THE MID STAFFORDSHIRE NHS FOUNDATION TRUST
PUBLIC INQUIRY – Chaired by Robert Francis QC

Report from the Forward Look Seminars

Dr Sarah Harvey, Loop2

PREPARED FOR AND ON BEHALF OF THE INQUIRY BY DR SARAH HARVEY, DIRECTOR AT LOOP2 AND FACILITATOR FOR THE INQUIRY SEMINARS

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THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY FORWARD LOOK SEMINARS

PREFACE

The Forward Look Seminars were organised to inform the Inquiry's work on applying the lessons of Mid-Staffordshire to the future of the NHS. The papers and presentations given at the seminars and podcasts of interviews with the authors have been published separately on the Inquiry's website at www.midstaffspublicinquiry.com. This paper provides a summary for Robert Francis QC, Chairman of the Mid Staffordshire NHS Foundation Trust Public Inquiry, of the discussions and the points made at the seminars. These are not recommendations. The report is not a verbatim account of what was said, but is simply intended to feed back to the Inquiry the key themes, reflections and ideas offered by those participating in the seminar discussions and as reflected by the seminar facilitator, to enable these to be taken into account.

EXECUTIVE SUMMARY: REFLECTIONS FROM THE MID STAFFORDSHIRE NHS FOUNDATION TRUST FORWARD LOOK SEMINARS

*"After the 1986 Chernobyl accident, the world's nuclear operators realised that an event at **one** plant impacted on **every** plant and that international cooperation was needed to ensure such an accident could never happen again."* Dr Andrew Spurr, Managing Director, Nuclear, EDF Energy

A key message from these seminars is that the NHS must go beyond hearing the lessons from the events at the Mid Staffordshire NHS Foundation Trust to taking decisive action to improve quality, safety and patient experience.

This paper highlights the issues that seminar participants feel need to be addressed in the way health systems operate to improve the focus on patient experience and service quality. They note the scope for more consistent application of good practice and for improvements in the way organisations work with each other. There is duplication of effort in some areas which could be streamlined and far better co-ordinated.

Healthcare providers do operate within a national framework but Trust boards have considerable freedom and influence in what they select as their most important

priorities. Some of the presentations have described excellent practice by Trusts that are putting patient experience and harm free care centre stage, engaging their staff in this quest, providing them with the freedom, tools and support to deliver it, and stretching them so they deliver continuous improvements. The case studies share a common characteristic - they admit that they are not perfect and are ambitious to get better. These case studies also demonstrate that there are different ways of delivering good care experiences and outcomes for patients.

Many of the actions that the NHS should take to improve the quality of care and patient experience are the responsibilities of local Trusts and healthcare commissioners. There are also things that could be addressed at a national level. In particular, a strong theme was the need for a fundamental review of the way care for older people in health systems is undertaken and the skills, knowledge and behaviours needed to deliver care safely, effectively and with compassion. The key points in the paper are outlined below.

PATIENT EXPERIENCE

- ***The health and care of older people*.** Many of the cases of poor care that occurred at Mid Staffordshire NHS Foundation Trust, as well as those in other places identified in the recent reviews by the Care Quality Commission (CQC) and the Patients' Association, concern the care of older people. Participants felt there are significant questions to be addressed concerning the appropriateness of hospital as a place for care, the way care is organised in hospitals and in community settings to meet the needs of older people and what skills and behaviours are needed from clinicians and healthcare support staff to meet the complex needs of this patient group. With increasing numbers of very elderly people in our society it was suggested there may be a case for a fundamental look at what constitutes good care and what should be done to provide the right network of care and support to older people and their carers.
- ***Measuring patient experience.*** What's measured is what matters. What matters is what should be measured. The seminars demonstrated that there is a growing array of measures that can be used by providers and commissioners to understand the impacts of their care on patients and carers, including the increasing use that people are making of social media to share their stories. Some Trusts already have a sophisticated approach to this, whilst others are barely using the published patient survey data. Participants felt that a prescriptive approach on how to measure patient experience may not be necessary but there may be a case for looking at how the various approaches, quantitative and qualitative measures of patient experience can be coordinated and interpreted by Trusts and local health systems to give them a holistic view of patients' experiences and opinions.

- A commitment to sharing information about healthcare performance with the public is important and on balance a diversity of outlets and display methods will help to promote its use and comprehension. Despite the improvements that have been made in making information more widely available, participants felt that patients and the public are still not that well informed about where they can go to get this information. The way that citizens access and share information is changing rapidly – it is important that the NHS takes account of these shifts in the way it interacts with the public and patients. There is little to be gained and a lot to lose by ignoring these developments.

ORGANISATIONAL CULTURE

- Organisational culture was a theme across all the seminars. Whilst poor culture is readily blamed as a source of poor care, participants acknowledged the difficulty of defining 'culture' clearly and therefore of identifying practical, replicable actions for the NHS. However, the seminars established some clear themes which participants believed underpinned success: clear leadership from the top, a commitment to honest conversations, systems to encourage and enable staff and patient feedback, a 'just' culture rather than a 'blame' culture in holding individuals to account, and a willingness on the part of organisations constantly to review and challenge their performance and behaviours
- Participants were clear that Trust Boards have responsibility for interpreting national policy and setting the right culture and priorities for their own organisations.
- Participants also identified that the national context influences the degree to which quality, safety and patient experience are given a priority and profile by local healthcare systems. The new Outcomes Framework and Quality Accounts were both felt to be positive initiatives. Participants suggested that a commitment to greater openness and transparency means that all parts of the NHS, including the Department of Health, need to use plain jargon free language, without excessive use of acronyms such as PREMs, PROMs and QIPP, so that patients can understand and thereby contribute to plans for health services and for their care.

LEADERSHIP AND MANAGEMENT

- ***The quality and consistency of NHS management.*** The seminars considered the arguments for and against a formal registration of NHS managers. It was recognised that managers worked in a wide range of different roles, and there was recognition that there was a stronger case for some form of regulation for

Board level directors than for all general managers. There was interest in the use of a 'fit and proper' person test as a possible approach.

- Participants highlighted two current tools that are relatively well respected yet under-exploited, which have the potential to help restore public confidence and ensure there are clearer and consistent expectations for NHS general managers. The first is the code of conduct, developed in 2002 which still has considerable value. That it continues to be relevant over a period in which there have been several NHS reorganisations is testament to its potential. Participants considered whether the Code of Conduct could be made part of the contract of employment as originally intended. They suggested that with some adjustments to describe in more detail the required and unacceptable behaviours it would have added value to employers and employees alike.
- The second tool is the NHS Constitution developed following a large scale consultation exercise under the previous Government. The Constitution brought together in one place statements about the values of the NHS, what patients have a right to expect from their care and pledges about the improvements the NHS intended to make. The importance of values in the NHS was emphasised in several seminars and it was felt the values and commitments contained in the NHS Constitution could be used by healthcare employers in their recruitment, induction and appraisal processes to reinforce what many patients value about 'their NHS'. It was felt that it is these values that are at the heart of the NHS 'brand'.
- ***Board development***. Participants in the seminars emphasised the central role of the Board, and the importance of investment in the collective body as well as individual executive and non-executive directors. Participants noted the role that the Appointments Commission, the NHS Institute for Innovation and Improvement and Strategic Health Authorities have played in providing opportunities for Boards to develop their skills and contributions to better patient care. It is unclear how this function will be fulfilled in the future, yet there are some potentially valuable development initiatives which it would not be cost effective for individual organisations to procure themselves. This is possibly something that the Leadership Academy could address in its future work programme.
- ***Peer review*** attracted a good deal of interest as a method for organisations to gain insights into how they can improve quality and performance, and participants suggested this was something that might be led by the NHS Confederation, Foundation Trust Network or professional bodies. Consideration will need to be given to how the learning from peer reviews is shared.

NURSING

- ***Ensuring quality and consistency in healthcare support staff.*** The seminars looked at the arguments for and against the regulation of people who act as care assistants to registered professionals: most participants believe that the current position is confusing and does not provide sufficient safeguards for staff or for patients. It is important that staff in these positions have the opportunity to progress in their careers and have their qualifications and skills recognised by different employers. There are existing tools such as the NHS Careers Framework, National Occupational Standards and the competency frameworks developed by Skills for Health that if combined could provide the building blocks for a more consistent approach or even the first step towards formal regulation. Reinforcing the duties of nurses and midwives concerning delegation of nursing tasks to support staff may also be important.
- ***Nurse education and training.*** While the basic architecture of the current approach to degree based nurse education was supported, participants agreed that the way nurses are trained to undertake the practical therapeutic and compassionate aspects of their role could be strengthened. With pressures on staffing as a result of the current financial challenges and with the changing pattern of medicine with its higher throughput, universities and Trusts need to ensure that they select people with the right attitudes and values and ensure there are practical, supportive and consistent clinical placements. Valuing the contributions that registered nurses make to the teaching of students and preceptorship is also important.
- ***Nurse staffing –*** the seminar considered the arguments around nurse staffing and whether minimum standards should be set. The arguments are complex and on balance a single methodology may not desirable. There was agreement that Trusts do need a systematic and evidence based approach to planning nurse staffing numbers. There was also a view that low nurse staffing ratios for older people's services was far from satisfactory.

INFORMATION

- Skills development in improvement science, audit and data analysis is becoming more widely available for clinicians and managers as part of the continuing professional development and it was suggested these could be better integrated into pre-registration clinical training.
- At a national level there is positive work being undertaken by the NHS Information Centre to reduce unnecessary central data returns. However, participants warned against a potential desire for regulatory bodies and others in similar positions to 'fill the vacuum' with new requests which are not directly linked to patient care. Trusts will be better able to foster a culture of information

use if the information they are being asked to supply to regulators is aligned to the data that clinicians need to inform their own practice and patient care.

- Participants felt that information systems, information skills and culture and information transparency are the key points to be addressed here. It was felt that with the demise of the NHS Programme for IT the Department of Health/NHS Commissioning Board could reiterate the importance of Trusts investing in the electronic patient records and developing performance systems that are aggregated from patient level data.

COMMISSIONING

- The new arrangements for Clinical Commissioning Groups (CCGs) are starting to take shape and there are significant expectations on what they will be able to achieve on a reduced level of management support. Where commissioners oversee areas where there is service/organisational failure these resources will be stretched. Participants felt that these new organisations needed to prioritise the improvement areas that they focus on, have flexibility to direct their capacity to areas where improvement is needed, be able to access independent clinical advice and be supported if they choose to 'decommission' those services that are putting patients at risk. Participants noted that the support that the NHS Commissioning Board gives to CCGs will be key.
- Many of the things that CCGs need to do to identify, tackle and improve the quality of care are already being performed by the best Primary Care Trusts. Participants identified four specific opportunities for the new commissioners to demonstrate their effectiveness in championing the 'people's NHS':
    - Making intelligent and imaginative use of qualitative and quantitative information that combines primary and secondary care data and diverse sources of information about patient experience.
    - Collaborative work between primary and secondary care clinicians to make sustained improvements in the quality and inefficiency of care.
    - More intensive and effective public and patient engagement, using deliberative processes to involve people in taking difficult decisions about priorities and resources and systematic processes for capturing patient experiences.
    - More assertive use of contract levers to incentivize providers to improve outcomes and patient experience.
- CCGs will need more robust early warning systems of poor quality care based on qualitative feedback and stories from patients (something only the best PCTs currently tend to do) as well as clinical indicators. In some services, such as maternity services, these indicators have been developed in response to incidences of poor care but there is further work to do to roll out this approach

across other services. CCGs will also need to be more assertive in the way they monitor contract outputs and outcomes.

- It was suggested that at a national level service specific early warning systems combining clinical indicators and patient experience might be helpful to support CCGs in monitoring the quality of local services.

REGULATION

- Participants recognised that the regulatory system is far from perfect and is still in a state of transition. They cautioned against further structural change for change's sake. The important priorities highlighted by participants were a) better and shared early warning and intervention systems b) more coordination of regulatory activities for organisations/services in difficulty, and c) continuing to improve the sharing of information between regulators – particularly between the system and professional regulators.
- For professional regulators the key message was to improve the speed of their responses to referrals from failing organisations, as these actions can be critical to the improvement programmes of those organisations

1. INTRODUCTION

THE PURPOSE OF THE SEMINARS

The terms of reference for the Mid Staffordshire NHS Foundation Trust Public Inquiry ask the Inquiry Chairman (Mr Robert Francis QC) to 'identify the lessons to be drawn ... as to how, in the future, the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals or their services are identified as soon as is practicable'. To inform this 'forward looking' part of his brief the Inquiry Chairman convened a series of seminars in October and November 2011. There were seven seminars covering the following topics:

- Patient experience
- Organisational culture
- Nursing
- Training and development of Trust leaders and managers
- The collection, use and management of information
- Commissioning
- Methods of regulation

The seminars brought together between 30 and 40 participants who were invited for their personal experiences and insights (see annexes for lists of attendees). The participants included patient representatives, doctors, nurses, managers from NHS Trusts and Foundation Trusts, commissioning and regulatory bodies and the Department of Health, people from independent and third sector organisations and some contributors from other sectors. Core Participants to the Inquiry were also able to send a representative if they so wished. The seminars were facilitated by Dr Sarah Harvey from Loop2 who is independent from the Inquiry and who was brought in specifically for this role.

To stimulate debate three or four expert contributors were invited to prepare and present papers for each seminar (see annexes). As well as discussing the issues raised by these papers, participants also discussed a set of specific questions which had emerged as issues during the Inquiry. Copies of the papers and presentations can be found on the Inquiry website[1]. The website also contains a set of podcast resources for each of the seminars that provide an overview of the discussions and short interviews with each of the speakers.

This paper does not attempt to summarise or reiterate those papers, which provide informative insights in their own right. Nor does the paper attempt a verbatim record of what was said in each of the seminars. It concentrates instead on

[1] [1] www.midstaffspublicinquiry.com

presenting the key themes which emerged from the seminar discussions and background papers and a flavour of the views expressed by those who took part.

The primary purpose of the paper is to inform the Inquiry Chairman as he puts together the final report and recommendations, although it is hoped it may also be of interest to the NHS by pulling together some insights and reflections from what were a lively and informative series of debates. The views and suggestions contained in this paper should not be construed as representing the views of the Inquiry Chairman or indeed areas where he has reached any conclusions: these will be set out fully in the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

THE RELEVANCE OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST EVENTS FOR THE WIDER NHS

The seminars demonstrated that the events at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 have provoked a range of responses. Some people feel it was an extreme case of wrongdoing. Others believe there are other parts of the NHS which exhibit similar characteristics and risks. Some seminar participants highlighted things that have improved since the events at Mid Staffordshire in response to the recommendations contained in Robert Francis QC's first report[2]. Others expressed strong disappointment that in 2011 there are still examples coming to public attention of health services failing to treat patients safely and with respect.

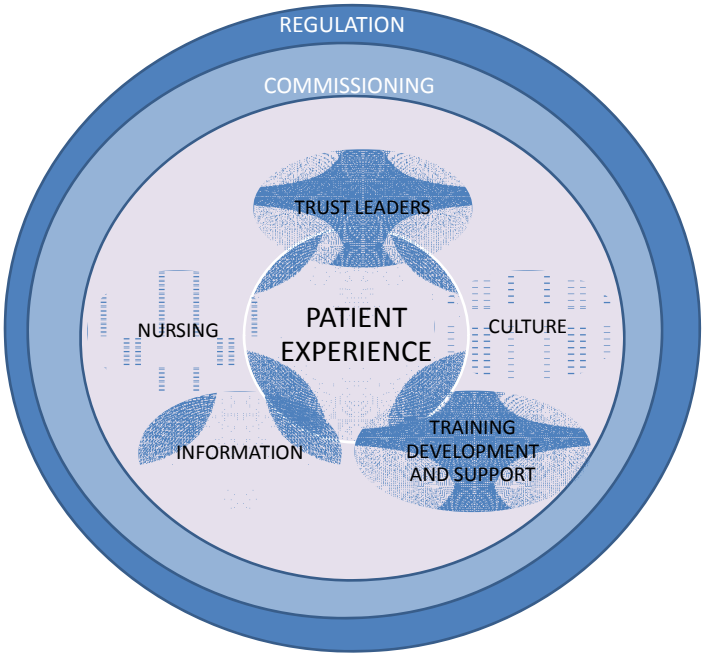
Introducing the seminars, the Chairman of the inquiry, Robert Francis QC highlighted some of the experiences that patients had of poor quality care at Mid Staffordshire NHS Foundation Trust during the period he has been asked to look at. He described the intense anger that patients and their relatives felt about how they had been treated both by the Trust and by those organisations that were supposed to be there to help them and to ensure such issues did not occur. Despite numerous investigations by the Trust itself, by commissioners and regulators, many of those people continue to feel that the NHS has let them down. Whilst there are of course examples across the NHS of excellent patient care, the opening message for the seminars is that while there are lessons to be learned from the events at the Mid Staffordshire NHS Foundation Trust, the NHS must also understand and feel the anger of those people who have been failed and harmed by the care that they have received from their National Health Service. It is only by recognising that emotion that NHS staff, healthcare commissioners and providers, and the NHS as a whole, can understand how important it is that they change the way they work.

[2] Robert Francis QC (24 February 2010) *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009, volumes 1 and 2*

2. About this report

The Inquiry Chairman has been asked to consider the failings in an acute hospital and the way those services were commissioned and regulated. This paper therefore, in the main, focuses on hospital care, rather than on primary and community services. However, there was an acknowledgement in many of the seminar discussions that the current pattern of care, particularly for older people, needs to change and that strengthening community and home based care has a significant role to play in improving the quality and patient experience of healthcare as a whole.

Some common themes emerged from the seven seminars so rather than producing separate summaries from each event this paper attempts to pull together the key points into a single document. The diagram below illustrates the way that the paper is organised. Rightly, patient experience is the starting point. This section includes comments that were made about how healthcare delivery needs to give a much stronger focus on patients' needs and preferences. The report then addresses the five internal domains that can contribute to patient experience in hospitals, followed by the two external domains of commissioning and regulation which set the context within which healthcare providers operate and care for patients.



For each domain the report summarises the ways in which each affects patient care and experience, highlights examples of good practice identified in the seminars and background papers, and sets out the participants' thoughts on any changes that might help to prevent, identify sooner or remedy situations of organisational failure such as the events at Mid Staffordshire NHS Foundation Trust.

3. PUTTING PATIENTS AT THE HEART OF HEALTHCARE

The events at Mid Staffordshire NHS Foundation Trust were documented by Robert Francis QC in his first report[3]. Patient needs were not systematically put at the centre of the way the Trust was organised and care was sub-standard. There was poor attention to personal care, to clinical quality, safety and care coordination and a defensive approach to complaints and concerns highlighted by patients and carers, staff and external bodies.

WHAT PATIENTS AND THEIR REPRESENTATIVES SAY ABOUT WHAT THEY WANT FROM THEIR CARE

The seminars started from a consensus that patient safety and quality should be at the heart of the delivery of healthcare. For every patient, carer, family member and healthcare professional, safety is pivotal to diagnosis, treatment and care. To create a truly great patient experience, care must not only be safe and harm free, but deliver good outcomes and treat people with dignity and respect. Many participants felt that although this sounds like a basic set of requirements, it is one which continues to challenge health systems in England. The first seminar on regulation coincided with the launch of a report from the Care Quality Commission (CQC) on the inspection of dignity and nutrition in 100 hospitals: 20% of the hospitals failed to meet one or both standards[4]. As this report was being drafted the Patients' Association published more case studies of poor care for older people.

During the seminars patient representatives described their expectations and hopes for a positive experience from their healthcare. Here is a selection of their comments.

> *"I want to have some control – to understand the plan for my care, check whether the things that need to be done have been done. I have a long-term condition so I want to take my care plan from home into hospital and have care coordinated around my needs'*
>
> *"I want to be able to see information about the performance of local services. If I had known about Mid Staffs' performance I would never have gone there"*
>
> *"We need to make better use of assistive technology. Many older people needn't be in hospital at all"*
>
> *"Staff who take time to care and reassure you"*

[3] Ibid
[4] CQC (2011) Dignity and nutrition inspection programme: national overview

"I just want to be treated as a person"

"The NHS should be thinking about the "pain points" along the journey of care: what is a patient thinking at each stage and how can we make it better"

"Elderly people value a routine. Hospitals should ask about the way people usually do things – do they eat breakfast or wash first in the morning?"

"Relatives should be involved in contributing to care plans if they want to"

"Visiting times shouldn't be rigid – that can be a problem for families"

"Nurses should show friendliness and courtesy to patients whose buzzers are going off"

"*Care should be organised around the whole person not buildings"-*

"It is about allowing the patient to decide which decisions they make and which they delegate to their clinicians. Some patients will wish to participate more than others"

Health professionals and managers at the seminars shared a simple test - care needs to be of a standard that they would be happy to have for their own family. There are many things that directly or indirectly determine whether health systems live up to that test. Trust leadership, culture, training, nursing staff, commissioning and regulation, all play their part: these elements are covered later in the report. The remainder of this section of the report covers:

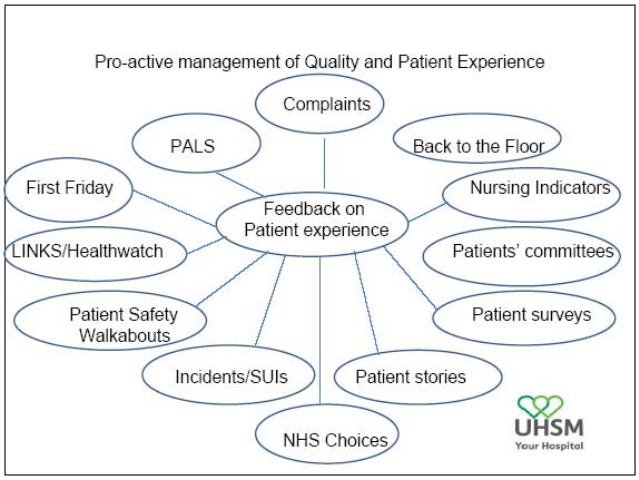
- How patients express views about their care
- The way care is organised and delivered
- Treating people with care and compassion
- Learning from complaints and feedback
- Conclusions

HOW PATIENTS EXPRESS VIEWS ABOUT THEIR CARE

There is an increasing array of ways in which patients can express their views about their care and treatment: from the traditional compliments and complaints, through patient surveys and bedside monitors, to the various social media. Figure 1 below from **Julian Hartley's** presentation highlights some of the sources that the University Hospital of South Manchester NHS Foundation Trust uses to assess patient experience. We heard from some participants that there is considerable variation

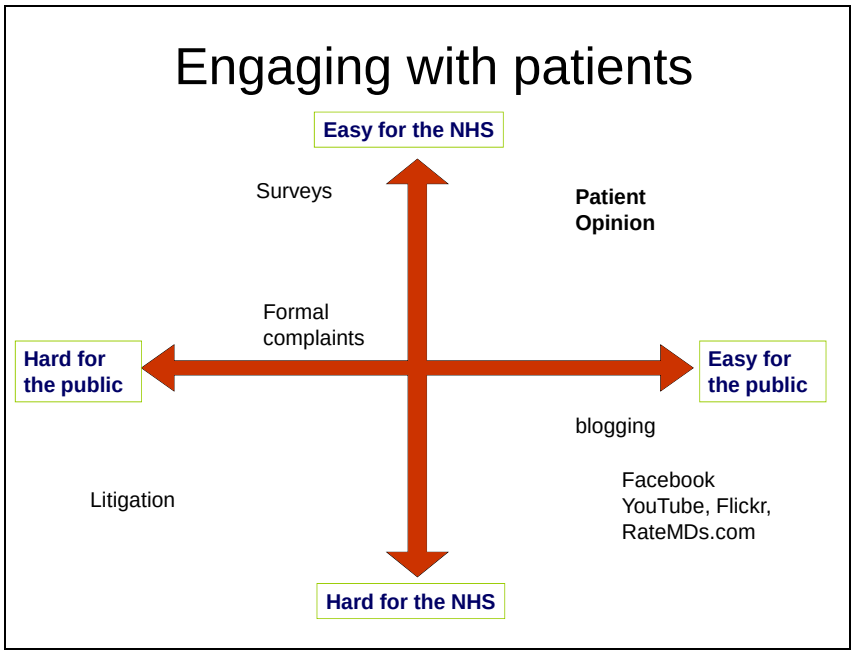
between Boards in how seriously they take patient experience measures, some giving only limited attention to the national survey results.

Figure 1: Sources of intelligence about Patient Experience



Source: University Hospitals South Manchester NHS Foundation Trust

Figure 2: Patient engagement processes – a classification



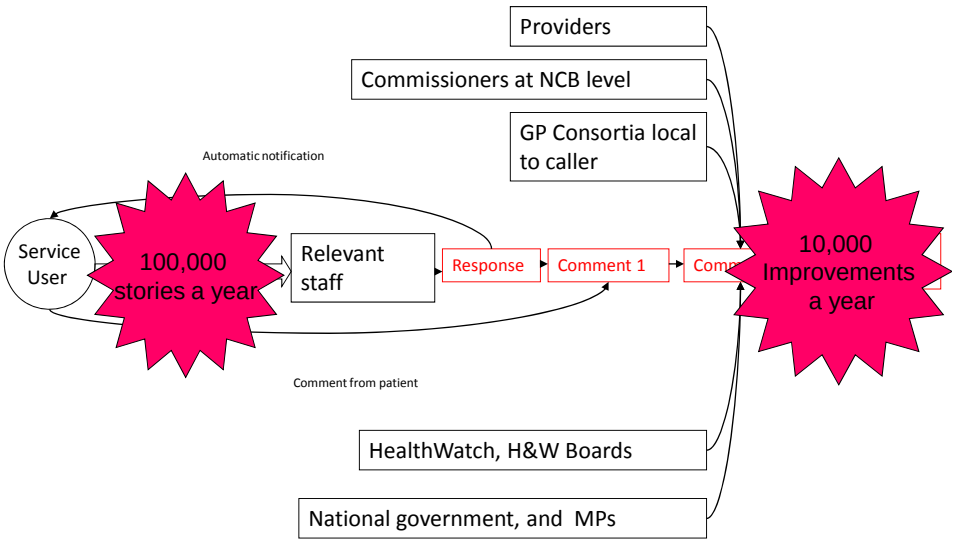
Source: Patient Opinion

Paul Hodgkin, Chief Executive Officer from Patient Opinion presented the slide in figure 2 to illustrate his argument that traditional methods which the NHS relies on to gather patient views can be difficult for some patients to use. He argued that social media are increasingly being used by people of all ages and social groups to

share their experiences of healthcare, not least because they are easier/less threatening to use. This sentiment was echoed by a patient representative who explained why patients can be fearful of complaining: *"we are afraid to comment or complain in case we get a red dot on our notes".* By contrast NHS commissioners and providers can feel overwhelmed by having to check social media sites such as Twitter to see what patients are saying about their organisations in addition to their mainstream communications activities. Like it or not, Paul argued that the NHS must embrace these forms of communication if it is to keep up with the way that patients exchange views. **Professor Martin Elliott**, Medical Director of Great Ormond Street Hospital, in his paper to the information seminar reported that his patients are increasingly expecting their consultations to be held virtually.

Paul Hodgkin explained how Patient Opinion aims to bridge the gap between patients sharing their stories and actions on the ground to improve the experience for people in the future. Trusts that sign up to the Patient Opinion site can follow patient stories that relate to their organisation then post comments in response (this includes stories that have been posted on the NHS Choices website as well). Dialogue between Trust staff and the patient can take place in a public or private space. There is a tracking mechanism that allows patients to check if anyone in the Trust has read their story and see whether improvements have been made as a result.

Figure 3: Patient opinion helps track patient stories into local service improvements



The structure of conversations on Patient Opinion.

At a local level the NHS has, and will have, a range of bodies that have responsibilities to represent the views of patients and the public, including the local HealthWatch, the local authority Health Overview and Scrutiny Committee, Foundation Trust Governors and Members, patient participation groups and Patient Advice and Liaison (PALs) services. There will also be a range of third sector organisations some of which provide an advocacy function and others who represent people with different types of needs or conditions. This is a potentially complex network of relationships. Participants noted that it was far from clear how these bodies will differentiate their roles or work together to secure improvements in local services. It is, however, imperative that these agreements are made at a local level to avoid confusion for patients/citizens and ensure that these different entities use their respective skills to make things better for people who use health and care services. As HealthWatch funding to Local Authorities is not ring-fenced there is an added impetus for the new arrangements to demonstrate that they can make a difference in influencing better care.

THE WAY CARE IS ORGANISED AND DELIVERED

Healthcare has changed considerably over the past ten years. **Dr Jocelyn Cornwell's** paper summarised this succinctly. She explained that the NHS in England now undertakes more than 9 million elective and 5 million non-elective admissions plus 20 million outpatient attendances and 20 million A&E visits a year.[5] "*Patients over 65 account for 70 per cent of hospital bed days and 80 per cent of emergency readmissions. Of these older people admitted to hospital, 60 per cent will have a mental disorder (depression, delirium, or dementia).*" [6]The number of people looking after these patients in hospitals has also increased and working time restrictions mean that working patterns have changed. "*More people, in more specialties and departments, are involved in looking after the same patient. The typical inpatient day is increasingly broken up; patients spend less time on their own ward and more time being transported around the hospital to investigations and treatment".*

Jocelyn explained that staff are under stress personally, working in big, very busy, pressurised environments, with little opportunity to establish good relationships with their patients and colleagues.

We heard several comments about the consequences of these working patterns and the stresses that staff experience.

[5] HES Online (IP) and DH (A&E & OP) Oct 2011

[6] Joanna Goodrich, and Jocelyn Cornwell, Director (2011) The contribution of Schwartz Center Rounds® to hospital culture The King's Fund

"*Patients do not feel as involved in decisions about their care as they would like to be. The national patient survey shows little improvement in this response over time. There is some way to go to make 'no decision about me without me' a reality."*

"Care is not properly planned around the patient's journey from home into hospital and back home with appropriate follow up care thereafter"

"Basic care tasks can be easily ignored"

"Staff do not get adequate training to cope with some groups of patients such as people with dementia"[7]

Jocelyn Cornwell's paper also highlighted that *"a large proportion of staff work in 'pseudo-teams'– in other words… having clearly defined tasks and clear objectives; meeting regularly to review objectives, methods and effectiveness; trusting each other; having a shared commitment to excellent patient care.* [8]

In several seminars participants highlighted the point that hospital may not be the best place to care for older frail patients. There are risks in improving the quality and patient experience within the current system when a more fundamental review of where and how care is delivered is required. Many participants recognised that while hospitals are now busier places with higher throughput, the way that personal care is provided to patients has not kept pace – new ways of organising care may be needed to reflect changes in medical practice.

The NHS is not short of initiatives designed to improve care. But it is not always good at sustaining them or building them into the mainstream pattern of work.

Participants and speakers also contributed ideas and good practice which they thought would help to improve the delivery of care and patient experience. They included:

- Putting in place arrangements at ward level for multi-disciplinary team meetings, ward rounds and handovers
- Linked to the point above, dedicated consultant leads for each ward would strengthen clinical leadership, particularly on general wards where patients may be cared for by doctors from many different specialties
- Ward accreditation systems that set out the standards and improvement targets that wards are expected to meet and strive towards

[7] See also Royal College of Psychiatrists (2010) Interim Report National Dementia Audit, that found that over 95% of hospitals do not have mandatory training in dementia awareness for all staff whose work is likely to bring them into contact with patients with dementia.

[8] Carter AJ, West M (1999). 'Sharing the burden: teamwork in health care settings' in Firth-Cozens J, Payne RL (eds), *Stress in Health Professionals*, pp 191–202. Chichester: Wiley.

- The harm free care programmes at University College London Hospitals NHS Foundation Trust and Great Ormond Street Hospital for Sick Children
- Having a zero tolerance approach where basic care standards are not met
- Real time patient feedback that can be acted on quickly. Bedside monitors at University Birmingham Hospitals NHS Foundation Trust for example have automatic triggers that provide feedback to appropriate staff e.g. to the catering department if patients are not happy with the food.
- Board performance agendas that start with patient experience measures rather than activity and finance.
- Patient stories discussed by the Board at the start of every meeting

Other contributions are noted in later sections of this paper.

While patient care is arguably more complex and risky than the retail sector, there are things that the NHS can learn from market leaders who excel in delivering great customer care. Some Trusts are already taking the opportunity to learn from retailers and organisations in the hospitality sector. From **Victoria Simpson,** Business Development Manager from The John Lewis Partnership, we heard that at John Lewis "*Truly great service combines both personal service and the right systems and processes designed to support the experience every time".* The systems are there to help ensure a consistent approach and brand yet staff have discretion to override these arrangements if necessary to deliver good customer service. Victoria noted that the processes they use are designed to be both simple and intuitive – processes that need detailed operational manuals are unlikely to work.

Victoria told us about how that organisation puts great emphasis on the happiness and wellbeing of its staff as it recognises that there is a clear link between staff satisfaction and customer experience. In routine staff surveys John Lewis ask a question that is similar to one included in the NHS staff survey – "would you be proud to recommend this store to your friends and family?". The responses are consistently over 95%. We heard from participants that the equivalent figure for the NHS is less than 50% and that for the Mid Staffordshire NHS Foundation Trust the figure during the period the Inquiry is looking at was around 26%. Participants noted that most NHS staff know when poor patient care is being delivered, although it may be easier for them to identify such shortcomings in other services or organisations than the one they work in. Regular local staff surveys can provide valuable insights to complement data that is directly sourced from patients. The broader point that this highlights is the need for Trusts to make sure that staff feel supported and valued in their work and help them make the connection with the impact that they have on patient experience and satisfaction.

TREATING PEOPLE WITH COMPASSION AND CARE

Safe and effective treatment is important but for patients it is also the manner in which they are treated that can make the difference between satisfaction and dissatisfaction: their personal care and the attitudes of staff.

Participants highlighted a number of factors that contribute to the lack of compassionate care. They included:

- Insufficient training for student nurses in basic care tasks (see section on nursing for more details)
- Staff who lack emotional intelligence – for example not appreciating the impact that their behaviour may have on others
- Job stress and the pace of work which inure staff to the needs and feelings of patients.
- Breakdowns in communication between patients, caregivers and carers
- Staff becoming inured to the distress of patients
- Caregivers making false assumptions about their patient's mental state or physical capabilities

Understanding the problem does not make it acceptable but it may help healthcare providers to put in place measures that can prevent these types of behaviours. Suggestions that participants made about how Trusts can encourage and support their staff to deliver compassionate care include the following:

- Experience based co-design – a method being developed by the NHS Institute for Innovation and Improvement that uses patient, carer and staff experience to design better healthcare
- Providing a sustained focus on employee satisfaction. A long standing CEO noted that his Trust conducts staff surveys monthly – far more regularly than the annual national survey, as the Trust recognises the connection between staff who are happy in their work and good patient care
- Regular measurement and reporting and feedback to wards
- Practical support for staff in dealing with the emotional stresses of patient care
- Recognition and reward for delivering compassionate care
- Leaders that are regularly out and about in the patient environment. Some Trusts for example, expect staff senior leaders such as finance directors who do not have a direct role in patient care to undertake a small number of bedside interviews or conversations with patients and carers as a way of connecting them to the Trusts' services.
- Specifying the behaviours expected of staff in the way that they interact with patients. Macmillan for example, has developed a set of behaviours required

from NHS staff if they are to adhere to the various human rights standards. Other Trusts such as South Tees Hospitals NHS Foundation Trust have used or adapted the NHS Code of Conduct for managers and look to embed this in staff employment contracts.

- Development initiatives that allow staff to see the delivery of care from the patient's viewpoint. This can be easier for people to assess when they see care being delivered in a place that is slightly removed from their own work environment.
- Recruiting people for their values. This goes beyond assessing whether people have the skills to do the job in question to looking at the level of fit between the attitudes and values of the individual against the demands of the job, the values of the organisation and the culture of the working environment. Assessment methods might include for example patient scenarios to test candidates' responses to poor quality care.

Jocelyn Cornwell described the Schwartz Rounds that the King's Fund Point of Care Programme is supporting in seven hospitals in England[9]. These are essentially facilitated lunchtime meetings designed to help staff discuss their feelings and emotional responses to the delivery of patient care. The evaluation to date shows that they are valued highly by those that take part and have the potential to improve the delivery of care. There are other ways in which Trusts may be able to achieve similar results. Jocelyn was clear that she felt the whole approach would lack credibility if it was centrally mandated e.g. by the Department of Health or the NHS Commissioning Board – "*Trust Boards have to own it and want to do it."*

LEARNING FROM FEEDBACK AND COMPLAINTS

Throughout the seminars participants made several references to the NHS Constitution and the need for it to be more embedded in the way the NHS operates and better understood by patients and the public. The Constitution reiterates the rights of patients to have "any complaint you make about the NHS dealt with efficiently and have it investigated properly".

The Constitution also contains some pledges:

"That the NHS will "ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment"

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[9] Joanna Goodrich and Jocelyn Cornwell (2011) The contribution of Schwartz Center Rounds® to hospital culture, paper for Mid Staffordshire NHS Public Inquiry Seminar on Organisational Culture

"When mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively"

"Ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services "

Robert Francis QC's first report on Mid Staffordshire highlighted problems with all three of these commitments.

Noting that these pledges continue to be a challenge for many other healthcare providers, participants also described some more specific issues concerning complaints and feedback.

- The NHS complaints system has been changed several times over the last decade and this does not encourage organisations to invest in their local systems to get their approach right. That said the current system may be too strongly oriented toward complaints, giving insufficient encouragement to patients to make neutral comments and suggestions. Several seminar participants described the fear that patients may have about being 'marked out' if they make a complaint.

- The legislation makes clear that all NHS and adult social care complaints, however handled within an organisation, need to be appropriately recorded - not least because complainants must be advised of the right to approach the relevant Ombudsman if not satisfied with the outcome locally. Even a verbal inquiry being handled by PALS, that is not resolved to the complainant's satisfaction by the next working day should therefore be recorded as a complaint, under regulation 8(1)(c) of the Clarification of the Complaints Regulations 2009. Accepting that, a speedy response to patient concerns is important. A number of people noted that the current standards requiring inquiries/comments to be resolved in 24 hours before the comment is redesignated a complaint may produce unintended consequences.

- Trusts continue to respond to patients in ways that people can find insulting. As one patient representative put it: *"responding to a complaint by saying 'this is what we are doing well' should be banned. It is shatteringly demoralising".*

- Trusts do not always have well developed processes for listening to and acting on staff concerns about poor patient care. **Victoria Simpson** described the approach to complaints taken by John Lewis termed 'first point resolution'. All staff are expected to develop universal skills in both preventing and managing complaints. Staff are trained to recognise the emotional responses that complaints can trigger in the client and the person to whom they are complaining – for both parties fear is a common response. The training given helps staff to both

empathise with the person making the complaint and take ownership of the situation to resolve it.

There are parts of the NHS where complaints and feedback are well handled and a number of examples of good practice were highlighted:

- Ensuring that the Board gives attention to complaints and the improvement cycle was mentioned by several people. *"In my view if you take the job of signing off complaints seriously then you should know about what's going on. When the CQC came in a couple of months ago, they found nothing we didn't know about and weren't dealing with. You know the main problems if you are connected to front line staff."* (Chief Executive cited in Nigel Edwards's paper)
- Brighton and Sussex University Hospitals NHS Trust has appointed a Patient Safety Ombudsman who acts as an "independent dispute resolution practitioner". Part of that service includes a 'Caring Café' where patients, carers and staff can talk to the Ombudsman over a cup of tea. A virtual caring café is also provided at patients' bedsides. When people are relaxed and have the opportunity to talk to someone independent of the Trust they can find it easier to share their experiences and concerns.
- Undertaking Root Cause Analysis. The National Patient Safety Agency diagnostic tool was also mentioned as a way of helping Trusts engage staff in understanding how safety or quality incidents have arisen and identifying potential solutions. Root cause analysis is also used by John Lewis to understand and solve customer service problems. **Dr David Rosser** described University Hospitals Birmingham NHS Foundation Trust's use of root cause analysis as part of the performance management process for clinical directorates.
- Having an independent director or a panel of trusted people to whom patients or staff can express comments or concerns.
- Raising the status of Patient Advice and Liaison Service (PALS) and complaints managers and ensuring that there are opportunities for them to move into other areas of healthcare management.

4. Organisational Culture

The role of NHS and organisational culture emerged as an issue in all seven seminars, not simply the event dedicated to that subject, and was a constant theme in the evidence heard during the Inquiry hearings. Particular themes drawn out by participants at the seminars were:

- What is culture and how does it impact on patient care?
- Establishing a culture of improvement

WHAT IS CULTURE AND HOW DOES IT IMPACT ON PATIENT CARE?

Anthony Sumara, who acted as a turnaround Chief Executive for the Mid Staffordshire NHS Foundation Trust, quoted Professor John Glasby in his presentation: "*The trouble with culture is everyone blames it when things go wrong but no-one really knows what it is or how to change it*". It was suggested that the frequent references to culture during the banking crisis provided a further demonstration of this observation. **Nigel Edwards's** paper went a little further "*While there is a general consensus that culture is one of the key variables in creating successful organisations and in generating continuous quality improvement, there is much less helpful material on what constitutes culture and even less on how to effectively change it."*[10]

A commonly used definition of organisational culture is *'the way we see and do things around here*'. It is part of an organisation's identity - *'who we are'*, *'what we stand for', 'what we do',* but it also encapsulates the beliefs, meanings, values, norms and language about how things are done. **Nigel Edwards's** paper and the interviews that he conducted with long standing Chief Executives remind us that culture is not a passive state of affairs - it is constantly reinforced and capable of being changed, either actively or passively. Trusts that tolerate poor care are effectively reinforcing the fact that this is acceptable.

Participants noted that incidents of poor quality patient care, particularly high profile cases such as Mid Staffordshire are often attributed to organisational culture. **Anthony Sumara** described a few of the early indicators that he noticed at Mid Staffordshire which exemplified the cultural problems that he needed to tackle. They included staff who did not smile and who were distracted from their work by their mobile phones, people who would walk past litter in a corridor and not pick it up (the tissue test), a shabby and dirty environment, and buzzers repeatedly rung by patients that were ignored by nurses.

Both presenters highlighted some of the cultural characteristics of failing NHS organisations that have been highlighted over the years by public inquiries and regulators' reports. These are shown in the box below (figure 4). Both concluded that there is an emerging consensus about these indicators but not enough proactive intervention to tackle problems when they arise.

[10] Nigel Edwards, Senior Fellow, The King's Fund & Ruth Lewis (2011), Balancing external requirements and a positive internal culture, paper for Mid Staffordshire Inquiry Culture Seminar

Figure 4: Cultural characteristics of failing NHS providers	
• A lack of explicit core values • A failure of leadership both corporate and individual • A high management churn • Poor accountability and governance • A lack of senior leadership visibility at ward and department level • A lack of openness (e.g. closed Board meetings) • Isolation and lack of engagement with wider NHS particularly at a clinical (network) level • Complaints dealt with as a process by middle management • A focus on process not outcome	• A failure to effectively engage clinicians • A lack of focus and/or a distraction • A poor relationship with local partners particularly commissioners • A sense of denial around poor performance • Executive Directors that stick with silo responsibilities • Overambitious or unrealistic goals • Weak financial management • Non-recurrent fixes rather than systemic solutions • Staff blamed and treated disproportionately when errors occur

A key theme from the seminars is that the prevailing culture in NHS Trusts influences the quality of patient care and experience both directly and indirectly. Yet despite the significance attributed to culture there is surprisingly little focus on measuring it. Moreover, hospitals are complex organisations that rarely exhibit a single set of cultural characteristics – there will be wards/services or even specialties where the prevailing culture, 'the way we do things round here', is at odds with the norms and behaviours expected by the corporate body. Trust performance information cannot always be relied on to highlight problem areas. Trust clinicians and managers may intuitively know that there is a problem in part of the organisation but lack evidence to pinpoint the nature of it. By failing to tackle it directly the Trust inadvertently sanctions and reinforces that behaviour as being acceptable.

Dr Maxine Conner, Head of Organisation Development at South Tees Hospitals NHS Foundation Trust explained the way such issues emerge and their net effects.[11]
"When team difficulties manifest they do so in a variety of ways, however in our experience, this has never directly manifested as a clinical quality issue, more typically it presents, in some way large or small, as an interpersonal difficulty. In its simplest form two individuals may struggle in their relationship and at its most complex whole teams have become involved in team dynamics which are stressful, unacceptable and present a risk to patient safety (Lamb 2004, Firth-Cozens 2004, Sexton et al 2000). Over the years we have had a number of clinical teams and clinicians who have needed support with such situations".

Maxine noted that in most Trusts staff know and talk about the problem areas. The difference between South Tees and many other parts of the NHS is that they have

[11] Dr Maxine Conner (2011) Dealing with the hidden side of organisational life: supporting teams and clinicians in difficulty

put in place mechanisms to listen to and act on that information: “What is clear is that people talk about what is happening, the grapevine, informal feedback and coffee shop conversations are often the first signals. Top teams must consider what they do with such intelligence”. Having identified teams that are experiencing tensions or relationship difficulties the Trust supports the team to confront the problems and to put in place remedial measures.

A key question that Robert Francis QC highlighted in his first independent inquiry of Mid Staffordshire NHS Foundation Trust was the extent to which the Trust’s culture was influenced or even determined by the policy context and performance management system in the wider NHS.

Nigel Edwards’s interviews with long standing Chief Executives in a number of different Trusts provided some interesting insights.

“I think that [this] Trust has been driven by external regulation and direction by a significant extent, but I don’t necessarily think that’s a bad thing. The Trust has a whole set of requirements it has to meet internally and externally and it has to be successful. It has to provide high quality services, and the regulations are focusing on Trusts providing high quality care. Not negative by any means, as it is helpful to focus on quality of care.” Chief Executive

“There are now two pages of nationally mandated targets, but the balance of context has changed, now much more quality and safety orientated, and you can’t argue with that”.

“What matters most is the quality of Board leadership and leadership in the wider organisation, that’s a cultural thing. Ultimately external focus is intermittent.”

Nigel concluded that whereas the number of external directives has waxed and waned the areas that are now monitored by external agencies are felt to be better aligned to Trusts’ own objectives, particularly around quality and patient experience. Nigel’s research which analysed the minutes of Board papers over a ten year period also revealed that quality, service reviews and patient experience appear to have increased in importance during that period. On these counts, at least, the policy context appears to be having a positive influence on NHS culture.

The Foundation Trust regime has encouraged Trusts to become more externally oriented and more competitive in their behaviour. Citing Russell Mannion’s research Nigel noted that “Boards in externally orientated organisations are more likely to be interested in performance information, management systems, process pathways and other mechanisms that create a more systematic way of working”. They are also

likely to be more competitive in comparing their performance with others. An external and competitive focus is not a bad thing in itself – it is the nature of that competition that is important in setting a positive culture for healthcare. Competition to offer best standards of medical care and safety could lead to improved care for patients, whereas competition focused on profit/surplus or organisational size might well have unintended consequences for the quality of care. The experience from Mid Staffordshire NHS Foundation Trust during the timescales for the Inquiry suggests that the Board was focused on the latter rather than the former.

ESTABLISHING A CULTURE OF IMPROVEMENT

What can NHS Trusts do to ensure that they set a positive culture that supports excellent patient care? This was a question addressed in several of the background papers and seminar discussions. Boards and Chief Executives are significant influences – their role is covered in the section on Trust leaders. Four further influences that were emphasised were:

- Staff engagement
- Positive relationships between clinicians and managers
- Open reporting of mistakes and errors and a just culture of proportionate responses
- Measuring the right things – this is considered more fully in the section on information

Staff engagement

High performing healthcare organisations that put quality and safety high on their agenda place a good deal of emphasis on getting staff actively engaged in this focus. In her paper on staff engagement in South Tees, **Dr Maxine Conner** argued that "*People who are engaged respond proactively, they don't wait to be told what to do; they know what must be done and get on with it. They are PROACTIVE in the face of opportunities, threats and challenges. When we are engaged we behave in a way which demonstrates personal initiative."*

Participants also noted that Trusts had to strike a balance between three things: a) engaging staff in the organisation's values and priorities, b) being clear about what behaviours the organisation expects and holding people to account for demonstrating them, and c) valuing and recognising staff contributions.

Relations between clinicians and managers

We heard from **Sir Cyril Chantler** about the reluctance that some doctors feel about being involved in management. "*It is not uncommon to hear doctors talk about 'the management' as if this was a separate part of the organisation in which they work or even a different species."* He argued that "*in a health system with finite resources, all clinicians, particularly doctors, have an ethical responsibility to be part of the management system, involved in decisions to ensure that resources are spent wisely. Doctors should also be managerially accountable for the resources that they use; profligacy in the treatment of one patient may be indirectly responsible for the denial of adequate resources to treat another. A failure to be involved in the management process risks clinical freedom being compromised as decisions will be taken by others, the consequences of which may not be in the best interests of patients."*

The importance of devolution of power to clinical divisions, increasingly run by doctors taking full managerial responsibility and supported by their own management team including finance and Human Resource support was also noted in **Nigel Edwards's** paper. Sir Cyril noted that one of the key problems that cause tension between doctors and managers is where there is a mismatch between responsibilities and accountabilities. "*Some NHS Trusts decentralise responsibility to clinical directorates or teams but then do not given them the financial or operational authority to manage effectively. Conversely there are also examples where clinicians are working in Trusts that have decentralised management arrangements and are reluctant to take on responsibility or accountability for their actions. A positive organisational culture is one where there is clarity and consistency in the way responsibility, authority and accountability are distributed and performed.*

Open reporting: just response

Over the past five years considerable efforts have been made in the NHS to encourage reporting of incidents and mistakes both within Trusts and to the National Patient Safety Agency. **Professor Sir Muir Gray's** paper however, notes that healthcare professionals have tended to be more interested in reporting patient safety problems and near misses than on reporting clinical errors that result in harm to patients.[12]

While there have been frequent exhortations for NHS organisations to establish a "no-blame" culture, which accepts that even the most experienced, knowledgeable, vigilant, and caring workers can make mistakes that could lead to patient harm,

[12] Muir Gray (2011) Report for the Mid-Staffordshire Inquiry led by Robert Francis QC on the benefits of knowledge management

participants were clear that this was neither feasible nor desirable. A more appropriate characteristic for the NHS is *a just culture*. NHS Trusts that demonstrate a just culture manage to create a reporting environment that encourages people to identify risks or admit mistakes when they have been made, and to learn from those situations while having well established systems of accountability.

Linked to this point several contributors supported the point made by **Anthony Sumara** that Trusts may need to demonstrate a 'zero tolerance' approach where required standards, behaviours or procedures are not adhered to, particularly those that are linked to harm free care. One example was a basic set of minimum standards for the basic personal care that all patients could expect to receive.

Dr Andrew Spurr, Managing Director Nuclear of EDF Energy, shared some of the ways that the nuclear industry encourages open reporting of errors and risks and emphasised similar points. The industry has a strong focus on safety and improvement which is reinforced by a culture where open reporting is expected, where there are clear responsibilities for the quality of systems and processes, and just and proportionate responses when things go wrong. It was also clear from the varied regulatory, internal and peer review mechanisms that the industry has in place a culture that is hungry for knowledge and improvement.[13]

In the seminar on commissioning participants discussed the proposed 'Duty of Candour' – a possible contractual requirement on NHS providers to be open with patients when things go wrong with their healthcare, currently the subject of a Department of Health consultation. Participants were not convinced that a contractual condition would be effective in changing Trust behaviour and highlighted other regulatory levers that could be used to encourage greater transparency: *"The duty of candour simply involves being honest with a patient. It's sad that you have to legislate when there should already be a culture of candour and honesty."*

The way that the NHS treats managers in situations where 'things go wrong' could be considered to be a touchstone of a just culture. **Nigel Edwards** pointed out in his paper that the NHS did not have a good track record of responding proportionately when dealing with Trust Chief Executives. "*My observation would be that the NHS has been very poor at being able to distinguish between the incompetent and the unlucky. There is a tendency to blame individuals for the failings of systems. It has also created a culture in which Chief Executives have had to guess which is the current "hanging offence" that they have to focus on. This and the general hazards of running complex organisations has led to a very high level of Chief Executive turnover*."

[13] Dr A Spurr (2011) The characteristics of effective and successful regulation in the nuclear industry, presentation to the Mid Staffordshire Public Inquiry seminar on regulation

The experience of an acute Trust Chief Executive interviewed for Nigel's research summarised the situation well: "*Fourteen people have worked for me who went on to be Chief Executives, of those, nine of which lost their jobs. The big danger period for Chief Executives has been in years 1-3*". **Dr Judith Smith and Professor Naomi Chambers**' paper on the regulation of managers in the NHS makes a similar point, citing research undertaken by the NHS Confederation in 2009[23] which described the 'top-down and directive style' of NHS management as a particular challenge and reported interviewees describing the environment in the NHS as *'brutal, arbitrary, prone to favouritism and intolerant of risk-taking that isn't successful' (p4).* Citing *S*ir David Nicholson's reported comment that the average tenure for an NHS Chief Executive was just seven hundred days Nigel concluded that "this has a chilling effect on the willingness of Chief Executives to take bold initiatives". Some participants suggested this situation discouraged risk taking and innovation. It was also felt by a number of delegates that this short period of tenure was also a major disincentive for leading medical staff to consider becoming chief executives.

The general consensus from the seminars was that the culture of NHS Trusts can be influenced in a positive or negative way by the external policy context and by the behaviour of commissioners, regulators and Ministers. The Secretary of State's mantra "No decision about me without me" is a positive message about the shifting balance of power between patients and clinicians. It could be balanced by more emphasis on the responsibility of Trusts and Commissioners to demonstrate harm free, safe and compassionate care which are equally important ingredients of patient experience.

The main determinant of whether an NHS Trust develops a culture in which quality, safety and patient experience are given top priority is not national policy or targets – it is how the organisation is led and managed that counts. Having a mission statement that says these things are important is not enough. An improvement culture is supported when there is an alignment between what the organisation says it believes in, the way its systems, processes and incentives operate, what it will not tolerate and how the Board is seen to behave. Culture in complex organisations such as hospitals is multifaceted: all Trusts have subcultures, both positive and negative. When organisations accept or tolerate poor practice or negative behaviours they effectively condone these characteristics. The more that Trust leaders embrace culture as something that they can help to steer, if not control, the better the chance they have of securing alignment between organisational goals and performance.

5. Trust Leadership and management

Seminar participants highlighted the following themes in relation to Trust leadership and management:

- The role of Trust leadership and governance in contributing to patient experience
- The contribution and development of NHS managers
- Whether there is a case for regulating NHS managers.

How Trust leadership and governance contributes to patient experience

The previous section of the report noted that Boards carry the ultimate responsibility for the quality of care provided by their organisation and for overall performance. Boards are also significant in influencing organisational culture.

In their paper on the role of Boards **Professor Naomi Chambers and Dr Judith Smith** [14] point out that there are three key tasks for NHS Boards: determining strategy (direction), assessing performance (control) and shaping organisational culture (values, rules, tone). They note that Boards tend to be best at monitoring, followed by setting direction and then contributing to culture. Perhaps the key message here is that Boards need to ensure that they pay explicit attention to culture rather than influencing it implicitly through what they choose to prioritise or not.

Nigel Edwards's interviews with chief executives and chairs highlighted that current NHS Boards are better equipped to understand their role than they were a decade ago and chief executives now expect more challenge from non-executive directors. However, he also cites a paper by the Institute of Chartered Secretaries and Administrators which conclude that there is still much more to do to strengthen governance and good practice of NHS Boards. The weaknesses that they highlight in the way Boards operate include:

- insufficient consideration and time given to strategy;
- insufficient appropriate challenge;
- too many items 'to note' rather than 'for decision';

[14] N Chambers and J Smith (2011) Briefing paper for the Mid Staffordshire NHS Foundation Trust Public Inquiry Seminar on development and training of Trust leaders: Issues in the training and development for effective boards in the NHS

- scope to improve the amount of time dedicated to clinical quality issues; and
- acquisition and use of information on clinical quality did not appear to be robust.

The point about the Board's willingness and competence to challenge on issues of clinical quality was a theme that emerged in several seminar discussions and is considered more fully in the section on information. Having a larger proportion of Board members with a clinical background was noted by some contributors as having a positive effect on the quality of Board discussions on quality, safety and patient experience.

A recent exploratory study (Chambers et al, 2011) examined the characteristics of high performing organisations and distinguishing features of their boards in the NHS, using a combination of measures, including staff and patient perspectives, clinical and financial performance and this may offer some insights into the contribution that Boards can make to great patient care. The research demonstrated a positive link was found between high performing organisations and:

- CEOs being in post for longer than 4 years
- Higher number of women on their Boards
- Greater contribution of non executive directors at Board meetings
- Dominance of specialist/tertiary Trusts over other types of organisations

Professor Chambers also noted there was evidence that the relationships between the CEO and the chair are of significant importance in ensuring effective Board working. Anna Walker, former Chief Executive of the Healthcare Commission recalled that it was not uncommon for the regulator to find that failing organisations had poor relationships and divided views between Board members as well as between managers and clinicians and other senior leaders.

There was interest in the potential contribution of an executive independent director - a role that **Dr Andrew Spurr** had highlighted as an interesting development in the nuclear industry. This director has an overall responsibility for quality and safety and is required to go outside the Board infrastructure and raise concerns directly with the Chairman of the company if the organisation has not dealt with the matter sufficiently well.

Effective Boards invest in the development of their members but also in their collective development. **Professor Naomi Chambers** highlighted that while there has been comparatively good developmental support for non-executives, executive directors moving into Board level jobs are not always well prepared for this new element to their role – a point that was echoed by participants in the seminar on

nursing. While there was an acknowledgement that Board development was important there has been "no research into the scope and effectiveness of different tools for Board diagnostics, assessment and development".

The North Western Leadership Academy's offerings for Board development linked to patient care and experience was mentioned by several contributors. The Patient Safety Ambassadors programme run by Dr. Robinah Shah, Chair of Stockport NHS Foundation Trust was one example. A second highlighted by **Julian Hartley**, Chief Executive of South Manchester University Hospital NHS Foundation Trust was a programme run by the US Institute of Health Improvement for whole Boards which provided a common frame of reference for the Board's ongoing work on patient safety and experience. There were mixed views about whether the demise of SHAs and the Appointments Commission would make it more difficult for Boards to access these types of examples of practical and applied Board development.

THE CONTRIBUTION AND DEVELOPMENT OF NHS MANAGERS

Seminar participants accepted that the public want and expect managers to do the right things, and the situation at Mid Staffordshire NHS Foundation Trust and other recent high profile cases of poor patient care dent public confidence in NHS managers.

The seminar on Trust leaders considered what could be done to improve the quality and consistency of NHS managers. **Dr Judith Smith and Professor Naomi Chambers'** paper[15] highlighted characteristics of NHS managers. *"The NHS has a strong tradition of recruiting its senior managers from within the health service (which is undoubtedly one reason for its relative lack of diversity of background and experience), and of being relatively agnostic about the specific nature of their academic background, leading to a focus on lay, rather than professional (in terms of accredited training) managers*. *A competency (rather than formal qualification) basis for NHS leadership has been developed and applied to chief executive (and other managerial) recruitment[16], including elements such as political acumen, emotional intelligence, and setting direction. This has recently been updated as part of the work of the NHS Leadership Council*.[17] "

Karen Lynas's paper[18] also referred to the competency based framework which underpins much of the leadership development work undertaken by the NHS

[15] Judith Smith and Naomi Chambers (2011) The regulation and development of NHS managers: a discussion paper for the Mid Staffordshire Public Inquiry Seminar

[16] NHS Leadership Centre (2002) NHS Leadership Qualities Framework, London, NHS Modernisation Agency

[17] Department of Health (2011) Leadership Framework for the NHS. Http://www.nhsleadership.org.uk/framework.asp (accessed 9 October 2011)

[18] K Lynas (2011) The Development and Training of Trust Leaders, Seminar Paper

Leadership Academy as well as development initiatives offered by universities and commercial companies. Karen noted that the framework is not mandatory and some Trusts develop their own set of competencies for senior clinicians and managers. So there is no national framework in place that would ensure a consistent set of skills and competencies required of NHS managers and the education and training that managers should have for their role. We also heard from **Karen Lynas** that "*It remains a matter of geography and opportunity the extent to which training is available, encouraged or required".*

Despite this variation there is a remarkable level of consistency in the leadership styles of the NHS's Top Leaders. Karen's paper cites the results of a set of diagnostic tools undertaken by the Hay Group which found that of the six styles of leadership 69% of leaders had 'pacesetting' as their predominant style and over half of them had no other strong style to draw on. "*Pacesetting is an excellent style for driving up standards and/ or creating a rapid short term improvement from teams and services… Pacesetting is a style which does not develop others; encourage them to take accountability for their actions or create a focus on a broader strategy beyond the tasks in hand*"…..*It is ideal in turnaround situations*. Earlier this paper highlighted the importance of staff engagement as a characteristic of high performing organisations that are focused on quality improvement. The pacesetting style would not appear to be a necessarily helpful approach to building a culture of engagement. This raises a significant question: why has the NHS not been more successful at recruiting or developing leaders with more diverse leadership styles and behaviours, particularly those that are known to be linked to the type of organisational culture that promotes sustainable improvements?

There was little support for mandated training delivered by a single provider for all NHS managers. There have been attempts to introduce this in the past - the NHS Training Agency and the NHS University for example, which have had limited success. Participants noted that there was a relatively competitive market for the delivery of management development and felt that this had helped to improve the quality of the development on offer. The following issues were identified as more pressing problems:

- ***People in their first line management roles***, such as ward managers and particularly people from clinical backgrounds, are not always given sufficient development and support and of the right nature. Yet these posts have a crucial connection to the delivery of good patient care. **Dr Maxine Conner** from South Tees Hospitals NHS Foundation Trust explained the importance of preparing nurses in these important roles to make the bridge between the realities of the job and their initial expectations of what it entails by helping them to understand their motivations for moving into a management position. Providing protected

time for learning and development, making ward manager posts supernumery and encouraging ward managers to concentrate on a limited set of very specific delivery and improvement objectives were further factors that participants mentioned as ways of supporting people in these important roles. Participants warned that the current resource outlook meant that some Trusts are reducing the working hours of ward managers and cutting back on their support.

- ***Executive directors, including Chief Executives in their first CEO post***, are not always fully prepared for the responsibilities that they take on. Some felt that the personal accountability of directors warranted tighter controls but there were different views about the form that this should take - a fit and proper person test, specific education requirements and a consistent set of competencies were suggested options.
- The importance of senior leaders having ***a network of informal support***, in the form of peers and mentors, was noted. The support of other senior leaders in the local community was also highlighted. The NHS Leadership Academy is supporting the latter through the Place Based Leadership initiative. Participants in the nursing seminar suggested that the loss of regional Chief Nurse roles may make it more difficult for senior nurses to access this support in the future.
- ***Opportunities to share leadership and management development tools and approaches***. Leadership and management development specialists in NHS Trusts both provide and commission developmental support, yet there have been few mechanisms for them to share their products, approaches and tools. We heard from **Karen Lynas** that this is something that the new NHS Leadership Academy plans to address.
- ***Ongoing investment in training and development***. At a time when healthcare resources are coming under increasing pressure, cutting investment in education and training can be an easy target. Some experienced Trust CEOs noted that they took a hard line with clinical directorates that tried to cut training and development in order to meet their cost improvement targets. There was some discussion about whether Trusts would find it easier to protect training and development if there were more robust measures of the return on investment. **Karen Lynas** noted that there is little evidence to suggest that Return on Investment measures drive education and training investment in the commercial sector –"there is a gut feel that the investment makes a difference". There was little support from participants for more investment in the evaluation of training and development as it was felt that this could limit the resources available for delivery even further. Participants warned that while there is already variation in the availability and accessibility of training and development across the NHS, the current resource situation could well exacerbate the situation.

REGULATION OF NHS MANAGERS

In his first independent inquiry Robert Francis QC recommended the development of a regulatory and accreditation scheme for senior NHS managers that mirrors those in place for clinicians and nursing staff. This proposal was explored in the seminar on Trust leaders. A similar conclusion was reached following the Bristol Inquiry which recommended that 'senior managers in the NHS should be subject to Continuing Professional Development, periodic appraisal and revalidation', with professional codes of conduct to be written into employment contracts. Following that recommendation a code of conduct for NHS managers was introduced in 2002. The principles set out in this code were:

- *To make the care and safety of patients one's first concern and to act to protect them from risk;*
- *To respect the public, patients, relatives and carers, NHS staff and partners in other agencies;*
- *To be honest and act with integrity*
- *To accept responsibility for one's own work and the proper performance of the people managed;*
- *To show commitment by working as a team member*
- *To take responsibility for one's own learning and development*

There are parallels between these requirements and the GMC's Duties of a Doctor.

Dr Judith Smith and Professor Naomi Chambers note that "*The current NHS Code of Conduct for Managers does not appear to have been applied and used in a consistent manner*".[19]Participants confirmed that the situation is variable – some do not use the code of conduct, others have included it within manager's contracts of employment and some such as South Tees Hospitals NHS Foundation Trust have adapted the code for local use by adding more specific indicators of required and unacceptable behaviours. There was support from participants for more research to understand how the code has or could be used as a stronger lever to improve the quality and consistency of management conduct in the NHS.

The issue of management performance causing public and professional concern was reviewed in 2008 by a group chaired by Ian Dalton, commissioned by the Department of Health (DH) in response to the Darzi Next Stage Review. The review noted the difference between generic and professional managers, concluding that generic managers are rarely accredited or regulated in any sector, regulatory systems in other sectors and countries being primarily focused on professions such as lawyers and accountants. The Dalton report set out ten recommendations

[19] Judith Smith and Naomi Chambers (2011) The regulation and development of NHS managers: a discussion paper for the Mid Staffordshire Public Inquiry Seminar

designed to provide effective assurance of the quality of senior managers. These ranged from replacing the Code of Conduct with a new statement of professional ethics embedded in all employment contracts and reinforced through the Operating Framework; a set of standards for the expected skills and competencies expected of good senior NHS managers and a system of independent and voluntary accreditation led by the National Leadership Council.

In reviewing the arguments for and against the regulation of NHS managers **Dr Judith Smith and Professor Naomi Chambers** summarised the mood of participants well: *"There seems to be consensus in most quarters about the value of enhancing recruitment and vetting processes for NHS management, reinforcing the code of conduct for managers and addressing further the corporate governance of NHS bodies. It is in the area of moving to formal registration, accreditation and regulation of managers that disagreement emerges."*[20]

The term regulation means different things to different people so it was perhaps not surprising that the question of formal regulation and accreditation triggered a healthy debate. A minority of participants felt *'all NHS professionals should be regulated'.* While all participants accepted that action needed to be taken to promote public confidence in NHS management through the improvement of management performance, the majority (including those from regulatory bodies) were not in favour of management regulation if it meant mandatory registration of NHS managers based on the prescription of essential qualifications. They felt that this could deter clinicians from taking on management positions and might add costs to the system without commensurate benefits for patients. While regulation might improve public confidence there was no guarantee that it would improve performance – training, development and informal support were felt to be equally if not more important contributions. Most were wary that formal regulation could be a '*sledgehammer to crack a nut'.* Some also noted that there had been previous attempts to regulate NHS managers which had not proved to be sustainable – the Institute of Health Services Managers for example in the past acted as an awarding body for the Diploma in Health Services Management. There are now multiple qualification routes for NHS managers, including applied MBAs.

A further point was that the requirement to open up some NHS care to 'any willing provider' meant that some services will be delivered by independent and third sector organisations. Any proposals to regulate NHS managers would need to take account of this context. Tight requirements on the management backgrounds of people in third sector organisations or social enterprises could limit their ability to bring innovative and nimble solutions to the delivery of better care for patients.

[20] Ibid

One area that participants felt did need strengthening was in preventing situations where managers have been found to put patient safety at risk only to be re-employed later somewhere else in the system. Such practices do little to gain public confidence in NHS managers. Employers are already required to meet a set of standards concerning the checks they undertake when employing staff and these provide Trusts with some safeguards. There are arrangements whereby NHS employers can submit alert notices to make other bodies aware that a healthcare professional may pose a threat to patients or staff, encouraging prospective employers to undertake thorough checks of the applicant's employment record and references. No such arrangement exists for managers but there may be a case for setting up such a system and/or a more formal test of 'fit and proper person' for Board directors.

6. Nursing

Dr Peter Carter, General Secretary and Chief Executive of the Royal College of Nurses reminded us that the vast majority of patients – patient surveys confirm well over 90% - are highly satisfied with the care they receive, but that still equates to more than 80,000 people a year who have less positive experiences of the care they receive. Poor quality nursing care and nurse leadership were highlighted in Robert Francis QC's first report on Mid Staffordshire. Professor **Katherine Fenton**, Chief Nurse at University College London Hospitals NHS Foundation Trust reminded us that similar issues have been identified in other high profile cases of poor patient care.

Healthcare is a multi-professional service but nurses have a very important role in the delivery process. As Katherine's presentation reminded us "*The fundamental role of the nurse and midwife is to be accountable for providing and overseeing total patient care"*[21]*.* Citing Albert Einstein's definition of insanity as *'doing the same thing over and over again and expecting different results'* Katherine argued that some fundamental changes need to be made in the leadership, development and standing of nurses if the NHS is to avoid a repetition of these high profile and unacceptable examples of poor care.

The seminars explored four different aspects of nursing that might warrant a change in approach:

- Training and development of nurses
- The standing of nurses in NHS organisations and their influence

[21] K Fenton (2011) Presentation to the Forward Look Nursing Seminar, 31st October

- Staffing levels
- Whether healthcare assistants should be regulated.

TRAINING AND DEVELOPMENT

In order to become a registered nurse, and work as such in the NHS, nurses must undertake a university degree or diploma that has been approved by the Nursing and Midwifery Council (NMC). The courses have a 50:50 split, balancing learning in university with practical, supervised patient care in a healthcare setting. Participants acknowledged that an academic programme and the ability to provide great care for patients are not mutually exclusive. **Katherine Fenton** argued that in order to deliver great care nurses need to be capable of being clinical decision makers that can practice autonomously and these qualities justify the focus on academic ability in the curriculum.

We heard from the NMC that *"teaching in universities is focusing on the right things – it is the quality of practical experience that needs to be addressed*". This point was something that many participants echoed. There appear to be several contributing factors. One is that student nurses are not always well prepared to undertake the practical aspects of patient care. Participants cited examples where student nurses had been instructed to undertake basic care tasks for patients but not shown precisely how to do it. They noted that Trusts should not assume that students know how to care or what is expected of them – they need to be shown how to do it properly. A second issue is that student nurses do not always see the whole care experience. As one participant put it *'They need to see the whole patient process from start to finish so they see what it's like for the patient if they are discharged on a Friday afternoon to an empty house, with no-one to check on them until Monday morning. We have examples like that and the nurses say it never occurred to them to ask about what happens at home".* A further factor highlighted was that qualified staff either do not always have sufficient time to teach and support student nurses or do not appreciate that teaching students is part of their role. Participants agreed with **Katherine Fenton's** analysis that while attrition rates in nurse education were comparatively high, Trusts and universities can feel under pressure to pass students who do not really match up to the standards that they are expected to achieve.

Several suggestions were made to improve the practical therapeutic and caring skills of nurses during the training period:

- Universities and Trusts needed to establish closer connections so that they can plan the combination of academic and practical work more effectively. They should consider re-establishing the role of clinical tutors who are responsible for the teaching of practical nursing skills.

- Trusts and universities should agree what is required from clinical placements, ensuring that there is a structured programme that helps student nurses in developing practical skills including giving them specific tasks in communicating with patients.
- Trusts should pay greater attention to the support offered to nurses in the preceptorship phase of their careers so that any gaps in skills and knowledge can be addressed.
- Professor **Katherine Fenton** argued that the final exam that nurses undertake should be standardised.

In addition to these points several participants argued for the inclusion of data analysis and improvement science in the nurse curriculum as these elements are assuming greater importance in the way healthcare is planned and delivered.

Professor Fenton made some wider recommendations for changes to nurse training and development. She suggested that the profession would benefit from having nationally recognised professional, clinical and academic benchmarks at each stage of clinical career development as well as more joint clinical and academic appointments.

THE STANDING OF NURSES AND THEIR INFLUENCE

Two issues concerning nurse leadership emerged during the seminars. The first was whether nurse leaders are properly developed and supported. Participants noted that there are no required competencies for Board level nurses – this is a matter for individual Trust appointments. Nevertheless some felt that there were too many examples of nurses entering these senior posts without sufficient preparation and insufficient attention paid to succession planning. Some were concerned that this situation could worsen without the role of the Strategic Health Authority Chief Nurse.

The second concerned the position that nurses occupy within the wider leadership arrangements in Trusts.

Participants highlighted a range of experiences in their roles as nurse leaders:

"Like a voice crying in the wilderness"

"Learned helplessness"

"Nursing has a low priority at Board level"

"It can be a lonely place"

"I have the support of my medical directors and CEO – it's a team effort so I don't feel lonely at all"

There is clearly a mixed picture. Participants suggested several factors that can enhance the standing and influence of nurses in NHS Trusts. They included:

- A supportive Chief Executive
- The promotion of positive and influential role models by the profession generally
- More structured career trajectories for nurses
- Having Boards with a larger percentage of people with clinical backgrounds, including non-executive directors
- Clinical assurance measures that can help nurses to highlight problems and improvements

NURSE STAFFING

Staffing levels were identified as a problem at Mid Staffordshire NHS Foundation Trust and participants suggested this may also be a factor in other NHS organisations which affects their ability to deliver high quality care for patients.

The seminar on nursing discussed the process of setting standards for nurse staffing levels. **Dawn Dowding**, Professor of Applied Health Research at the University of Leeds[22] shared evidence that nurse staffing levels have changed over the past three years and that wards for the care of older people have some of the highest ratios of patients to qualified nursing staff and total staff – nearly 11 patients to 1 nurse. This level of staffing she felt needed attention.

Participants discussed whether setting minimum standards for nursing might improve current levels – such an approach exists in California although it has not demonstrably improved patient care. On balance participants felt minimum standards were a last resort and could have unintended consequences – a minimum can become a ceiling.

There are many different methods for establishing nurse staffing levels so it can be difficult for Boards to know whether resources that they have in their organisations make for safe/unsafe care. There was broad agreement that it is too simplistic to expect a single answer to the question "how many nurses do we need?" The more important question is whether nurses are doing the right things that add value to caring for patients. As one Chief Nurse put it *"when we looked at our staffing in some wards we have invested in more and in some we have shifted some of our nursing*

[22] D. Dowding (2011) Establishing Effective Staffing Levels: presentation to the Mid Staffordshire Forward Look Seminar on nursing

resources to provide better administration support". The Nursing and Midwifery Council (NMC) and others noted that Mid Staffordshire NHS Foundation Trust had experienced difficulties in nurse staffing but they had not been an outlier compared with other Trusts.

Participants also considered whether the standards set by the Royal College of Nursing are sufficiently influential, and specifically whether having an independent Royal College dedicated to setting and monitoring standards in the way medical Royal Colleges do, would make a difference. One of the more compelling arguments was that the size and diversity of the nursing profession militates against a single standard setting body. In the medical profession for example there are different colleges for each medical specialty and faculties for sub-specialties. **Katherine Fenton** described the dilemma further. On the one hand as a Regional Nurse she had found the RCN in its trade union role helpful in highlighting issues where Trust management decisions were affecting the quality of nursing practice. On the other hand, she noted that there was a danger that employers can too easily dismiss RCN reports on standards because of their trade union associations.

On a more practical note, some participants observed that a split in the roles of the RCN may not be supported by nurses, who may only be prepared to pay for one representative body and a body that protects them as employees would be valued more highly than one that sets professional standards.

There was agreement that the current position was not ideal but no consensus about the best way forward. Some argued that having a set of defined standards for nursing might not have helped prevent the situation at Mid Staffordshire NHS Foundation Trust. On a practical note some participants suggested that the RCN could do more to engage a broader base of stakeholders in the way that it researches and sets standards. For example, there have been several instances of joint work between the RCN and the medical Royal Colleges and regulators which has proved helpful and influential.

Concluding the discussion, participants noted that at a minimum all Trust Boards should expect their nurse directors to have a specific methodology which they used to plan nurse staffing which links numbers to patient acuity. Boards should also have a range of quality and safety indicators so that they can understand potential linkages between resource inputs and patient outcomes.

THE REGULATION OF HEALTHCARE ASSISTANTS

There are rising numbers of healthcare assistants or clinical support staff. We heard from Dr Peter Carter from the RCN that "*We are approaching a position when their numbers will equal or exceed the number of nurses*." Unregistered staff carry out a

wide range of patient care tasks such as personal care (washing and dressing), feeding, communicating with patients as well as more specialised tasks such as recording observations or vital signs and carrying out some procedures. The precise nature of their work varies from Trust to Trust and there are different names given to these varied roles. A participant from Unison suggested that there are over 100 different job titles used across NHS and care organisations for these roles. She noted that there is *"no consistency in what unregistered care staff do, what they are expected to do or training to underpin their roles*.

While this situation provides employers with flexibility it also presents some difficulties. Patient participants noted *"It is confusing for patients - we don't know which people are nurses and what we can expect of different staff*." A second issue is that the delegation of clinical tasks to unregistered clinical support staff or healthcare assistants is not always taken as seriously as it should be. Both nursing and patient participants described examples where clinical support staff had been given too much responsibility or asked to undertake tasks that should only be performed by a qualified and registered health professional.

There was broad agreement that the current position concerning the position of unregistered healthcare workers provides insufficient safeguards for patients and limits the career options available to this increasingly important section of the workforce. From this point on opinion was split. The Nursing and Midwifery Council (NMC) were one of the first to note the limitations of regulation in safeguarding the quality of patient care. They pointed out that Mid Staffordshire NHS Foundation Trust had not given them any cause for concern at the time as they had had very few referrals to investigate the conduct of registered professionals employed by that Trust. Others argued that the NMC's code of conduct for nurses and midwives already places explicit duties on nurses and midwives concerning the delegation of tasks to non-registered staff and this should be more rigorously pursued. It was suggested that the NMC could give clearer traffic light guidance about the tasks that are generally suitable for delegation (green), those that can be safely delegated with proper supervision (amber) and those that should not be delegated under any circumstances (red).

A different view was presented by Gail Adams from Unison. She noted that healthcare assistants (HCAs) want to be regulated because it would mean that they would have a set of acknowledged skills, transferrable between employers, which indicate recognition of their role and contribution and provide the basis for ongoing professional development.

In her presentation **Gill Heaton**, [23] Chief Nurse/Deputy Chief Executive Central Manchester University Hospitals NHS Foundation Trust outlined the structured programme of requirements and development used in the employment of non-registered clinical support workers in her Trust. While supportive of greater consistency in job titles, national competencies for different roles and even accredited training for those competencies Gill argued that full registration would limit the flexibility of Trusts to manage their workforce. She suggested that, at a time when healthcare delivery is being opened up to a diverse mix of healthcare providers, flexibility was important, provided that healthcare providers had the right assurance systems in place to safeguard quality and outcomes for patients.

Some participants noted that Skills for Health has developed a bank of competencies which are used as part of the National Occupational Standards programme and by individual NHS employers in defining the job and person specifications for healthcare support staff. Either Skills for Health or NHS Employers would be well placed to lead further work on establishing greater consistency in the job titles for unregistered staff and for helping employers make better use of these resources.

Mid Staffordshire NHS Foundation Trust and other examples of poor care by NHS organisations continue to rock public confidence in the nursing profession as well as in NHS managers. As one contributor put it *"We are no longer the angels. And it's not enough to be nice but not very good at patient care".*

Participants felt that turning this situation around would require ownership of the situation at all levels of the NHS but it is chiefly nursing professionals and doctors that will make the biggest difference to public confidence. This would need a broad range of actions – changes to training and development, ward managers that have adequate time for clinical supervision, the development of clinicians in leadership positions, and measures that enable quality of care to be understood and assured from ward to Board. For the profession as a whole participants concluded that nurse leaders and the RCN could do more to promote role models that illustrated both the diversity of opportunities in nursing and the positive and rewarding aspects of their role in caring for patients.

[23] Gill Heaton (2011) The Regulation and Training of Healthcare Assistants, presentation to Mid Staffordshire forward look seminar on nursing

7. Information

Seminar participants observed that is had become commonplace in the NHS to hear clinicians and managers complain that they do not have the right information in the right format and at the right time to do their jobs effectively. They felt it was equally the case that staff frequently complain that the data they collect is of little use or value. Mid Staffordshire NHS Foundation Trust had had data on comparative mortality rates and chosen to ignore it, preferring to challenge the details of the indicator rather than look at their performance. It was thought that these apparent contradictions had been part of NHS culture for many years. The seminars looked at how this situation is changing and could be changed further to improve patient care. Two elements were explored:

- Using information to improve quality, safety and patient experience
- How healthcare organisations can establish a stronger culture of using information to drive performance improvements

USING INFORMATION TO IMPROVE QUALITY, SAFETY AND PATIENT EXPERIENCE

Robin Burgess, Chief Executive of the Health Quality Improvement Partnership summarised the current position in his paper: *"Overall in the NHS too much data is collected which is simply process data which neither drives change nor improves outcomes. It is not embedded in change programmes or systems which enable it to be used meaningfully to drive change activity; it's just data. This includes HES and a lot of QOF data, which simply record processes that have taken place."*[24]

It was suggested that all healthcare information needed to be collected for a purpose; on its own, without incorporation in *systems* which ensure it is used actively to drive practice, or in the wrong hands, it is often meaningless. Participants supported the review that the Information Centre is undertaking on central returns and hoped that could reduce the information collection burden on NHS Trusts. **Professor Sir Muir Gray's** paper supported this point but went further arguing that the NHS needs to move from a focus on data collection to knowledge and knowledge management. He argued that healthcare organisations should not only make use of explicit knowledge such as the results from research, audit and information collected about clinical activities, they should also make use of tacit knowledge of 'know how' that clinicians and indeed patients have about how to deliver good care.[25] The

[24] R. Burgess (2011) How can information be better used within the NHS, paper to the Mid Staffordshire forward look seminar on information.
[25] Muir Gray (2011) Report for the Mid Staffordshire Public Inquiry on Knowledge Management

importance of valuing qualitative information as well as quantitative measures was emphasised by several commentators.

In the information seminar we heard two contrasting case studies from two Trusts that have invested heavily in information collection, analysis and use – Great Ormond Street Hospital for Sick Children (GOSH) and University Hospitals Birmingham NHS Foundation Trust (UHBT). The systems that they have developed differ but they share some common characteristics. These were summarised by **Professor Martin Elliot**, Medical Director at GOSH, who highlighted four linked components which need to be in place to enable information to drive quality improvement. **Dr David Rosser,** Medical Director at UBHT, produced a similar list.

- The data has to be **complete**
- The data has to be **valid and accurately coded**. This requires common standards and definitions so that Trusts can compare data both internally and externally with peers. While some specialties have agreed standard definitions, in other cases the position is more variable. The responsibility then falls to Trusts to ensure that data standards are agreed locally by clinicians.
- Data has to be **relevant to the quality of care delivered to patients** – if possible the data should be collected at the point of care
- Data has to be **useful to the recipient** – getting clinicians involved in defining the indicators and analysis to be done helps ensure that the information is used to drive performance improvement. This point was emphasised by **Dr Rosser** who noted that at UBHT the clinicians and managers who access the aggregated performance information regularly are more likely to have a well performing service than those who use the system rarely.

Both GOSH and UBHT were clear that information cannot be delivered to the teams providing care in a sufficiently accurate and timely way to drive change using paper based systems.

The UBHT system goes further than measuring and monitoring care by providing a mechanism for decisions. The box below gives a flavour of the complexity and value of the system.

Figure 5: Using information to reduce errors and improve quality

Real time clinical decision support is the central plank of the error management strategy. At UHB this is delivered by the in-house Prescribing, Information and Communication system (PICS)1, a clinical decision support system which supports clinicians in the management of a wide range of activities including all inpatient drug prescribing and administration, laboratory investigation requesting and interpretation and clinical observations. The system has over 4,000 registered users, manages 25,000 new prescriptions and 125,000 drug administration events a week. It has been in use in the Trust for over 10 years, has fully covered all inpatients for around 5 years and has just been implemented in outpatients.

Decision support is delivered by the generation of tiered, context specific warnings to users at the point at which actions (e.g. a new prescription) are initiated, or by the system initiating context specific actions. They can be related to any data, combination of data, or rate of change of data within the system. The rule base which the system uses to generate these warnings currently holds over 16,000 separate rules, most of which are specialty specific and managed by the specialty clinicians.

The UBHT system has

- Automatic emails that are triggered and sent to the appropriate clinician/manager
- Escalated emails if different quality thresholds are reached
- A dashboard display system allowing trends to be tracked

Dr Rosser explains that by concentrating on reducing errors the Trust has been able to reduce mortality rates within 30 days for patients admitted as an emergency and undergoing a procedure compared with peers in the rest of acute Trusts in England by 16.9% over a 12 month period. But he also emphasised how important it was for Trusts to concentrate on errors rather than mortality rates per se. Reducing errors makes a significant contribution to both patient experience and better outcomes:

"We believe that the fall in mortality seen at UHB represents the mirror image of the problems at Mid Staffs. At Mid Staffs there were multiple reports of episodes of care which were clearly substandard but relatively few episodes where single disastrous errors can be shown to have led directly to a patient death, despite the strong suspicion of a higher than necessary death rate. At UHB we have seen a significant reduction in errors temporally associated with a reduction in mortality, although few, if any, of the sort of errors which have been prevented would have directly caused death. We can no more identify those 100 patients per year whose deaths appear to have been avoided at UHB than we can the potentially avoidable deaths at Mid Staffs."

The case studies and discussions highlighted two further ways in which good clinical information supports improved service quality. **Professor Martin Elliot** pointed to the role that data presentation can play in improving the understanding and use of information by both clinicians and by patients. He argued that this is undervalued in the healthcare sector. Both the GOSH and UBHT information systems are visually compelling, displaying information in a way that makes it easy for clinicians to understand how they should respond. Participants highlighted that this was also important for the performance reports that are presented to Trust Boards.

The second method is through benchmarking clinical performance internally and externally. While GOSH benchmark their performance against the Cincinnati Children's Hospital, **Professor Elliot** was clear that all Trusts, not only teaching hospitals, should be expected to compare their clinical performance with others as a tool for learning improvement.

It is not only clinicians that need data to drive quality improvement. Trust Boards and regulators use information to oversee organisational performance. To do so they need to understand the robustness and reliability of the data that they are presented with, particularly if that data comes from external sources. **Dr Peter Homa** described a kite marking system that the Board of Nottingham University Hospitals Trust uses to assure itself about the validity of the information they are considering. This includes an overall assessment from the relevant Executive Director about the validity of the data as an indicator of Trust performance.

AN INFORMATION CULTURE

The previous section outlined ways in which healthcare providers can collect and use information to drive performance improvements and reduce errors. In several seminars participants noted that many parts of the NHS still do not have a strong enough information culture that encourages people to use and improve the information that is available. **Professor Sir Muir Gray** summed up the problem as follows:

> *"The inability of many physicians, patients, journalists, and politicians alike to understand what health statistics mean - often without recognising their inability – has been called collective statistical illiteracy*"

Participants highlighted several barriers that need to be overcome:

- Board members are not always skilled or confident enough to question or challenge clinical data
- Similarly patients and the public do not always have technical mastery to provide external challenge. In some cases people can find it difficult to actually find information on the performance of local services. A recent study by NHS Choices

confirmed that even people who use that website can be unaware of how to get comparative information on local services. Education on quality improvement is extremely limited in all disciplines – in medicine, nursing and in management. There are more programmes available for clinicians and managers as part of their continuing professional development but improvement science is not yet part of basic training. **Robin Burgess** also highlighted that teaching of audit skills, conducted at Foundation Year 1 and 2 levels for doctors, is not always carried out well. It is important that clinicians understand the value of data driven scientific methods of quality improvement through their training and can then apply these methods in practice.

- Clinicians do not always 'own' the data they collect and so do not have a stake in ensuring quality
- Lack of capacity invested in data analysis to provide meaningful information to inform clinical practice and performance monitoring and improvement.

Clinically relevant and clinically led electronic data collection information systems such as described above can help to encourage a culture of information use but they are unlikely to be sufficient in themselves as **Dr Rosser** readily pointed out. The error reduction and mortality improvements achieved by his Trust are not only the product of a sophisticated information system; they are backed by a strong performance management system in which clinicians are held to account for the recording of data and its use: "*there are huge benefits from advanced IT systems, but it must be understood that their benefits will inevitably be limited without the cultural change to personal responsibility and accountability".*

We heard several references to the need for an information culture that spans "the Board to the ward". What the Board chooses to measure in its dashboard of information and the order in which it is considered not only drives organisational performance it also has symbolic meaning about what is of greatest importance. The information that is collected and shared at ward level is equally important. Participants highlighted further opportunities to strengthen an information culture within healthcare providers and commissioners and across the NHS:

- Making ward based performance more visible for patients and carers to see – at patients' bedsides or in information leaflets for example – may be more effective than displays at the back of nursing stations or at the entrance to the ward.
- Information collection and use that is championed and owned by clinical leaders at the top of the organisation. At both GOSH and at UBHT the medical directors take a leading role in promoting the development and use of the clinical information system.
- **Sir Muir** recommended that Trusts should have a Board level director with responsibility for knowledge management. This role would include responsibility

for improving the management and application of knowledge, leading the change in systems and culture within the organisation and the ways that it imports, stores, distributes and shares knowledge internally and with other providers and with patients and the public.

- Investment in skills and capacity of information analysts plus training to improve the information literacy of clinicians, managers and Board members. Several participants noted that having a larger proportion of people on the Board who have clinical backgrounds can help provide greater challenge over clinical performance. Yet it is also the case that all Boards, whatever their composition should ensure that they are as comfortable in reading and challenging clinical as financial performance information.
- Commissioning organisations have a role to play in specifying the information they require Trusts/services to collect, use and share in service specifications and contracts. Some participants from NHS Trusts for example expressed surprise that commissioners were not more demanding about the information they request on clinical quality and outcomes.
- National audits such as the large scale diabetes audit run by HQIP have potential to generate significant insights concerning good practice and performance improvement but they remain optional. Even where organisations do participate their Boards do not always have the opportunity to discuss the results. Given the move to national outcome measures some participants suggested there may be a case for compulsory participation in audits relating to national standards.
- The goal of sharing clinical performance information publicly can be an incentive for improving the quality and use of information but it needs careful handling to get the support of clinicians.

On this last point participants had mixed views. Some felt that NHS organisations needed to be more transparent about sharing their performance with the public. Foundation Trust quality accounts were felt to be a step in the right direction but are still far too variable in content. On a wider front there were some who felt that the NHS should share activity and performance data more widely, allowing a variety of users to access it and display the information to the public in different ways, welcoming the Government's commitment to transparency. They argued that it was important to keep up with the way people use information and communicate in their everyday lives – using smart phone applications and social media, which are becoming more widespread. However, it was also noted that while there is evidence of growing demand for websites such as NHS Choices there is less evidence that the performance information actually changes behaviour.

Robin Burgess highlighted that there are risks in such a plural approach: "*this is profoundly misguided. It opens the door to publicity for bad science, where inadequate teams conduct methodologically flawed analyses. At the very least it can*

create misleading reporting, that people believe tells them something but is poorly analysed or constructed". He warned this could lead to poor choices, confusion and poor commissioning.

Participants agreed that good quality information to drive performance improvement is neither cheap nor a quick fix yet it is an essential ingredient for driving quality improvements in the care of individual patients and for services and organisations.

The electronic record was felt to be a minimum requirement for all Trusts. Without this it will be difficult for Trusts to access, analyse and present relevant outcomes that can connect care that patients receive across primary, secondary and tertiary care. With the demise of the national IT programme Trusts needed to prioritise local investment to deliver electronic records as soon as possible and use these records as the core basis for aggregating clinical performance information. One commentator suggested that Trusts should not ask '*can we afford to do this but can we afford not to'.*

8. COMMISSIONING

Introducing the discussion on commissioning Robert Francis QC described the way that commissioners (the Primary Care Trust and GPs) had performed in identifying and responding to the events at the Mid Staffordshire NHS Foundation Trust. GPs in particular had not shared the concerns that their patients had raised, perhaps because there was no systematic way of gathering patient views and experience.

Both this Inquiry and previous public inquiries such as that on children's heart surgery at Bristol have highlighted the question of accountability for the quality and safety of healthcare and whether is it healthcare providers or healthcare commissioners who are ultimately accountable for the quality of services delivered to local people. The commissioning seminar participants had mixed views about whether the ultimate accountability rests with the new clinical commissioning groups (CCGs) or providers. They were reminded by **Dr Judith Smith's** research that past experiences and incarnations of commissioning leave significant questions about whether commissioners will have the skills, capacity and courage to identify situations of poor performance and take sufficiently decisive action to remedy the problems[26].

[26] J. Smith and N. Curry (2011) NHS commissioning – learning from the past, reflections on the future. Paper for the Mid Staffordshire Public Inquiry Seminar on the role of commissioning in securing safety and quality in healthcare

The commissioning seminar looked at two issues:

- What can be learned from the history of commissioning regimes and international experience?
- What the new commissioning system needs to do differently if it is to be effective in preventing/addressing a situation such as that which occurred at Mid Staffordshire?

WHAT CAN BE LEARNED FROM THE HISTORY OF COMMISSIONING AND INTERNATIONAL EXPERIENCE?

Introducing this discussion **Dr Judith Smith**, Head of Policy at the Nuffield Trust explained that there have been seven different forms of commissioning since the purchaser-provider split was introduced in the early 1990s. While these organisational changes make it difficult to track achievements over time she suggested that the research evidence points to the following achievements and limitations.

Figure 7: the achievements and limitations of commissioning

The achievements of commissioning	Where commissioning has struggled
• Implemented numerous national service plans and strategies • Contributed to major reductions in waiting times, and the achievement of other access targets • Specialised commissioning that is respected internationally • Put in place a range of new providers that extended choice and competition • Innovative public health developments with local authorities and others	• Difficulty in controlling GP referrals and activity in general • Inability to shift care to ambulatory settings, encourage new forms of care, etc. • Lack of power relative to providers, especially Foundation Trusts • Lack of clinical engagement in and support for commissioning decisions • Lack of technical capacity and capability in analysis of need & demand, risk profiling, budget management, prioritisation, etc.

Drawing on their past and current experiences participants concluded that with each iteration of commissioning, including the transition to clinical commissioning groups, the attention has tended to focus on the structure or 'anatomy' of the arrangements. More discussion is needed about the 'physiology' of the commissioning process - how it will be different to the previous regime and how

clinical commissioners can overcome the power imbalance with large healthcare providers that has dogged previous iterations of commissioning.

Participants identified three things that they felt would continue to challenge the new commissioning arrangements:

- meaningful public and patient engagement in decision making;
- the shift towards commissioning for outcomes and for whole care pathways and whether an outcome approach would be sufficient to enable CCGs to identify situations of poor clinical care; and
- the degree of freedom that CCGs will have when they become statutory bodies.

WHAT DOES THE NEW COMMISSIONING SYSTEM NEED TO DO DIFFERENTLY?

Participants supported **Professor Dr David Colin Thomé's** view that CCGs need to be even better than their predecessors in making sure that healthcare providers put quality and safety as top priorities[27]. He noted that GPs are highly trusted by the public to work in their best interests and it is important that CCGs do not compromise this and they should instead think of themselves as representing the 'people's NHS'. Participants acknowledged that many of the things that CCGs need to do are already being done in commissioning systems across the country. The key differences will be how they combine and apply these elements, the way that they engage and deploy the clinical skills of GPs in the commissioning process and the nature of the commissioning support that they secure to support them.

The case study presented by **Dr Ken Aswani**, Medical Director and **Conor Burke**, Director of Commissioning Support for NHS Outer North East London (ONEL) reinforced these points[28].

From the presentations and discussion several themes emerged concerning the characteristics of the new commissioning system if it is to be more effective in identifying and tackling examples of poor performance:

- Commissioners need to invest in intelligent and imaginative use of qualitative and quantitative information that combines primary and secondary care data and diverse sources of information about patient experience to inform their commissioning plans and contract monitoring. There is no shortage of data that can be used but it needs to be combined to provide useful insights on needs and

[27] David Colin-Thomé (2011) NHS Commissioning: paper for the Mid Staffordshire Foundation Trust Inquiry Seminar

[28] K. Aswani and C. Burke (2011) Commissioning for quality and safety: using levers and incentives for improvement: presentation to the Mid Staffordshire Inquiry commissioning seminar

demands on the one hand and healthcare performance and outcomes on the other.

- There will need to be more collaborative work between primary and secondary care clinicians to identify and agree how poor quality or inefficient care should be addressed. However, CCGs may also need to access independent specialist advice from outside the local system to advise them about improving services or supporting the turnaround of poor care by local providers. The NHS Commissioning Board may be able to help establish this support across CCGs.
- Public and patient engagement needs to be more intensive and more effective. CCGs will need to make better use of deliberative processes to involve the public and patients in difficult decisions early on rather than using formal consultations to ratify predetermined options. CCGs also need to have systematic processes for capturing patient experiences.
- CCGs will need more robust early warning systems of poor quality care based on qualitative feedback and stories from patients as well as clinical indicators. In some services, such as maternity services, these indicators have been developed in response to incidences of poor care but there is further work to do to roll out this approach across other services. CCGs will also need to be more assertive in the way they monitor contract outputs and outcomes.
- CCGs will have limited management resources to support the commissioning process. To be effective they need to prioritise how they deploy their expertise and understand the risks that this entails. The ONEL case study highlighted the scale of support and scrutiny that commissioners need to invest in to remedy situations where there are significant concerns in the quality of care provided locally and limited opportunities to buy services from alternative providers. This example also highlighted that CCGs will need to have both flexibility in their commissioning support arrangements to be able to target problem areas and great persistence in pursuing improvements. Related to this point participants warned that with lower management costs than their PCT predecessors it is important that CCGs are not weighed down with a huge burden of central requirements – they need to use that management support to improve and develop local services.
- Some participants felt that Health and Wellbeing Boards had significant potential to complement the work of CCGs as well as securing local commitments to significant service changes.
- CCGs need to be prepared to use contract levers and incentives imaginatively to encourage a focus on the outcomes they want to secure for their patients, including a specification of the information to be collected and shared. While the national contract allows for some incentive payments for quality (CQUINs), some argued that local commissioners might want to negotiate a higher percentage.

There was agreement that incentives are best developed locally rather than nationally imposed.

Overall, participants were optimistic that the new commissioning system will help to improve the quality of care. This optimism appeared to be based less on the evidence that clinical commissioning can make a difference (as set out in **Judith Smith's** paper) than on goodwill and a belief that better relationships between primary and secondary clinicians will enhance the system's ability to identify and solve problems and to make care better within the resources available. The case study presented illustrated that if CCGs are to represent the 'People's NHS' these clinical relationships cannot be too cosy. Commissioners need to take decisive action, use appropriate sanctions if local services present unacceptable risks to patients and doggedly pursue and monitor the improvements that they want to see.

9. Regulation

The history of events at the Mid Staffordshire NHS Foundation Trust raised questions about the speed and response, and the respective roles and relationships of and between different regulators. The seminars considered:

a) How the evolving regulatory system operates, what improvements can be made and what lessons the NHS can learn from other sectors
b) The levers and powers that regulators should have and how they should work together
c) Whether there is a case for a single NHS regulator going forward

THE CURRENT REGULATORY SYSTEM AND OPPORTUNITIES FOR IMPROVEMENT

The system of healthcare regulation is in a state of transition with some elements, such as the future role of Monitor, being subject to changes in legislation. Seminar participants were unclear about how standards and outcomes might be set under the new health reforms and whether NICE, for example, would coordinate standards set by others or just set their own new ones. Despite this uncertainty the seminars provided some interesting insights about the changes to date.

The seminar on culture looked at whether the way that targets and standards are set by the Department of Health and enforced by regulators are key determinants of Trust performance. Interviews undertaken by **Nigel Edwards** for his paper to the seminar on culture revealed that the current regime has *some* positive features.[29]

[29] Nigel Edwards (2011) Balancing external requirements with a positive internal culture, paper for the Mid Staffordshire NHS Foundation Trust Public inquiry seminar on organisational culture

"You have to be top of your game to make meeting the targets and regulation work, there's no room for learning. You can't just monitor on financial results. Often the Trust with the best financial record does not have the best clinical outcomes, and you need to manage the two together." Chief Executive

"10 years ago, before we became a Foundation Trust, regulation was primarily around finance and waiting times, and then Monitor came along and brought a completely new business-like approach to the process." Chief Executive

In the seminar on regulation we heard too that the focus of the Care Quality Commission on quality and outcomes is more in line with the priorities that most Trusts would want to set for themselves.

The main point of contention is how well the regulatory system responds to situations of organisational failure. **Nigel Edwards** concluded from his research that "*Where the Trust is performing well the external regulatory system is tolerable if not benign. However, once an organisation gets into difficulties an unhelpful spiral of intervention, performance management and other activities can create the type of narrow focus and loss of grip seen in all of the most significant quality failures in the last decade…… Perhaps the most concerning aspect of this is that much of the action taken has the appearance of being about the management of the reputational and other risks to the performance management body or regulator. The questions that are asked and the oversight that is given may be intended to assist the Trust that is in difficulty, but it has very little added value and can be a significant distraction".*

Similar points were made during the seminar on regulation. Further issues that participants identified with the current system's ability to identify poor quality care and support its improvement were:

- The complex regime of oversight of NHS Trusts by professional, technical and service regulators means that Trusts have too many standards and information requests to meet and there is confusion between minimum standards and aspirational ones – participants were clear that they thought aspirational standards should be a matter for local providers and commissioners to set with input from patients.
- Professional regulators can be slow to respond to referrals from NHS Trusts which can jeopardise care and add to its costs.
- It was also acknowledged that there was room to improve the linkages between system and professional regulators. Participants cited examples of interventions by regulators that were not coordinated, where information was not shared and even withheld and where insufficient account was taken of the local operating context.

- The system of predictive analysis to identify risks of organisational or service failure still needs to be improved, particularly given how much is known about the characteristics of vulnerable organisations and behaviours.
- The role of regulators in advising on how care can be improved and in sharing learning remains unclear. There are risks if regulators move too far into prescribing the way care should be delivered as this could put them in the awkward position of 'marking their own homework'.
- While self assessments do not provide sufficient safeguards for the public and patients, there are some concerns about whether an inspection system might present a disproportionate response to the level of risk.

In the seminar on regulation we heard presentations from two different systems. Dr **Andrew Spurr**, Managing Director Nuclear, EDF Energy [30] and **Nick Hardwick**, the Chief Inspector of Prisons[31]. We also heard from **Dr Peter Homa**, Chief Executive of Nottingham University Hospitals Trust[32] about his experience of previous iterations of healthcare regulation, including the Commission for Health Improvement.

The key learning point from **Dr Andrew Spurr** was the very strong focus within the industry on accountability for quality and standards within organisations. As Andrew put it "*I don't expect the regulator to do my job for me"*. Robust data, control and monitoring systems and Board visibility in power plants to validate what the data tells them were the ingredients of success that struck a chord with NHS participants.

From the Prisons Inspectorate's methodology, participants noted three things that could have relevance to the NHS. The first was their primary focus on the impacts and outcomes of the prison system on prisoners. The second was the immediate feedback that the inspectorate gives to local stakeholders at the end of an inspection visit, followed by fast confirmation of the findings in a formal report. The third was the secondment arrangements between the prisons services and inspectorate which are seen as part of the career path of prison officers. This helps to ensure that the inspectorate keeps up with current trends in practice.

The presentations from **Dr Andrew Spurr** and **Dr Peter Homa** triggered a discussion about the potential benefits of a system of peer review. If well managed this can offer valuable learning for the reviewers as well as the reviewed. While acknowledging its potential contribution to improving healthcare, participants felt that on balance peer review would be most effective if it sat outside the regulatory system.

[30] Dr A Spurr (2011) The characteristics of effective and successful regulation in the nuclear industry, presentation to the Mid Staffordshire Public Inquiry seminar on regulation
[31] Nick Hardwick (2011) presentation to the the Mid Staffordshire Public Inquiry seminar on regulation
[32] Dr Peter Homa (2011) We live life forwards but understand it backwards, presentation to the Mid Staffordshire Public Inquiry seminar on regulation

In addition to these insights participants identified some practical things that could improve the current regulatory system.

- Further rationalisation of standards, data requests and data sharing, focused around the quality of care and outcomes for patients;
- A stronger focus on the regulation of systems rather than individual organisations. This would require regulators to consider commissioner contributions and would also provide greater attention to the whole care experience of patients, particularly where they need care from several healthcare providers.
- Closer working between organisational and professional regulators. While Memoranda of Understanding do exist this does not always translate into good behaviour in practice. A system by which regulators could get feedback from those they are regulating might help in identifying specific areas for improvement.
- Coordinated early warning systems and procedures for escalating interventions and a clear timetable for the production of the conclusions from regulatory reviews. Some went as far as to suggest joint inspections would be a step forward.

THE LEVERS AND POWERS OF REGULATORS

Participants identified three discrete roles for healthcare regulators:

- Permitting – the process that gives providers/professionals a licence to operate or practice;
- Checking– ensuring they continue to meet required standards;
- Raising standards – through adjusting standards and providing comparisons with others.

The current powers and levers available to healthcare regulators were felt to be adequate but the way they were deployed could be improved. The powers and levers that regulators have not only need to be specific in relation to each of these responsibilities they also need to take account of the responsibilities and activities of other bodies. It is not only the CQC and Monitor for example that have a responsibility for checking and raising standards - the NHS Commissioning Board and CCGs also have responsibilities in performance management and incentivising quality improvements.

NHS regulators already have considerable powers. There have been recent examples where the CQC has withdrawn a licence to operate from social care providers. Participants felt that that the CQC appeared to be more reluctant to apply such

sanctions in the healthcare sector but should not be deterred from using this lever if patients were being put at risk.

FUTURE RELATIONSHIPS BETWEEN CQC AND MONITOR

Subject to the passing of legislation all NHS providers will have a joint licence overseen by CQC and Monitor, with the CQC responsible for essential levels of safety and quality and Monitor responsible for ensuring continuity of essential services and for financial regulation. Participants considered whether there was a case for a simpler system with a single NHS regulator that looks at both financial stability and governance and service quality. While accepting that there is some logic to this argument participants were fearful of yet another structural change to the regulatory system. They noted **Dr Peter Homa's** warning that *"The Government often assumes that newly created inspectorates can operate more quickly than practical. There is considerable risk during a new inspectorate's early days due to new legal duties, staff, methods, untested Quality Assurance and internal and external relationships".* A further argument was that the regulatory system will shift considerably once all Trusts become Foundation Trusts and Monitor focuses solely on economic regulation. At that point there would be less potential overlap in regulatory roles.

Representatives from regulatory bodies pointed to the scale of responsibilities that such a body would have: *"to license significant numbers of providers and inspect over 50,000 locations as well as overseeing the operation of the market is too broad a spread"*

Concluding the discussion participants noted that it is not the regulators that are ultimately accountable for balancing financial stability and the quality and safety of healthcare. This rests with the Boards of healthcare providers and the bodies that commission their services. The primary role for regulators is to provide safeguards to the public and taxpayers by ensuring that required standards are met. Regulators can incentivise improvements in quality and performance through their regulatory systems and inspections but Trust Boards should be setting their own goals for improvement as a commitment to the people they care for and the staff that they employ.

Annex A

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Regulation Methods – Manchester – Thursday 13 October 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Mr Nick Hardwick (CBE)	Chief Inspector of Prisons	HM Inspectorate of Prisons
Dr Peter Homa (CBE)	Chief Executive	Nottingham University Hospitals NHS Trust
Dr Andrew Spurr	Managing Director	EDF Energy

Attendees

Ms Frances Blunden	Senior Policy Manager	NHS Confederation
Mr Patrick Cadigan	Registrar	Royal College of Physicians of London
Mr Adam Chapman (CP)	Partner	Kingsley Napley - Representing the Patients Association and AvMA
Mr Steve Coneys (CP)	Director of Communications and Public Affairs	West Midlands Strategic Health Authority
Mr John Coutts	Governance Advisor	Foundation Trust Network
Mr Ian Cumming	Director of Quality	National Quality Board
Mr Niall Dickson	Chief Executive and Registrar	General Medical Council

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website: www.midstaffspublicinquiry.com

Dr Anna Dixon	Director of Policy	The Kings Fund
Ms Ursula Everett	Legal Advisor	Collaboration and Competition Panel
Ms Bridget Fletcher	Chief Executive	Airedale NHS Foundation Trust
Mr Alan Hall	Director of Performance	Department of Health
Mr Charlie Helps	Data Protection Officer	University Hospitals Bristol NHS Foundation Trust
Dame Joan Higgins	Chair	NHS Litigation Authority
Mr Kevin Hunt (CP)	Associate Director of Business Planning and Development	National Clinical Assessment Service - National Patient Safety Agency
Ms Amanda Hutchinson	Interim Director of Regulatory Development	Care Quality Commission
Professor Peter Hutton	Inquiry Expert Assessor	University Hospitals Birmingham NHS Foundation Trust
Mr Nick Jones	Director of Compliance	Human Fertilisation and Embryology Authority
Mr Ken Lownds		Cure the NHS
Mr Don MacKechnie	Chair and Vice President of the Professional Standards Committee	College of Emergency Medicine
Ms Clare Marx	President	Royal College of Surgeons of England
Mr Adrian Masters	Director of Strategy	Monitor
Professor Jonathan Montgomery	Chair	NHS Hampshire
Ms Cathy Morgan	Senior Policy Manager	Department of Health
Dr Kieran Mullan	Head of Engagement & Strategy	Patients Association
Mr Kevin Myers	Deputy Chief Executive	Health and Safety Executive

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website: www.midstaffspublicinquiry.com

Dr Manjit Obhrai (CP)	Medical Director	Mid Staffordshire NHS Foundation Trust
Ms Julie Philips (CP)	Head of Corporate Governance	South Staffordshire Primary Care Trust
Dr Umesh Prabhu	Medical Director	Wrightington, Wigan and Leigh NHS Foundation Trust
Mr Alan Rosenbach	Special Policy Lead	Care Quality Commission
Professor Alastair Scotland	Former Director	National Patients Safety Agency
Mr Alex Sienkiewicz	Director of Corporate Affairs	Brighton and Sussex University Hospitals
Professor Terence Stephenson	President of Royal College of Paediatrics and Child Health	Academy of Medical Royal Collages
Mr Antony Sumara	Former Chief Executive (Aug 2009 – June 2011)	Mid Staffordshire NHS Foundation Trust
Dr Peter Venn	Chairman of the Professional Standards Committee	Royal College of Anaesthetists
Dr Lisa Walder	Deputy Director and Head of CQC legislation, policy and sponsorship	Department of Health
Mr Steve Walker	Chief Executive	NHS Litigation Authority
Ms Eileen Walsh	Director of Assurance	Oxford Radcliffe Hospitals NHS Trust
Dr Mike Watson	Medical Director	Conference of Postgraduate Medical Deans
Dr Suzette Woodward	Director of Patient Safety	National Patient Safety Agency

Observers

Mr Murray Anderson-Wallace
Mr Arthur Briggs
Mr Miguel Cubells

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website: www.midstaffspublicinquiry.com

Ms Jo Lenaghan
Ms Katrina McCrory
Dr Ross Hutchinson
Mr Steve Scott
Ms Diana Smith
Ms Stephanie McNamara
Mr Ralph Tomlinson

Inquiry Team

Miss Sarah Bromley	Inquiry secretariat team
Miss Joanna Edwards	Inquiry secretariat team
Mr Bill Gilliam	Inquiry solicitor team
Mr Phil Hayes	Seminar videographer
Miss Suzanne How	Inquiry secretariat team
Miss Gaby Insley	Inquiry press officer
Ms Isabelle Makeham	Inquiry solicitor team
Mr Alan Robson	Secretary to the Inquiry
Miss Tina Wing	Inquiry solicitor team

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website: www.midstaffspublicinquiry.com

Annex B

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Training and Development of Trust Leaders – Leeds – Tuesday 18 October 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Professor Naomi Chambers	Head of the Health Policy and Management Group	Manchester Business School
Dr Maxine Conner	Organisational development lead	South Tees Hospitals NHS Foundation Trust
Ms Karen Lynas	Director of NHS Top Leaders	Department of Health
Dr Judith Smith	Head of Policy	Nuffield Trust

Attendees

Ms Gill Bellord	Director for Employment Relations and Reward	NHS Employers
Ms Christine Braithwaite	Director of Policy and External Relations	Commission for Healthcare Regulatory Excellence (CHRE)
Ms Alex Bush	Interim Programme Director for Emerging Leaders	NHS Institute for Innovation and Improvement
Mr David Cain	Committee member for the North West	Managers in Partnership
Ms Suzanne Clabby (CP)	Deputy Director of the Mid Staffs Liason Team	Department of Health
Ms Clare Curren	Director of Human resources and organisational development	North Tees and Hartlepool Foundation Trust

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
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Dr Martin Else	Chief Executive	Royal College of Physicians
Mr Tony Giddings	Founder	Risky Business
Mr Mark Goldman	Governor	The Health Foundation
Professor Peter Hutton	Inquiry Expert Assessor	University Hospitals Birmingham NHS Foundation Trust
Mr Richard Jeavons	Chief Executive	Independent Reconfiguration Panel
Mr Toby Lambert	Policy Director	Monitor
Mr David Levy	Director of HR	Tees, Esk and Wear Valley NHS Trust
Mr David Loughton	Chief Executive	The Royal Wolverhampton Hospitals NHS Trust
Sir Stephen Moss	Chair	Mid Staffordshire NHS Foundation Trust
Mr Mark Redhead	Head of Policy	Foundation Trust Network
Mrs Janice Scanlan	Deputy chief executive	Appointments Commission
Mr David Scott	Chair	British Medical Association
Ms Julia R A Taylor	Programme Director	NHS Institute for Innovation and Improvement
Mr Gary Tharme	Account Development Director	Unipart Expert Practices
Ms Dawn Wickham (CP)	Assistant Chief Executive	South Staffordshire Primary Care Trust
Ms Caroline Wigley (CP)	Director of Leadership	West Midlands Strategic Health Authority

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Observers

Mr Antony Sumara
Ms Elizabeth Hopper
Ms Jo Lenaghan
Mr Steve Scott

Inquiry Team

Miss Sarah Bromley	Inquiry secretariat team
Miss Joanna Edwards	Inquiry secretariat team
Mrs Sarah Garner	Inquiry solicitor team
Mr Phil Hayes	Seminar videographer
Miss Suzanne How	Inquiry secretariat team
Mrs Alice Oliver	Inquiry press officer
Ms Catherine Pearson	Inquiry secretariat team
Mr Alan Robson	Secretary to the Inquiry
Mr Peter Watkin Jones	Solicitor to the Inquiry
Miss Tina Wing	Inquiry solicitor team

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
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Annex C

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Information – Leeds – Wednesday 19 October 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Dr Robin Burgess	Chief Executive	Health Quality Improvement Partnership
Professor Martin Elliott	Medical Director	Great Ormond Street Hospital
Dr Dave Rosser	Executive Medical Director	University Hospitals Birmingham NHS Foundation Trust
Professor Sir Muir Gray – paper prepared	Director	Better Value Healthcare Ltd

Attendees

Dr Martin Bardsley	Head of Research	Nuffield Trust
Ms Lucy Baxter (CP)	Secretariat and Parliamentary Manager	Department of Health
Mr Adam Chapman (CP)	Partner	Kingsley Napley – representing the Patients Association and AvMA
Mr Ian Cumming	Director of Quality	National Quality Board
Dr Mark Davies	Executive Medical Director	NHS Information Centre
Mr Charles Eales	Head of Government Relations	Microsoft UK
Ms Deborah El-Sayed	Programme Director	NHS Choices

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Mr David Evans	Senior Policy Officer	Information Commissioners Office
Ms Beccy Fenton (CP)	Deputy Chief Executive	Mid Staffordshire NHS Foundation Trust
Dr Cath Finn	Medical Director	UK Specialist Hospitals South West
Mr Tom Fothergill (CP)	Director of Finance	NHS Litigation Authority
Mr Forrest Frankovitch	Associate Director of Information and Corporate Reporting	NHS Yorkshire and the Humber
Ms Lindsay Garcia	ITU Manager and Clinical Lead	South Tees Foundation Trust
Mr Chris Graham	Director of survey development	The Picker Institute Europe
Mr Howard Grey	Director of Information	NHS Stockport
Dr Charles Gutteridge	National Clinical Director for Informatics	Connecting for Health
Ms Tricia Hamilton	Chief Nurse and Clinical Director	NHS Direct
Ms Gill Husband	Nursing Service Improvement Lead	South Tees NHS Foundation Trust
Professor Peter Hutton	Inquiry Expert Assessor	University Hospitals Birmingham NHS Foundation Trust
Mr Toby Lambert	Policy Director	Monitor
Ms Libby MacManus	Chief Nurse	York Teaching Hospitals NHS Foundation Trust
Mr Chris Mason (CP)	Head of Quality and Risk Profiles	Care Quality Commission
Ms Val Moore	Programme Director for Implementation	National Institute for Clinical Excellence
Mr Tim Straughan	Chief Executive	NHS Information Centre
Mr Mark Svenson	Deputy Director of Knowledge and Intelligence	Department of Health
Dr Mark Temple	Acute Care Fellow	Royal College of Physicians
Mr Dan Wellings	Health of Public Health Research	Ipsos Mori

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Professor John Williams	Consultant Gastroenterologist and Professor of Health Services Research	School of Medicine
Mr Richard Wilson (CP)	Head of West Midlands Quality Observatory	West Midlands Strategic Health Authority

Observers

Ms Elizabeth Hopper
Ms Jo Lenaghan
Ms Diana Smith
Mr Antony Sumara

Inquiry Team

Miss Sarah Bromley	Inquiry secretariat team
Miss Joanna Edwards	Inquiry secretariat team
Mrs Sarah Garner	Inquiry solicitor team
Mr Bill Gilliam	Inquiry solicitor team
Mr Phil Hayes	Seminar videographer
Ms Catherine Henney	Inquiry solicitor team
Miss Suzanne How	Inquiry secretariat team
Mrs Alice Oliver	Inquiry press officer
Ms Catherine Pearson	Inquiry secretariat team
Mr Alan Robson	Secretary to the Inquiry
Mr Peter Watkin Jones	Solicitor to the Inquiry

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Miss Tina Wing	Inquiry solicitor team

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
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Annex D

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Organisational Culture – London – Tuesday 25 October 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Sir Cyril Chantler	Chair	University College London Partners
Dr Jocelyn Cornwell	Programme Director for the Point of Care Programme	The Kings Fund
Mr Nigel Edwards	Senior Fellow of Leadership Development and Health Policy	The Kings Fund
Mr Antony Sumara	Former Chief Executive (Aug 2009 – June 2011)	Mid Staffordshire NHS Foundation Trust

Attendees

Ms Raja Al Khatib	Chief of Staff and Internal Communications	Vodafone
Professor Sir George Alberti	Chairman	Kings College Hospital NHS Foundation Trust
Ms Tracy Allen	Chief Executive	Derbyshire Community Services
Ms Jane Barrie (OBE)	Chair	NHS Somerset
Professor David Black	Inquiry Expert Assessor	Kent Surrey and Sussex Deanery
Ms Frances Blunden	Senior Policy Manager	NHS Confederation
Mr Steve Coneys (CP)	Director of Communications and Public Affairs	West Midlands SHA

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Mr Niall Dickson	Chief Executive and Registrar	General Medical Council
Mr Jim Easton	National Director for Improvement and Efficiency	Department of Health
Professor Brian Edwards		
Ms Kathlyn Fallon	Chief Executive	Bridgewater Community Healthcare NHS Trust
Mr Jan Filowchowski	Chief Executive	West Hertfordshire Hospitals NHS Trust
Ms Brenda Hennessey	Director of Patient Experience and Public Engagement	Cambridge University Hospitals NHS Foundation Trust
Ms Cathy James	Chief Executive	Public Concern at Work
Dr John Jenkins	Chair of the Postgraduate Board	General Medical Council
Ms Jane King (CP)	Non Executive Director	Mid Staffordshire Hospitals NHS Foundation Trust
Sir Thomas Legg	Non Executive Director	Imperial College Healthcare NHS Trust
Ms Jo Lenaghan	Director of Reform	National Quality Board
Sir Robert Naylor	Chief Executive	University College London Hospitals NHS Foundation Trust
Professor Christopher Newdick	Professor of Health Law	University of Reading
Dr Manjit Obhrai	Medical Director	Mid Staffordshire Hospitals NHS Foundation Trust
Ms Linda Pattison	Clinical Vice President	Royal College of Physicians
Ms Sue Price (CP)	Director of Primary Care and Specialist Commissioning	South Staffordshire Primary Care Trust
Mr Steven Ramsden	Director	Transforming Health Ltd
Ms Denise Randall (CP)	Mid-Staffordshire Public Inquiry Official Liaison	Department of Health

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Observers

Mr Murray Anderson-Wallace
Ms Papiya Chatterjee
Ms Erin Dean (Press)
Ms Paula Higson
Ms Louise Malloy
Mr Steve Scott
Ms PollyAnna Jones
Ms Stephanie McNamara
Mr Ralph Tomlinson
Ms Sarah Calkin (Press)

Inquiry Team

Ms Abigail Bright	Noting Counsel
Miss Sarah Bromley	Inquiry secretariat team
Miss Joanna Edwards	Inquiry secretariat team
Mr Bill Gilliam	Inquiry solicitor team
Mr Phil Hayes	Seminar videographer
Miss Suzanne How	Inquiry secretariat team
Miss Gaby Insley	Inquiry press officer
Ms Isabelle Makeham	Inquiry solicitor team

CP – Core Participant.
The person named is representing one of the Inquiry's designated core participants. A list of CPs can be found on the Inquiry website:
www.midstaffspublicinquiry.com

Mr Rhys Meggy	Noting Counsel
Ms Catherine Pearson	Inquiry deputy secretary
Mr Alan Robson	Secretary to the Inquiry
Miss Tina Wing	Inquiry solicitor team

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Annex E

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Nursing – London – Monday 31 October 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Professor Dawn Dowding	Professor of Applied Health Research	University of Leeds
Professor Katherine Fenton	Chief Nurse	University College London Hospitals NHS Foundation Trust
Ms Gill Heaton	Director of Patient Services and Chief Nurse	Central Manchester University Hospitals NHS Foundation Trust

Attendees

Ms Gail Adams	Head of Nursing	UNISON
Mr Darran Barnes	Chief Nurse	University College London Hospitals NHS Foundation Trust
Ms Ann Bates	Patient representative	
Dame Christine Beasley	Chief Nursing Officer - England	Department of Health
Ms Elaine Burke	Executive Nurse Director	Salford Royal NHS Foundation Trust
Dr Peter Carter	Chief Executive and General Secretary	Royal College of Nursing
Professor Hilary Chapman	Chief Nurse	Sheffield Teaching Hospitals NHS Foundation Trust
Mr Clive Constable	Director of Professional Affairs	Royal College of Physicians

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Mr Ian Cumming	Director of Quality	National Quality Board
Ms Jane Cummings	Chief Nurse	NHS North of England
Mr Niall Dickson	Chief Executive and Registrar	General Medical Council
Professor Judith Ellis	Council member	Nursing and Midwifery Council
Baroness Audrey Emerton		House of Lords
Ms Nancy Fontaine	Deputy Director of Nursing – Patient Safety and Quality	Whipps Cross University Hospital NHS Trust
Dr David Foster	Deputy Chief Nursing Officer	Department of Health
Ms Sandra Grey (CP)		West Midlands SHA
Ms Lillian Hamuntili	Chief Nurse	University College London Hospitals NHS Foundation Trust
Ms Tricia Hart	Inquiry Expert Assessor	South Tees Hospitals NHS Foundation Trust
Susan Hinchcliffe CBE	Chief Operating Officer and Chief Nurse	Leicester Hospitals NHS Trust
Ms Ruth Holt	Chief Nurse	Leeds Teaching Hospitals NHS Trust
Professor Peter Hutton	Inquiry Expert Assessor	University Hospitals Birmingham NHS Foundation Trust
Dr Varo Kirthi	Clinical Advisor to the President	Royal College of Physicians
Ms Jenny Leggot CBE	Deputy Chief Executive Officer and Director of Nursing	Nottingham University Hospitals NHS Trust
Ms Susan Mistry	Patient representative	
Ms Trish Morris-Thompson	Chief Nurse	NHS London
Mr Colin Ovington	Nurse Director	Mid Staffordshire Hospitals NHS Foundation Trust
Ms Flo Panel-Coates	Director of Nursing	Maidstone and Tunbridge Wells NHS Trust
Ms Jo Pattmore	Lead Nurse	Whipps Cross University Hospital NHS Trust

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Ms Liz Pryor	Patient representative	
Ms Denise Randall	Mid Staffordshire Public Inquiry Liaison	Department of Health
Ms Melanie Robertson	Oncology Nurse Consultant	City Hospitals Sunderland NHS Foundation Trust
Ms Eileen Sills	Director of Assurance	Guys and St Thomas NHS Foundation Trust
Ms Elaine Stevenson	Head of Project Development	South Staffordshire Primary Care Trust
Mr Antony Sumara	Former Chief Executive (Aug 2009 – June 2011)	Mid Staffordshire NHS Foundation Trust
Sir Richard Thompson	President	Royal College of Physicians
Ms Helen Thompson	Director of Nursing and Deputy Chief Executive	Calderdale and Huddersfield NHS Foundation Trust
Ms Jan Warren	Director of Nursing	NHS North Staffordshire
Ms Caroline Waterfield	Deputy Head of Employment Services	NHS Employers
Ms Amanda Webb	Chief Nurse	University College London Hospitals NHS Foundation Trust
Ms Em Wilkinson-Brice	Director of Nursing and Patient Care	Royal Devon and Exeter Hospitals NHS Foundation Trust
Dr Hamish Wilson	Council Member	General Medical Council
Dr Suzette Woodward	Director of Patient Safety	National Patient Safety Agency

Observers

Mr Murray Anderson-Wallace
Mr Robert Caldiera
Mr Darryl Chapman
Ms Papiya Chatterjee

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Ms Melanie Coombes
Mr Mark Docherty
Ms Jean Flanagan
Ms Paula Higson
Ms Petra Kendall-Raynor (Press)
Mr Peter Nolan
Professor Jane Reid
Ms Sharon Schofield

Inquiry Team

Ms Abigail Bright	Noting Counsel
Mrs Sarah Garner	Inquiry solicitor team
Mr Bill Gilliam	Inquiry solicitor team
Mr Phil Hayes	Seminar videographer
Miss Suzanne How	Inquiry secretariat team
Miss Gaby Insley	Inquiry press officer
Mr Rhys Meggy	Noting Counsel
Ms Catherine Pearson	Inquiry secretariat team
Mr Alan Robson	Secretary to the Inquiry
Miss Tina Wing	Inquiry solicitor team

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Annex F

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Patient Experience – Stafford – Wednesday 2 November 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Mr Julian Hartley	Chief Executive	University Hospitals of South Manchester NHS Foundation Trust
Mr Paul Hodgkin	Chief Executive	Patient Opinion
Ms Victoria Simpson	Director of Customer Services	The John Lewis Partnership

Attendees

Mr Malcolm Alexander	Chair	National Association LINks Members
Mr Murray Anderson-Wallace	Executive Producer	Patient Stories
Miss Julie Bailey	Founder	Cure the NHS
Mr Lee Bennett	Assistant Director Patient Experience and Public Engagement	PALs
Ms Sally Brearley	Chair	Health Link
Ms Tricia Curran (CP)	Associate Director of Quality	West Midlands SHA
Ms Angela Coulter	Senior Researcher	Oxford University Department of Public Health

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Mr Jim Easton	National Director for Improvement and Efficiency	Department of Health
Ms Deboarh El-Sayed	Programme Director	NHS Choices
Ms Louise Fish	Director of Communications and Engagement	NHS Confederation
Mr Tim Gilling	Deputy Executive Director	Centre for Public Scrutiny
Mr Chris Graham	Director of Survey Development	The Picker Institute
Ms Valerie Harrison	Chief Executive	POhWER
Ms Tricia Hart	Inquiry Expert Assessor	South Tees Hospitals NHS Foundation Trust
Mrs Deborah Hazeldine	Member	Cure the NHS
Ms Julie Hendry (CP)	Director of Quality and Patient Experience	Mid Staffordshire NHS Foundation Trust
Ms Brenda Hennessey	Director of Patient Experience and Public Engagement	Cambridge University Hospitals NHS Foundation Trust
Ms Penny Henrion	Chair	NHS Berkshire West
Ms Delilah Hesling	Safety Ombudsman	Brighton and Sussex University Hospitals NHS Trust
Ms Elaine Hide	Director of Quality	Luton and Dunstable Hospital NHS Foundation Trust
Ms Kathryn Hudson	Deputy Parliamentary and Health Service Ombudsman	NHS Ombudsman
Ms Suzie Hughes	Chair of the Patient and Carer Network	Royal College of Physicians
Professor Peter Hutton	Inquiry Expert Assessor	University Hospitals Birmingham NHS Foundation Trust
Ms Hana Ibrahim	Equality and Human Rights Project Manager	Macmillan Cancer Support
Ms Jo Lenaghan	Director of Reform	National Quality Board
Mr Russell Levy	Chair of the Clinical Disputes Forum	Leigh Day and Co

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Dr Martin McShane	Director of Strategy and Commissioning	Director of Strategy and Commissioning
Ms Nicola Monte	Member	Cure the NHS
Dr Kieran Mullan	Head of Engagement & Strategy	Patients Association
Ms Jane Parker	Assistant Director of Organisational Development	Peterborough and Stamford Hospitals NHS Foundation Trust
Ms Julie Philips (CP)	Head of Corporate Governance	South Staffs PCT
Ms Margit Physant	Policy Advisor (Health and Well-being)	Age UK
Dr Michael Rudolf	Patient Involvement Officer	Royal College of Physicians
Ms Joan Sadler	National Director Patient and Public Affairs	Department of Health
Mr Antony Sumara	Former Chief Executive (Aug 2009 – June 2011)	Mid Staffordshire NHS Foundation Trust
Mr Sam Sumara	Trainee Nurse	Mid Staffordshire NHS Foundation Trust
Mr Jeremy Taylor	Chief Executive	National Voices
Mr Nigel Thompson (CP)	Head of Involvement, equality and human rights	Care Quality Commission
Ms Ruth Thorlby	Senior fellow in Health Policy	Nuffield Trust
Mr Peter Walsh (CP)	Chief Executive	AvMA
Ms Mandy Wearne	Director of Provider and Market Development	NHS North West
Mr Michael West (CP)	Policy Manager	Department of Health
Dr Suzette Woodward	Director of Patient Safety	National Patient Safety Agency

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Observers

Mr Robin Bastin
Ms Jenny Betteridge
Ms Christine Bowers
Ms Sonia Burnhill
Ms Shanna Crispin (Press)
Mrs Christine Dalziel
Mr Roger Dobbing
Mrs Ann Dobbing
Professor Brian Edwards
Ms Joyce Farnham
Mr Jeff Guest
Mr Steven Hazeldine
Ms Jo Hornby
Mr John James
Ms Sharan Johal
Mr Chris King (Press)
Ms Tanya Love
Ms Mary Millington
Mr Keith Morris

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Ms Katie Morris
Mr Peter Nolan
Mr Patrick Nyarumbu
Ms Aileen Orr
Ms Nicola Sawyer
Ms Kay Sheldon
Ms Diana Smith
Ms Judy Turner
Mr Robert Vaughan
Mr John Waterfall
Ms Paula Wells

Inquiry Team

Ms Abigail Bright	Noting Counsel
Miss Sarah Bromley	Inquiry secretariat team
Miss Joanna Edwards	Inquiry secretariat team
Mr Bill Gilliam	Inquiry solicitor team
Mrs Sarah Garner	Seminar videographer
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Mr Alan Robson	Secretary to the Inquiry
Mrs Alice Oliver	Inquiry press officer
Miss Tina Wing	Inquiry solicitor team

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Annex G

Mid Staffordshire NHS Foundation Trust Public Inquiry

The Forward Look Seminars

Commissioning – London – Thursday 3 November 2011

List of attendees

Inquiry Chairman

Mr Robert Francis QC	Chairman	Mid Staffordshire NHS Foundation Trust Public Inquiry

Facilitator

Dr Sarah Harvey	Director	Loop 2

Speakers

Dr Ken Aswani	Medical Director	Outer North East London PCT Cluster
Mr Connor Burke	Executive Director of Commissioning	Outer North East London PCT Cluster
Professor David Colin-Thome OBE	Director	DCT Consulting
Dr Judith Smith	Head of Policy	Nuffield Trust

Attendees

Dr Charles Alessi	Chair elect	National Association of Primary Care
Mr Patrick Cadigan	Registrar	Royal College of Physicians of London
Mr Darren Catell (CP)	Director of Finance and Performance	Mid Staffordshire NHS Foundation Trust
Ms Caroline Clarke	Director of Finance	Royal Free Hampstead NHS Trust
Ms Natasha Curry	Senior fellow in Health Policy	Nuffield Trust
Dr Peter Dickson	Senior Policy Adviser	National Clinical Assessment Service
Dr Amanda Doyle	Medical Director	NHS Blackpool

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Ms Moira Dumma (CP)	Director of Commissioning Development	West Midlands SHA
Mr Ben Dyson	Director of policy, commissioning and primary care	Department of Health
Professor Steve Field	Chairman of Council – Royal College of General Practitioners	Academy of Royal Medical Collages
Dr Clare Gerada	Chair	Royal College of General Practitioners
Mr Geraint Griffiths (CP)	Acting Chief Executive	South Staffordshire PCT
Dame Barbara Hakin	National Director of Commissioning Development	Department of Health
Dr Jane Halpin	Chief Executive	NHS Hertfordshire
Ms Caron Heyes (CP)	Head of Clinical Negligence	Blake Lapthorn – on behalf of Action Against Medical Accidents
Ms Jo Lenaghan	Director of Reform	National Quality Board
Ms Cathy Maddaford	Director of Nursing, Quality and Performance	NHS Cheshire
Ms Elizabeth Manero	Director	Health Link Ltd
Mr John McIvor	Chief Executive	NHS Lincolnshire
Dr Kieran Mullan	Head of Engagement & Strategy	Patients Association
Ms Denise Randall (CP)	Mid-Staffordshire Public Inquiry Official Liaison	Department of Health
Professor Elizabeth Robb	Chief Executive	The Florence Nightingale Foundation
Mr Graham Urwin	Chief Executive	PCT cluster
Ms Elizabeth Wade	Senior Policy Mangager	Primary Care Trust Network
Mr Mike Weston	Patient representative	
Mr Paul Zollinger-Read	Medical Advisor and Clinical Lead on Primary Care	The Kings Fund

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Observers

Ms Sarah Calkin (Press)
Mr Andy Cowper
Mr James Ewing
Mr Patrick Keady
Ms Maeve Lawrence
Alex Morton
Ms Mary Parkes
Ms Diana Smith
Ms Lesley Tittlotson
Mr George Wiskin

Inquiry Team

Ms Abigail Bright	Noting Counsel
Miss Sarah Bromley	Inquiry secretariat team
Miss Joanna Edwards	Inquiry secretariat team
Miss Suzanne How	Inquiry secretariat team
Mr Rhys Meggy	Noting Counsel
Ms Catherine Pearson	Inquiry secretariat team
Mr Alan Robson	Secretary to the Inquiry
Mrs Alice Oliver	Inquiry press officer

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Mr Peter Watkin Jones	Solicitor to the Inquiry
Miss Tina Wing	Inquiry solicitor team

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