as she highlighted the department's ability to use locums and acute physicians.

The Witness states not to have seen the outcome of an investigation into allegations that two members of staff, that she had management responsibility for, had encouraged nurses and clinicians to falsify times on A&E documents in order for the hospital to meet its four-hour target. She agrees that the allegations were serious and she was aware of them at the time, but said, "I

knew it was being investigated, but it isn't something that has stuck in my mind as being a very important issue."

In May 2006, the Witness produced a paper proposing the amalgamating of paediatrics into the medical division and surgery and obstetrics and gynaecology into the surgical division. According to the Witness, there were no clinical implications as it was about the infrastructure of having a separate management structure. The Witness was asked how she could be certain these mergers posed no risk to patients without undertaking any examination or analysis. The Witness said she "accepted the point".

The Witness was questioned in detail over the hospital's plan in 2006 to save £4.47 million by reducing the number of posts in the hospital. The Witness accepted that one would expect such reductions to be subject to objective risk analysis. The Witness was asked why therefore the assessment undertaken for the medical floor failed to consider the impact of reducing the nursing staff by 15 full time equivalents. The Witness said she didn't know. The Witness was asked why the risk assessment for the surgical floors that proposed a reduction of 24 nurses only examined the risk of removing four nurses. She told the Inquiry that she accepted that the risk assessments carried out were not adequate and that the board did not properly challenge this.

The Witness was involved in deciding whether applications for early retirement should be accepted. This decision, according to the Witness, was based on the ability of the Hospital to provide care and on finical implications. The Witness is not aware of the total number of nurses that were cut as part the workforce reduction plan.

The Witness was asked about the medical floor (Wards 10, 11 and 12). The Inquiry had heard that the floor was originally meant to have 64 beds with an additional capacity for 20 additional beds. The Witness does not recall any discussion concerning the number of beds on the floor. The Witness said she was not able to comment on whether it was appropriate for one senior sister to be responsible for up to 78 beds on the medical floor, "I am not a clinician and I do not have that clinical expertise to give you a right or a wrong answer to that one."

The move to surgical floors had been difficult in the Witness's view. Witness C11 said she was aware of the concerns about nurses loosing specialist knowledge and commented that the reconfiguration of the wards was not 'whole heartily' supported by staff.

The Witness told the Inquiry that the hospitals application process for foundation Trust (FT) status helped the hospital identify and implement systems and processes that had previously been missing. The process also assisted in identifying issues at the hospital.

The findings of the Healthcare Commission's (HCC) report did not surprise the Witness. The Witness is critical of what she views as the report's failure to

recognise the ‘improvements’ that had been instigated at the hospital. In the Witness’s mind the cases of poor care highlighted should have been placed in context as “not every single patient had a bad experience in the hospital” and “some people perceive certain things in different ways than others”.

The complaints about poor care were taken seriously, according to Witness C11. Nevertheless, she recognises that if managed properly the cases that the Inquiry has been told of would not have occurred over an extended period. As chief operating officer at the time, the Witness said she accepted responsibility for the lack of thorough investigation at the time.

Tuesday - Witness D11

The Inquiry heard from a Witness who has worked at the hospital for over ten years. Witness D11 has held responsibility for National Institute of Clinical Excellence (NICE) and National Service Frameworks (NSF) implementation as well as Medicines Management. In 2006, he became the lead on clinical governance.

It was apparent to Witness D11 that whilst their existed a few basic governance principals at the hospital prior to 2006 there was no functioning governance structure in place. The hospital's clinicians were disengaged from the governance process. The Director of Nursing who also held responsibility for governance, the Witness believes, was ignored by many staff as they felt unable to work with her. According to the Witness, these factors were in part responsible for the poor governance arrangements in existence prior to 2006.

No risk assessment of the surgical floors plans had been undertaken to the Witness's knowledge. He reports that some consultants did express concerns about the proposals, but "got nowhere with them".

In 2006 there was no was clear incident reporting process. The Witness recalls that many staff felt their reports were given little attention and often ended up in a 'black hole'. When a new Director of Nursing joined the Trust in 2006, the Witness reported that she inherited a six-month backlog of incident reports. The new electronic system that was introduced in April 2007 did little to improve incident reporting in the Witness's mind. The Witness favours a system where people are alerted quickly to an incident allowing immediate interventions to be considered before an examination of any longer term implications.

Upon taking responsibility for clinical governance, the Witness was keen to implement a number of changes. In particular, Witness D11 wanted the hospital to adopt an evidence-based approach to clinical governance based on the standards proposed by the Royal Colleges, NICE and NSF's. The Witness states that his attempt to introduce a new approach was met with reluctance from the consultant staff at the hospital, who did not want to give up their viewed "clinical autonomy".

The hospital had too many committees and groups with ill-defined terms of reference and a lack of purposes the Witness believes. The Witness chaired the Clinical Quality and Effectiveness Group, which reported to the Executive Governance Group. The expectation was that each division in the hospital would manage governance issues, but it was apparent to the Witness that the divisions lacked the personnel to do this.

The Clinical Quality and Effectiveness Group was aware that a high proportion of incidents being reported related to staff shortages, but no analysis of the reports was carried out according to the Witness. The Witness also reported being aware that there was insufficient nursing staff to care for

patients, which was the result of the hospital’s financial management. It is the Witness’s judgment that staff at the hospital felt disempowered and unable to tackle issues they were facing on wards, as so few decision could be taken at ward level.

It was evident to Witness D11 that the majority of staff failed to audit their personal clinical practices. The Witness introduced the Dr Foster reporting system but he does not judge this as being a universal success. Each consultant received training on the new reporting system, however only 12 consultants in the hospital used the new system. The view of the Witness was that it was “incredibly disappointing that after all that effort, people weren't individually going hunting for their own performance.”

In 2007 the Witness met members of Dr Foster to discuss the hospital’s end of year report Witness D1 learnt that the Hospital Standardised Mortality Ratio (HSMR) national average was 100 and the hospitals was 114. The Witness informed the Executive Governance Group of the results and belief that it was the result of coding problems in syncope and mental health.

When the HSMR data was published by Dr Foster the hospital’s HSMR figure had increased to 127, which was well above the national average and placed the hospital in the bottom ten in the country. The increase, Witness D11 reports, was the result of a late change in Dr Foster’s methodology. The Witness does not believe the figures were or are a reliable indicator as in 2007 the hospital’s crude actual mortality rate was similar to most other hospitals in the country.

In response to the HCC’s criticisms of the handling of HSMR alerts, the Witness said the hospital had concerns that the coding was responsible for the high HSMR levels. It therefore made the decision to focus on identifying any coding issues as opposed to considering the possibility that there were genuine clinical problems within the hospital.

The Witness still questions why the HCC did not choose to investigate the hospital in 2004 when the hospital’s HSMR figures were higher than they were in 2007. The Witness said, “I am not here to defend anything that happened in the Trust …. but I really do have concerns about the Healthcare Commission's functioning and why it should be that they decided to investigate us at a time when our mortality was falling from an even higher value two or three years beforehand.”

Tuesday – Witness E11

On Tuesday, a former Director of Nursing gave evidence to the Inquiry.

Upon arrival at the Trust in 2006, the Witness recalled being quite surprised at what she discovered "within nursing". It was apparent that the governance and reporting arrangements were inadequate. The nursing establishment skills mix was not right and the hospital had insufficient registered nurses and clinical leaders in key areas, in the Witness's view.

In the Witness's mind, the nursing workforce was quite stagnant. Many of the nurses had worked in the hospital for a long time. Staff did not gain experience from rotations within the hospital or from secondments to outside organisations. In her view, this had resulted in a lack of progression at the hospital. To the Witness this was a clear contrast to the large teaching Trust where she had previously worked.

Within three months of joining the hospital, the Witness instigated a skill mix review that was incorporated into the Trust's business plan. This was done because of her immediate concerns over staffing. The Witness did not believe that anyone at the Trust had the necessary skills or impartiality to conduct the review. An external consultant was therefore recruited to complete the review. It was extremely difficult for Witness E11 to determine either the nursing establishment or the funded nursing establishment as the data was not readily available. The Witness described the process of the review making clear that in her eyes it was not a simple numerical exercise. In hindsight, Witness E11 told the Inquiry she would have preferred for the review to have been concluded in less than the year it took.

As part of the review the external advisor met with all ward managers individually to discuss the ward requirements, based on the type of ward and the patient mix. Shift patterns were also reviewed along with financial information. The Witness then met with the ward managers and matrons to challenge the requirements they had suggested, as she felt that they might be reluctant to ask for more staff as they had got used to functioning with such low staffing levels. The Witness believes this was imperative as it assisted in engaging staff in the process, which was essential in her view if staff were to be accountable for the running of wards. .

Towards the end of 2007 as a short term measure until the skill mix review was completed the Witness set up a virtual ward which involved recruiting full time staff who worked at the hospital every day and would then be deployed where needed on a shift by shift basis.

The review, which concluded a year later found that there was shortfall of 120.39 full time equivalent nurses at the hospital (surgical division: 30.28; medical division; 76.78: clinical support services; 5.05: corporate division 8.28). The Witness accepted that the number of nurses required would have

been higher if the figures used for the review had not included temporary staff staff.

As a result of the review, the board agreed to an initial investment of £1.1 million. The board minutes are misleading as they imply that this investment would meet the staff shortfall the Witness admitted. In reality, the investment would fund 38.4 whole time equivalent nurses with a shortfall of 82 full whole time equivalent nurses. It was agreed that the board would review the investment and would work to reduce the gap between the professional review and the establishment figures.

Following the skills review, the number of matrons was increased from 3 to12. The matrons were necessary in order to improve clinical leadership and for there to be greater visibility in clinical areas in the Witness's view.

According to Witness E11, a recruitment freeze was not implemented as implied in the September 2008 board meeting notes. In November 2008, the board agreed to additional funding to meet the establishment review figure. The Witness reports that funding for additional nurses has continued and stated that it is now £2.4 million. It is the Witness's belief that the impact of additional nursing staff led to the reduction of nursing related complaints seen in 2008 – 2009.

In the Witness's judgment, the hospital would not have been able to recruit sufficient staff to fill the posts identified by the skills mix review even if the finance had been available. The Witness told the Inquiry that when positions were advertised the response was very poor. She also found it difficult to get any support with recruitment from inside the hospital.

There was no defined training plan for nursing staff when the Witness joined the hospital. There were some teaching programmes but a structured approach to training was not applied with the exception of nursing practitioners. The money for nurse education and training had been underspent year on year prior to 2007. When Witness E11 came into post she reviewed the training needs, and the entire budget for nurse training was spent.

The appraisal rate for nurses at the hospital was very low, according to Witness E11. This was an organisation-wide issue and did not just relate to nurses. There were some pockets where appraisal of nurses was good and the overall levels of appraisal have now improved according to Witness E11.

Witness E11 was asked about Wards 10, 11 and 12 and whether there was a particular problem with nursing there. She said the problems on the wards became more apparent throughout 2007. The Witness accepted that there were examples of poor patients care, but said there were also patients who received good care in these wards. In her opinion the care delivered on Wards 10, 11 and 12 "was patchy, which if you are one of those patients who is not getting good care, that is not good enough." In 2008, Witness E11

prepared a Confidence in Care action plan to improve patient care, quarterly progress reports were produced for the board.

Infection control was a portfolio that Witness E11 acquired in September 2007. In the Witness's view the infection control team, was "slightly dysfunctional". The relationship and communication between the nursing and medical team was not good. There was also no clear strategy across the organisation. Witness E11 secured the appointment of an infection control matron and an action plan was produced. In the Witness's opinion, good progress was made and staff were engaged with the issue.

The Witness was asked about the Accident and Emergency Department. She stated that the board had discussed the need for an independent review. After the first review, she recalled that the board decided to look at the impact of the acute care physicians and better governance arrangements. When the second review was carried out the board learnt that the Healthcare Commission was planning an investigation. The Witness was asked if it was fair to say that at this time A&E was not fit for purpose. Witness E11 responded, "I am not sure you can really say that … there were a number of patients that were treated well."

The Healthcare Commission's report, in Witness E11's mind, did not present a balanced view. The Witness also commented that the Healthcare Commission focussed on what was written in board minutes that did not always reflect what was presented to the board on clinical topics.

Tuesday – Witness F11 – week three

On Tuesday, the Inquiry heard evidence from a consultant who has worked at Stafford Hospital for over twenty years. The Witness held various management positions at the hospital including the role of Medical Director from 2006 – 2009.

The role of a Medical Director, according to the Witness, had evolved from advising hospital boards on clinical matters to promoting clinical excellence and quality along with the Nursing Director. The Witness also advised the Trust on the development of medical staff employed throughout the hospital and professional standards. The Clinical Leads, all of whom were consultants within the hospital, supported the Witness in her role.

When the Witness took the position, the governance arrangements were ineffective the Witness recalls. Witness F11 became the Deputy Chair of the Clinical Quality and Effectiveness Group that was established in 2006. The groups remit was professional standards, promotion of clinical excellence clinical outcomes and clinical audit as well as nursing care.

The Witness states that she had concerns about the introduction of surgical floors, which had began before she was appointed as medical director, and the change to the skills mix within nursing. In hindsight, it is much easier to link the number of posts to the quality of care the Witness believes. Yet at the time the Witness said, "We were aware that we had to balance our budget."

The Witness was not involved in the nursing skills mix review. When asked why it had taken a year to complete the Witness said the intention of the executive team was to ensure they got the review right. "Yes it took a long time, there were a lot of other things to do at the same time and we wanted to do it properly".

The main driver for Foundation Trust (FT) status was the desire to raise standards at the hospital in the Witness's view. Financial control was regarded as an important element of the process and finance was always very high on the Board's agenda. The Witness told the Inquiry that concerns about standards of care were discussed at the board. According to Witness F11, the board minutes are misleading for not highlighting the discussions that took place surrounding clinical issues. The Witness accepts that the discussions around clinical concerns and care were not effective in light of what the Healthcare Commission found.

As Medical Director, the Witness had immediate concerns about some of the outcomes of surgery and about the way that the general surgeons worked together. These issues, according to the Witness, had never been addressed by the hospital. In spring 2007, after approval from the Executive team, the Witness invited the Royal College of Surgeons to review the Colorectal Surgery, Laparoscopic Cholecystectomy Surgery and Out of Hours surgical provisions at the hospital. The Witness agreed with the report's main

conclusion that the general surgical team was dysfunctional in terms of how they behaved towards and co-operated with one another.

One of the Royal College of Surgeons recommendations was that particular surgeons should undergo psychological assessments with a view to improving working relationships. Another suggestion was to undertake an audit of Laparoscopic Cholecystectomies. This was deferred because at the time one of the surgeons had stopped doing these procedures while the review was undertaken, the Witness recalled. By the time the review was completed it was agreed that some retraining was required and this was organised. Counsel asked why it had taken a year to replace a surgeon from the colorectal team, the Witness said, “It sometimes does take that time.” The Witness agreed that there was a need for a further review of surgery at the hospital because the issues identified in 2007 had not been adequately tackled.

The Witness reported having concerns about the handling of Serious Untoward Incidents (SUIs). One problem in the Witness’s opinion was that clinicians failed to report incidents as SUIs because they were not aware of what constituted an SUI. However, the board, according to the Witness, took SUIs seriously.

The Clinical Quality and Effectiveness Group collated the complaints made to the hospital. The Witness accepted that the committee only produced a summary of the complaints to the board and that in hindsight; this probably diluted the independent scrutiny that the non-executive members brought to the process.

In the Witness’s view, there was not a clear clinical audit strategy at the hospital. Individual clinicians were required to complete audits, yet the Witness reported that some clinicians did this more effectively than others. The Witness agreed that clinical audit was not the hospital’s strength and needed more focus and direction.

When the Witness was appointed as Medical Director, there were no mortality review groups. The Witness said that the hospital’s attention was drawn to mortality rates by a letter from the Dr. Foster Research Unit in about July 2007 in relation to jejunum surgery. A Mortality Group within the hospital was established to review mortality issues. The Witness states that the hospital genuinely believed that the mortality rates were the result of coding errors, but told the Inquiry that consideration of whether this implied problems with clinical care was given.

Staffing levels within the hospital (particularly nursing staff) within the medical division posed a particular problem the Witness recalled. Witness F11 reported that the board was aware of the shortage of consultant cover in the Accident and Emergency (A&E) Department and should have been aware of the impact this had “it should have been obvious from the description of what I was saying, what the problems were”.

Efforts to fill the consultant post in A&E were unsuccessful according to the Witness. Attempts to cover this gap were made with an appointment of an Acute Physician. The Witness said that the board felt the increase in incidents might have been the result of people feeling more able to report incidents.

Witness F11 confirmed to the Inquiry that the board did consider the possibility of closing A&E for a period of time because of the staffing situation but had not chosen to do so because “closing A&E has a huge impact and we knew that our local sister hospitals also had their own problems.” Prior to the HCC letter setting out concerns about A&E the Witness said, “I think it is fair to say that we were aware of our problems and we were doing our level best to address each one”.

The findings of the HCC report did not “tell us anything that we didn't know”. The Witness said the report made the Trust “act more quickly on things that we were already doing.” Witness F11 told the Inquiry that her main regret was that the organisation did not identify and tackle the problems at the hospital earlier.

Wednesday – Witness H11

The Inquiry heard evidence from a non-executive Director of the Trust who was appointed in 2007.

The Witness had no particular experience of managing an NHS Trust and remembered that at the first board meetings it was difficult to understand NHS terminology. To get a sense of the organisation a programme of meetings was organised with key directors.

The Trust's Chair was asked by the Witness about the difficult financial position at an early meeting. Witness H11 was assured by the executive board members that the issue was now settled. With hindsight, the Witness would have liked to have dug deeper into the difficulties.

Throughout Witness H11's period as a non-executive, vacancy rates were constantly an issue. The Witness believed that there was a strong link between the sickness rates and vacancies.

Counsel asked the Witness about Board minutes during 2007. At one meeting the accuracy of Dr Foster data was queried and the board was advised that the data was getting better as coding improved. The Witness remembered that the executives were strongly of the view that there were significant problems with coding and that this was the cause of the high mortality figures. In turn, this caused the Board to accept the numbers, the Witness reports.

The scrutiny that the Trust was under by the Strategic Health Authority (SHA) and Monitor as part of the FT process gave comfort to the Board. The Witness recalled that coding was the cause of the high mortality figures. In the final part of the FT process for example, at a meeting with Monitor the issue around mortality was discussed. The Witness said that Monitor expressed that they were satisfied – i.e. accepted the explanation that the mortality figures were due to coding.

Witness H11 was asked about the skills mix review. The Witness said that the recent Director of Nursing, who the Witness had a high opinion of, had initiated this. The review addressed the balance between non -qualified and qualified nursing staff. The Witness did not recall any discussion of why a skill mix review was necessary or about the impact of earlier cuts.

The Witness told the inquiry that the Trust was still struggling to fill vacancies. This is partly due, in his opinion, to Stafford being quite isolated as an area, which makes it more difficult to recruit people from the surrounding areas. The Witness reported that the board found it difficult to recruit a senior human resources (HR) professional to help tackle the human resources issues that the Trust faced.

The Board regarded Foundation Trust status as a positive achievement in the Witness's mind. The Witness said that the Board felt assured by the

executives that the hospital was fulfilling the requirements of the application for FT status including those related to patient care. The Witness said there was no basis on which to challenge the assertions of the executives because most of the news the board received was positive. The Department of Health's assessment process the previous year had deemed the hospital ready for FT status, infection rates were being tackled and the Hospital was meeting national targets. This gave the Board a degree of comfort. The issues raised by Cure the NHS were not apparent to the Board according to Witness H11.

The Witness talked about the role of non-executives. The role was for two and a half days a month. At the training, it was made clear the non-execs should not get involved with the running of the hospital. The Witness states that in reality when the FT application was being made Governors were required to spend far more than two and a half days devoted to the role and the Witness had to increasingly take holiday from his full time employment to deal with the workload.

Complaints were collected under broad headings and in the Witness's view did not tell the Board much. They gave a "30,000 foot view" which did not provide sufficient detail to inform the Board where something was seriously wrong. After a considerable length of time, the Witness asked for the five worst complaints under each heading. The Board did have one complaint that was sent directly to non-executive directors from the family of a cancer patient. The Witness recalls that a non-executive took the lead in meeting the family. Although the family were unhappy their relative had died, they had a better understanding of what happened after the meeting and did not feel the hospital mistreated them according to Witness H11. It is apparent to the Witness that meetings are a far more productive way of resolving complaints then letters.

The FT application process was not solely a financial process according to Witness H11. Operational issues were also significant. The Witness told the inquiry that the board had various practice board to boards with different organisations prior to the FT board itself.

Following the successful FT application the Witness reported that board meetings were held in private. This was due to a view that the Trust was now in a more competitive business environment with competing hospitals. The public board meetings were, according to Witness H11, appallingly attended. There were no dissenting voices on the Board to oppose this change. The Witness agreed that there were many issues that were not commercially sensitive which could have been discussed in public. After the Healthcare Commission (HCC) report, meetings were again held in public and the Witness found this refreshing with some insightful questions asked.

The Witness told the inquiry that the problems with A&E were not on the board's radar. They assumed that the building work around A&E had caused a disruption to services and that once complete complaints would reduce. The HCC letter that followed (which was very critical of A&E) came as a surprise

to the Witness. The Witness believes that the Board was not given all the information available on the situation in A&E. However, the Board were aware that there was only one full time consultant in A&E and that guidance stated there should be three or four. Action to recruit a consultant was taken the Witness recalls.

Witness H11 cannot understand how the problems at the hospital did not become apparent to the Board. Despite having systems in place such as being able to write to non-execs and the complaints procedure the issues were not coming to the surface, according to Witness H11.

The Witness questioned to some extent the validity of the Dr Foster figures given that the Trust is now in the top 10 hospitals according to Dr Foster. In the Witness's mind, the most meaningful judgment is from external organisations such as the Royal College of Surgeons.

It is clear to Witness H11 that the Board's focus has changed dramatically and that quality of care is now the priority of the Board. Today the Witness reports that executive directors walk around at night to view the situation on the wards directly.

The Witness admits asking the question, "if I had know [what I] was letting myself in for, would I have taken it on?" On reflection, the Witness believes that the scrutiny the hospital has received will assist it in constructing a first class example of what a good district general hospital should be.

Wednesday - Witness J11, Witness K11, Witness L11

On Wednesday the Inquiry heard from three former Non Executive Directors of the Trust (Witness J11, Witness K11, Witness L11).

Witness J11 told the Inquiry that the Board had been concerned for some time, not about the standard of care, but about the standard of leadership, management and financial planning at the hospital. The introduction of a new national contract for consultants, the Agenda for Change programme and changes to the appointment process of junior doctors all put the hospital under financial pressure. According to the Witness the hospital had no clear plan to manage this. The Witness reports that concerns were raised with the new Chair in 2005, which resulted in the appointment of a new Chief Executive.

All of the Witnesses recalled visiting most parts of the hospital during the day during their tenure on the Board. On these visits the Witness's said they would speak to both patients and staff and reported that no serious concerns about the level of care provided were ever raised. Neither had anyone from the local community ever raised concerns with any of the Witnesses.

Counsel asked if the Witnesses could recall the proposals to reorganise surgical wards. None of the witnesses recalled a risk assessment accompanying these proposals as had been agreed by the Hospital Management Group. Witness J11 told the Inquiry that prior to 2006 risk management at the hospital had been non-existent and that this was something the board had taken steps to address with the new Chief Executive.

Witness K11 said that he had been concerned about the impact of the proposals on staffing levels and had sought reassurances from the Director of Nursing. The Director of Nursing had been a strong advocate of the project and Witness K11 said that assurance was given that the reconfiguration would produce financial savings and improve patient care. The Witnesses were not aware that any concerns about these proposals had been raised by nurses or clinicians. Had there been concerns they would have expected these to have been communicated to them by the Medical Director or the consultant's representative who both attended board meetings.

The Witnesses said that they became aware of concerns that elements of the clinical floors proposals were not having a successful impact, particularly in relation to A&E and EAU. However, they did not have the impression that the project as a whole was a failure. The Witnesses were not aware that one senior sister was responsible for up to 78 beds across wards 10, 11 and 12, but stated that they would not necessarily have expected to be informed of such detail. The Witnesses told the Inquiry that if there were concerns about the impact of staffing levels on patient care they would have expected them to be raised with them by the Director of Nursing or the Medical Director.

Counsel asked the Witnesses about the 2006 plan to tackle a projected deficit of £10m and in particular the proposal to cut staff numbers by 160 in relation to this. Witness L11 said that it would have been difficult to address such a deficit without it impacting on staff but was of the view that every effort was made to minimise the impact on clinical staff. Witness J11 recalled that the Board was dependent on advice from medical colleagues as to whether the proposals would compromise patient care and safety.

Witness L11 confirmed that part of the deficit was the result of changes to the tariff, which the Primary Care Trust only made them aware of shortly before the start of the new financial year. The Witnesses said that they were not able to challenge this at the time as this situation faced the entire NHS and the hospital had no other source of funding.

Witness K11 said that the board had seen the breakdown of the proposed staff reductions and recalled that 52 of these were to be nursing posts. Witness K11 told the Inquiry that whilst this figure was viewed as being necessary, not all the posts were actually filled at the time. The hospital at the time had a number of vacancies which it proved hard to fill so the actual number of redundancies would have been significantly less Witness J11 told the Inquiry. The Witnesses confirmed that they had received assurances from the clinical representatives on the board that these reductions would not impact on standards of care provided.

The Witnesses confirmed that in October 2006 the Board had received a report raising concerns about the level of staffing in A&E but said that steps had been taken to address this problem. Witness K11 told the Inquiry that they had concerns about the standard of clinical leadership in A&E at this time but did not feel this was due to the pressure on the consultant at the time. The hospital had been trying to recruit to a vacant surgical post for almost a year, according to Witness J11. The Witnesses confirmed that the Board had received further reports in March 2007 and March 2008 reassuring them that action was being taken to address problems highlighted in complaints relating to A&E. In addition the increase in complaints had coincided with a period of refurbishment in A&E so it was not apparent that they were related to the standard of care, according to the Witnesses. All three Witnesses said they had been surprised by the severity of the concerns raised in a letter from the Healthcare Commission (HCC) in May of 2008.

All Witnesses expected the hospital to meet key targets and reported that the board would request an explanation where this had not happened. They added that they would accept that on occasion targets would not be met for clinical reasons and that this would be a justifiable explanation. The Witnesses said they would be extremely concerned if staff were under the impression that their jobs were in danger or felt required to falsify records to maintain compliance with such targets. They added that if staff had raised concerns with them about their ability to comply with these targets they would have been open and receptive to the issues raised.

Witness K11 told the Inquiry that the Board had employed the services of Dr Foster in 2007 to gain feedback on the hospital's mortality rates. They had concerns about the methodology that was used which Dr Foster accepted. The Board challenged the executive directors about these rates and a Mortality Group was set up to look into individual cases. Witness L11 added that the Board had been advised by the Executive Directors that incorrect coding was affecting the mortality rates. This had been confirmed by other reports by external bodies. Monitor had also scrutinised their approach to recording mortality rates and had been satisfied with the hospital's approach. The Witnesses felt that the HCC had been unreasonable in refusing to accept that coding was a factor behind their high level of unexpected deaths that were reported. According to the Witnesses the HCC had been unfair in leading local people to believe that members of the Board had been aware that there were high numbers of unexpected deaths at the Trust and had taken no action.

According to the Witnesses the decision to apply for Foundation Trust (FT) status was a helpful way of driving the necessary governance improvement at the hospital. The Witnesses accepted that their application stated that the hospital was providing high quality care and said that this was based on assurances by numerous outside inspection bodies including patient groups, Royal Colleges, the Strategic Health Authority (SHA) and Inspection Authorities.

It is accepted by all Witnesses that there were failings in care at the hospital at certain times but they did not accept that this reflected the general standard of care. Witness L11 believes such incidents were the result of failings by individual staff rather than being representative of a systemic failure. The Witness cannot understand how such issues occurred without the Board ever being made aware.

The Witnesses felt that one of the lessons they had drawn from their experience was that it is important to have a robust complaints process and for members of the board to have a role in considering the most serious complaints made by patients. Much has been achieved by the Board since 2005 to establish proper governance procedures which, given time, would have delivered improvements Witness L11 stated.

As Board members the Witnesses said they had to take ultimate responsibility for any failings in the care provided. At the same time, they made clear that they were to a large extent dependent on the assurances they received from the Executive team, particularly the senior clinicians.

Wednesday – Witness M11

The Inquiry heard evidence from a former governor at the Trust, on Wednesday.

Witness M11 had been a chaplaincy volunteer at Cannock for several years. During this time, the Witness recalled witnessing a number of incidents that, she deemed unacceptable, such as a lack of privacy and dignity for patients and food left out of reach of older patients. It is her view that the staff at Cannock were good in the main, but that there were not enough staff on the wards.

The Witness was unhappy about the care of her late father and the way she had been treated by the Bereavement Officer. The Witness had a meeting with the Chief Executive about this and at the meeting she also informed him of her general concerns about the hospital. Witness M11 offered to speak to staff directly and gave a talk to over 80 staff at the hospital. She spoke of her personal experience of the hospital and of her concerns about the care provided. The Witness reported that she tried to make it as light hearted as possible in order not to upset anyone and recalled she received a round of applause following her talk.

In an attempt to improve conditions, the Witness decided to stand for election as a public governor at the Trust. The Witness stood on the promise that if elected she would highlight the need of patients and families. Witness M11 was elected as a governor in 2007.

At the time of standing for election in 2007 Witness M11's mother was admitted to Stafford Hospital's Accident and Emergency (A&E) department at night with suspected deep vein thrombosis (DVT). During her time in A&E, the Witness saw many cases of concern. A woman in the next cubicle was left on a commode and sounded very distressed. A young woman in utter "agony" who despite requests for help was left in reception. A man in a wheelchair who was left in a draught who kept requesting oxygen and help to go to the toilet. The Witness recalled that there was plenty of staff on duty some of whom spent time discussing their private lives.

After attending one Governor meeting the Witness was suspended. In the Witness's opinion, the motivation of the suspension was connected to the talk she had given to staff at Cannock hospital. The Witness recalled meeting the Chair of the Trust at a governor's introduction meeting . She described her as hostile in her tone of voice when she spoke to her about the talk she had given at Cannock hospital.

The Witness told the Inquiry that despite the high volume of paper work on the role of a governor it was not clear what the position actually involved. In the Witness's views at the Governors meeting the Governors were controlled and were not encouraged to express their views or opinions or challenge the board. It is the Witness's view that the information that was provided to Governors at this meeting was not truthful. The Witness recalled asking about

the mortality figures which she were told were due to a coding problem and were very difficult to explain.

The Witness told the Inquiry that the Governors were discouraged from speaking to members of Cure the NHS because they were "protesters". In March 2008, Cure the NHS was invited to attend a meeting attended by the Governors and all the non-executive Governors. At the meeting, the Witness recalls that the Chair of the Trust informed the members of Cure the NHS that they only had three minutes each to speak and should not talk together. The Witness said, "She was so rude to these people, it was dreadful". Members of the groups spoke of their experience of the hospital. According to the Witness, some Governors were in tears by the accounts of what had taken place. One Governor said he had never heard such awful stories and walked out. The Chair then asked if anyone would like a break before continuing the meeting as "if nothing had happened". No further reference was made at the meeting of what they had been told. The Witness said she regrets not standing up and saying something about the situation. At the 2008, AGM the Witness reported that the Governors were asked to enter through the back door to avoid the protestors from Cure the NHS.

The findings of the Healthcare Commission's (HCC) report did not come as a surprise to the Witness. At a meeting with the Chief Executive prior to the publication of the HCC Report the Governors were warned that the report would not be "terribly good". The Chief Executive informed them that they had the right to remind neutral and that they were hiring a Public Relations company to help manage the public and media's reaction. The Witness also stated that he told them they were "getting MPs on board". According to the Witness up until the publication of the report, there was no acknowledgment by the board that there was a problem. In her opinion, they "either didn't know that things were so bad or they were so arrogant that they thought they would get away with it." Today the Witness reports that the Governors meetings are much improved and that Governors are able to have frank discussions and ask questions.

Thursday – Witness N11

The Inquiry heard evidence from the former Finance Director and Deputy Chief Executive who worked at the hospital from 1992 - 2008.

In 2006, the hospital faced a difficult financial year. It had a historical deficit of £2.8 million, the agenda for change loan that was meant to be paid back over two years now had to be paid back within a year, and the hospital faced a 2-3 % funding cut from the Primary Care Trust (PCT). Overall, the Witness reported that the hospital faced an anticipated deficit for the following financial year of £10 million.

At the Hospital Management Board (HMB) in March 2006 the Witness, recalled that the Chief Executive reported that the cost improvement programme had identified 4.6 million but that a shortfall of £5.4 millions remained that had to be tackled immediately.

In May 2006, a workforce reduction plan was proposed. It involved a reduction of 166.81 posts, 52 of which were nursing posts. The removal of these posts would produce a saving of £4.4 million. This staffing cut was planned on a ratio of 2/3 non-clinical, 1/3 clinical reductions. The posts would be identified from the vacancies currently at the Trust. The Witness explained how a vacancy that no one was being paid for would help with the deficit. According to the Witness if funding existed for a post that was not being utilised it was taken out of future spending projections hence a reduction in the overall projected budget. The workforce reduction plan was agreed.

Each division was given a target savings figure and charged with devising their own strategy to meet it. These plans were submitted for consideration and review by Executive/Divisional panels, finance sub committee and from there to the Board. The Facilities Division plan was based on a rationalisation of back-office services. The Surgical Division's plan was based on bed reductions and faster discharging of patients and a reduction of staff. The Medical Division's plans was based on altering the nursing skill mix to increase the number of staff but shift the balance from skilled nurses to trained healthcare assistants therefore reducing the overall running costs.

By November 2006, the Witness predicted that there would be virtually no vacancies. Counsel asked the Witness how the reduction of 194 vacancies to an anticipated no vacancies over ten moths had arisen. The Witness said that during 2006, the Trust experienced high staff turnover and it transpired that the number of nurses & nursing assistants in post was less than expected. Several senior nurses left and nurse sickness levels substantially increased. This not only reduced the level of trained staff available to provide patient care, training and supervision but also created an additional recruitment pressure.

The Witness was asked about evidence presented to the Inquiry that the hospital did not have reliable information on the number of people in post and that this would make workforce decisions unreliable. The Witness said that

the Trust did have information on establishment figures and on the number of people in post. Information was also available on the number of temporary staff who had been employed according to Witness N11. The Witness stated it was “quite staggering” for people to claim it was not and that the issue was that people were not able to grasp the system or data.

The Witness said that a substantial number of the posts were lost because of the workforce reduction programme. The criteria applied to determine whether to accept an application for early retirement or voluntary redundancy was based according to Witness N11 on the post no longer existing after the event and on financial grounds. It was “cheaper to get rid of cheap people” as part of the exercise according to the Witness.

The Witness said the driving force behind the clinical floors project was based on a mixture of providing better care and reducing the hospital’s expenditure by £600,000 per annum. At the HMB , a number of concerns were expressed about the proposals and it was decided that there would be a clinical risk assessment. When the executive board considered the proposal, no clinical risk assessment was considered and the Witness states he did not see one. He accepted that if one had been carried out it would have been referred to at this meeting. The Witness accepted that the papers for the Trust Boards’ January 2006 discussion of the plans did not include any reference to the concerns raised by staff at the HMB.

In 2006 / 07 financial year, the Trust had an operational surplus of £1.22 million. The Witness said one million was brokerage that was taken back by the Strategic Health Authority (SHA).

The main drivers for FT status were the financial freedoms that FT status would bring the Witness recalls, particularly to plan over a longer-term period, and the capital flexibility provided. Greater autonomy and local community input and representation were also factors but were not the driving factors in the application according to Witness N11.

The Witness was asked about the hospital’s application for FT status, which indicated that the Trust was providing high quality care. The Witness said that this was based on the indicators that the hospital had at the time. The FT assessment process itself was very rigorous in the Witness’s mind. For example, Monitor spent 6 weeks at the hospital and its financial and governance arrangements were closely scrutinised.

Thursday – Witnesses P11 & Q11

On Thursday, the Inquiry heard evidence from two Governors of the Board. Witness P11 was a Governor from 2007 – 2008. Witness Q11 is a current Governor who was elected over a year ago.

Witness P11 has experience of the local Borough Council's Health Scrutiny Committee and told the Inquiry of its role. He reported that the committee's function is to ensure that the area's National Health providers deliver high quality care. The Witness confirmed that the committee has the power to scrutinise NHS services and to call NHS employee to give evidence. Local Involvement Networks (LINks) has the power of entry and is supposed to inspect and report to the Care Quality Commission (CQC) and to the Council's Overview and Scrutiny Committee (OSC).

In Witness P11's opinion, Stafford Borough Council did do an effective job in scrutinising the hospital. Concerns about patient safety came to the attention of the committee from reports, which counsellors received from constituents. Cure the NHS members also gave reports of problems with staffing, cleanliness and the Accident and Emergency (A&E) department. After May 2008, the committee asked the hospital to provide statistics on infections and mortality rates from non-elective admissions. Every two months the committee would receive reports and those who prepared them would attend and give evidence. The committee also visited the hospital in August 2008 and were given a presentation on hospital acquired infection by the then Chairman, according to Witness P11.

With respect to the high mortality rates, the Chief Executive gave reassurances that there was nothing out of the ordinary and the excessive results were due to coding errors. When asked by Witness P11 about evidence to support this, the Chief Executive pointed to work undertaken by Birmingham University, the results of which he said would be made available to the committee. Witness P11 reports that no information was received.

The committee was aware that the Healthcare Commission (HCC) was looking into the procedures and practices at the hospital. However, it was not aware, according to the Witnesses, of either of the letters sent by the HCC in May and June 2008 outlining concerns about A&E and poor nursing care. The witness felt that at the visit to the hospital in August 2008 the Chairman and Chief Executive could have been more frank with the committee.

The Witness said that prior to Cure the NHS forming in September 2007, the committee was looking at healthcare acquired infections by requiring reports from the Trust. The Witness said the value of the committee is that they can require the directors of the Trust to give evidence on matters – the committee supports improvement by holding executives to account publicly. At most meetings the press and the public are present. The witness felt there was a high level of awareness amongst pressure groups about what the committee could do.

The Links network had not functioned well and Witness Q11 told the Inquiry that the present system was being terminated. A problem with Link according to the Witness was that it did not have the power to ask questions of NHS staff.

Witness P11 was a Governor from February 2008. The Witness was unimpressed by the way in which the governing body functioned. At the first meeting of the Governors, the Chief Executive told the group that he had plans to make radical changes to Cannock Hospital. When some of the Governors from Cannock wanted to explore this in more detail, they were told it was an operational matter and did not concern them. The Witness also had concerns about the management of the meetings. The agenda of the Governors was controlled by the Chairman of the Trust, which restricted the role of the Governors, and this was particularly difficult given the strong personality of the Chair.

The Witness had a disagreement with the Chairman about the discussion of the Chairman's remuneration. A nominations and remuneration subcommittee was established to deal with the Chairman's pay. It met for the first time in January 2008. At that meeting no decision was made about pay because the Witness was not satisfied with the evidence provided which was simply a handful of comparisons with other Trusts, without any analysis or explanation of where they had come from. The Witness undertook some research and found that the remuneration increase proposed did not, in his view, align with the pay of chairs at Trusts of a similar size. A much bigger increase was being proposed.

After the first meetings, a consultant's report was prepared of comparative remuneration levels. There was however nothing to say whom it had been commissioned by or what its terms of reference were. It was not properly divided into upper and lower quartiles so comprassions could not be made.. At that point, the witness resigned.

Witness P11 recounted the meeting of the Council in 2008 where Cure the NHS attended. The group had brought with them numerous photographs of their relatives showing lesions, bedsores and untreated wounds. They asked whether they could address the meeting but the Chairman said no. The Witness wanted to hear what Cure had to say and so the session was adjourned for 10 minutes. Some of the Governors were not terribly sympathetic and accused the group of not taking up the invite of coming to the hospital to help solve the problems. The Witness had given Cure advice that they should not become involved with the management of the hospital. Without experience of medicine or management training, they would have been silenced by getting involved "after all if you complain to the Council that there is a hole in the road, they don't expect you to pick up a shovel and help fix it". Cure the NHS were then allowed to address the meeting.

Witness Q11 believes that Cure the NHS was treated poorly in the early stages by the Trust. She described one occasion where the police were called

to move the group from the front of the hospital where they were protesting silently.

Particularly troubling for the Witness was how all the episodes of ill treatment could have been allowed to continue for so long. “It must have been apparent within a few days of the complaint and yet it continued and it went on for about four years”. According to the Witness it was a failure of the management, the Strategic Health Authority (SHA) and the Primary Care Trust (PCT) not to consider the quality of care being provided.

Witness Q11 joined the Governor’s Council in the middle of 2008. The Witness questioned why she was there because everyone agreed with everything. During the investigation by the HCC, the Council of Governors were given no information about what was going on “we lived in cloud cuckoo land. Nothing was ever discussed”.

Since the appointment of a new Chief Executive, the structure is much improved. The Council of Governors is more inclusive according to Witness Q11. The Governors can ask any questions and they get straight answers. The Chief Executive has said that if the Governors hear of anything they should send the individuals concerned straight to him. The Witness had referred families a couple of times in this way and the Chief Executive had given them considerable time. The Witness said things were improving but that the Chief Executive had said it would take at least two years to sort out the problems and it would be a slow and painful process. Recently it was agreed that the Governors could make unannounced visits to the hospital to see what was happening in practice.

Thursday – Witnesses R11, S11 &T11

On Thursday the current Chief Executive, Chair, and Medical Director of the Trust gave evidence to the Inquiry.

All Witnesses were thanked for the help and co-operation of the Trust to the Inquiry.

The Chief Executive read a prepared statement to the Inquiry. The Chief Executive's initial impression of the hospital was that it was clean and the staff were welcoming. Yet he reported that it soon became apparent that there were serial failings at the Trust that were repetitive and deep. There was an overwhelming sense of denial in the organisation and belief that other organisations were the same "but had not bee caught". The governance structure lacked clarity and focus. There was a lack of clinical engagement and poor leadership. The senior team was inexperienced. The organisation was very closed and did not welcome challenge or scrutiny. Financial and workforce data was poor. . The complaints process was inadequate. The Trust had no sense of direction and was not focused on patient care. The behaviour of certain staff was appalling. Areas of the hospital remained unsafe and there were continuing examples of poor basic patient care.

The witnesses report that they immediately worked to recruit a very competent senior team and non-executive team who they worked with to implement a number of measures. A zero tolerance to poor care, safety and behaviour was introduced. The requirement for agency staff has been reduced by improving the bank staff arrangements. Clinical involvement in decision-making has increased. Complaints management has been reviewed. New governance arrangements focusing on the patient have been introduced. The role of Governors has been reviewed. Workforce complaints are now monitored.

The clinical floor projects was universally criticised by all three Witnesses. The Chief Executive said he could not believe that "anyone had thought it a good idea". The Medical Director highlighted the loss of nursing expertise because of the project the Inquiry.

Despite a number of requests by the Trust's Chairman, he has not been able to see the risk assessment for the proposal to reduce the number of nursing staff. He said, "So one can only assume it didn't happen." Since the Healthcare Commission (HCC) report, the nursing establishment has increased by 140 whole-time equivalents. The Chief Executive told the Inquiry that he was unclear as to why the Trust had previously felt they have to reduce the staffing levels dramatically, "I do not get why we can now afford to employ an extra 140 nurses and two or three years ago they took 120 nurses out"

In the past, the trust had relied too heavily on the reviews of external organizations, in the views of the Chairman. It had failed in his eyes to make

the connection between “feedback from national bodies and the local intelligence that they were picking up”.

The recent Dr Foster mortality figures, which placed Stafford Hospital in the top ten safest hospitals in the country was “no more than reassurance” to the Chief Executive. He told the Inquiry there is more work to do before any of the Witnesses would feel content.

Today clinicians feel able to speak directly to the Chief Executive or Chairman about his or her concerns and ideas the Medical Director reported, as “Nobody is saying you can’t go through such-and such structure”.

The Chief Executive is now convinced that the overwhelming majority of staff at the hospital strive to do a good job. He said as long as you “weed out” those who do not want to provide excellent care than the culture of the Trust can change. According to the Chief Executive there is a real desire amongst staff for the Trust to change, “The staff are desperate for people to say actually this place is great, this place is good and that helps me with sorting out the cultural issue. The Trust Chairman ended by telling the Inquiry that the “problems at Stafford are solvable”.